



Service Name and Description

Short Term Residential Stabilization

Short Term Residential Stabilization (STRS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active habilitation services and supports to assist them with skill acquisition to live as independently as possible in the community. STRS is a community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD). STRS is an alternative definition in lieu of ICF-IID under the Medicaid 1915(b) benefit. This service enables Alliance to provide short term comprehensive and individualized active treatment services to adults with I/DD, who meet ICF-IID level of care requirements, to maintain and promote their functional status and independence while keeping crisis facilities and emergency departments open to serve medical needs. There are individuals that are currently in Emergency Departments awaiting admission to ICF-IID. Alliance intends to utilize this service framework to move members from the Emergency Departments as an alternative service to ICF-IID once the emergency is resolved.

Each participant in STRS must have presented to or was admitted to Emergency Departments, Hospitals or Facility Based Crisis immediately prior to admission. STRS does not include room and board payments. STRS must be provided in the least restrictive level of Residential Supports based on the assessed needs and health and safety of the individual.

Procedure Code:

T2016 TF U5

Provider Organization Requirements

Providers must be enrolled in NC Tracks and is provided by organizations accredited and have a NCDHSR license as a group home provider (.5600c.)

Provider enrolled in Alliance Health's (Alliance) network or providing similar service in other LME-MCO catchments.

State Nursing Board regulations must be followed for tasks that present health and safety risks to the member as directed by Alliance' Medical Director or designee.

Staffing Requirements by Age/Disability

Direct Support 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)

Qualified Professional

Bachelor's Level Qualified Professional with two or more years post-graduate experience with the population served. In accordance with 10 NCAC 27G.0104

Program and Staff Supervision

All staffing must comply with NCAC 10 A 27G .0203 as well as the regulating licensing boards, or recognized tribal code.

Service Type/Setting

This service is provided in small group homes, licensed .5600 C's AFL's or .1700 for co-occurring disorders.

Objectives and Goals

STRS provides individualized services and supports to enable a person to live successfully in a Group Home setting of their choice and be an active participant in his/her community. The intended outcome of the service is to assist the individual to acquire the behavioral skills and prevent or decelerate regression of functional skills , provide the supervision needed, maximize his/her self-sufficiency, use self-determination and ensure the person's opportunity to have full membership in his/her community.

STRS is provided in licensed .5600C group home facilities. STRS includes acquiring and retaining skills to assist the person to complete an activity to his/her level of independence. STRS includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety.

STRS provides for services, including integrated health care services and nutrition, and may include nursing support when needed based on the person-centered plan. The service needs are based on a comprehensive assessment and the person-centered plan is developed with the person with input from their chosen provider agency and team.

STRS is Group Living (group homes with 4 or less people) with 24 hour awake staff.

STRS may require 1:1 staffing as a documented need in the beneficiaries' PCP.

The service includes:

- Choosing and learning to use appropriate assistive technology to reduce the need for staffing supports
- Being a participating member in community life
- Managing personal financial affairs, as well as other supports
- Addressing issues that led to presentation to crisis services
- Members in this service may be eligible for therapeutic leave for up to 15 days per episode of care.
- 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. STRS 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:

- Ensure beneficiaries are not utilizing crisis medical resources due to lack of ability to admit to an ICF-IID
- Enable stable living in the community at the least restrictive level of care. State of North Carolina

- Provide supports to enable the acquisition and maintenance of necessary skills to live as independently as possible in the community
- Enable effective use of the intrinsic strengths necessary for sustaining behavioral, functional and habilitative improvement and enabling stability
- Services include both direct face-to-face, indirect contacts, and collaboration with other systems. However, most of contacts are face to face direct with the individual.

Expected Outcomes:

- STRS assists individuals with meeting their daily living needs while exercising meaningful choice and control in their daily lives. Services and supports are implemented in accordance with each individuals' unique needs, expressed preferences and decisions about their life in the community. Services and supports include education and resources for members and caregivers to maintain personal safety, the safety of others and obtain resources required to remain in the community. These services will allow individuals to continue living in the community and avoid functional decline leading to costly emergency department visits and hospitalizations,.
- STRS is designed to foster individual's nurturing relationships, full membership in the community, and avoid crisis leading to hospitalization, presentation in emergency departments or facility based crisis.
- STRS 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 STRS provider is responsible for all activities, including Day Services as allowable. STRS participants are expected to move into more independent settings once stabilized in the community with other supports. Transition and discharge planning begins at admission and must be documented in the PCP.
- As an In-Lieu-of service to ICF-IID Level of Care, member's stepping down or out of this service are eligible to receive Innovations or ICF-IID.

Entrance Criteria & Eligibility Requirements

The beneficiary is eligible for this service when all of the following criteria are met:

- a. Has an Intellectual Disability or related condition resulting in functional limitations in three or more of the following major life areas:
 - i. Self-Care
 - ii. Understanding and use of language
 - iii. Learning
 - iv. Mobility
 - v. Self-Direction
 - vi. Capacity for Independent Living

AND

- b. The related condition manifested before age 22 or the presence of an Intellectual Disability as defined in NCGS 122C-3 (12a)

AND

- c. NC SNAP Index D (93-230)

OR

- d. **Supports Intensity Scale (SIS)** - Members will have a completed SIS assessment which documents at least one score of “2” in either the Exceptional Behavioral Supports or Exceptional Medical Supports sections. This score of “2” indicates a need for extensive support for the member to remain safe and well in the community.

AND

- e. Present for admission to the hospital, Emergency Room, or Facility Based Crisis with a need for intensive post-stabilization support services.

This service may be a part of an aftercare planning process (time-limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

Continued Stay Criteria

The Re-assessment of the individual’s needs must occur every 30 days to assess for progress towards goals.

The individual is eligible to continue this service if:

- a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual’s PCP; OR
- b. The individual continues to be unable to function in an appropriate community based setting, based on ongoing assessments of functional gains.

AND

- c. One of the following applies. The individual:
 - i. Beneficiary has achieved current PCP goals, and additional goals are indicated as evidenced by reassessments of support needs. OR
 - ii. Beneficiary is making satisfactory progress toward meeting goals, and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP. A step-down plan has been established for titrating intensive supports needs. OR
 - iii. The beneficiary is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with his or her level of functioning, are possible.
 - iv. Beneficiary fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The individual’s diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria

The beneficiary meets the criteria for discharge if:

Beneficiary’s level of functioning has improved with respect to the goals outlined in the person centered plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and ANY of the following apply:

- a. Beneficiary has achieved goals, discharge to a lower level of care is indicated; OR
- b. Beneficiary is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

Authorization

Prior approval is required. When it is medically necessary for the length of stay to exceed 120 days per episode of care, a new comprehensive assessment or addendum to previous assessments must be completed. A copy of the member's PCP, Service Order and comprehensive assessment are required for initial authorization. Updated PCP is required for reauthorization.

Service order by a physician is required for this service on the date of admission.

General Criteria Covered:

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

Service Documentation Requirements

A service note must be documented for each shift and staff time spent on direct and indirect contacts in compliance with APSM 45-2.

Service Exclusions

Members participating in the Innovations or TBI waivers are not eligible to receive this service.

Members enrolled in or receiving Medicaid B3DI are not eligible to receive this service unless part of a transition step-down plan. Up to 30 days may be authorized at the same time as B3DI to facilitate transition planning.

This service may not be provided in inpatient hospitals, nursing facilities, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF).

This service may not duplicate any other Medicaid or state reimbursable service, including but not limited to Medicaid (b)3 Services.

Family members or legally responsible persons of the beneficiary may not provide this service for reimbursement.

Tailored Care Management is allowed concurrently. Any activities associated with directing or linking care are done in coordination with the Care Plan to ensure no duplication of these activities and those functions are directed toward this service intervention.

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed Qualified Professional). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed Qualified Professional; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. That is unsafe, ineffective, or experimental or investigational.
2. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem.