

**Alternative or “in Lieu of” Service Description**  
**Template**

**1. Service Name and Description: Short Term Residential Stabilization**

**Procedure Code: T2016 TF U5**  
**STRS \$303.00 per diem**

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.

**2. Information About Population to be Served:**

<b>Population</b>	<b>Age Ranges</b>	<b>Projected Numbers</b>	<b>Characteristics</b>
<p>Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports and presenting to hospitals and crisis services.</p>	<p>Age 21 and over</p>	<p>15-20 individuals are anticipated.</p>	<p>Available only for individuals in need of and receiving comprehensive and intensive habilitative supports— aggressive, consistent implementation of a program of specialized and generic habilitative training, treatment and integrated health services.</p> <p>Medicaid eligible</p> <p>Age 21 or older</p> <p>Meet ICF-IID eligibility criteria and/or the definition of developmental disability at NCGS 122C-3 (12a)</p> <p>In need of immediate post crisis stabilization from an emergency room, facility based crisis or inpatient facility.</p>

### **3. Treatment Program Philosophy, Goals and Objectives:**

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.

- 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.

#### **4. 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.

#### **5. Utilization Management:**

##### **Entrance Criteria**

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

- A. Require active treatment necessitating the ICF/IID level of care;

AND

- B. 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

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

AND

D .Is likely to continue indefinitely;

AND

E. NC SNAP Index D (93-230)

OR

F. .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

G. 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**

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

## **6. 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.

Medicaid shall not cover active treatment when it includes services to maintain generally independent beneficiaries who are able to function with little supervision or in the absence of a continuous active treatment program (42 CFR 483.440(a)(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.

**7. EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age**

**a. 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 practitioner).

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 practitioner; 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.

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 problems.

#### **b. 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: <https://medicaid.ncdhhs.gov/>

### **7. Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:**

Provider Qualifications:

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

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:

Alliance Health

Frequency of Verification:



Alliance verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by Alliance, 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 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.

**8. Unit of Service:**

Per Diem

**9. Anticipated Units of Service per Person:**

- **90-120 units**

This may be longer or shorter dependent upon needs identified in the Person Centered Plan.

**10. Targeted Length of Service:**

90-120 days maximum

**11. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**

Currently, individuals are placed in ICF-IID services in state institutions or community-based ICF-IID facilities due to a lack of available services for this population. ICF-IID's are not freely admitting new beneficiaries, creating a backlog of individuals, already underserved that are utilizing precious medical resources in emergency rooms and crisis facilities. STRS are needed for these adults with IDD as a bridge to moving back into their families, and or in their community. There are no other services available to meet this need.

STRS is temporarily intended to replace or divert the use of ICF-IID, but will be utilized to prevent people from accessing higher levels of care in the absence of services and address the unmet needs of Medicaid eligible individuals to have the opportunity to get the active treatment needed to live in the community. While historically service provision has favored institutional settings, the pendulum has swung toward a preference for community based services and independent living, which decrease isolation and increase integration for individual with developmental disabilities. NC has done little to downsize institutions that are the costliest level of care available in the state.

Alliance intends to use STRS to facilitate admissions during to avoid individuals being presented in crisis to medical facilities or crisis facilities. This continues to be a need for the Alliance continuum.

**10. Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.**

- a) **Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)**

Service	Procedure Code	Unit Definition	Units of Service	Unit Cost of Service	Annual Cost
ICF-IID Community & Institutional	Revenue Codes 100, 101 and 183	Per diem	365	Avg of \$323.71 per day per individual (rates vary but this is avg daily rate)  Range of ICF- IID's vary greatly from 800 per day to 250 per day.	Avg of 38,845 per individual, for 120 day stay.  At high end it could be 96,000 per 120 day stay. Cost at current ICF Rate is \$776,900 for 20 individuals
Emergency Department Costs	Codes Vary based on procedures	Per procedure	Per Diem	Average base cost per episode \$442.52 per day	\$53,102 per individual for 120 day stay.,  If 20 individuals receive their care in the ED, the cost for 120 days is \$1,620,400

**b) Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)**

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service*
SHORT TERM RESIDENTIAL SUPPORTS	<b>T2016 TF U5</b>	Per diem	120 days per year	\$ 36,330 727,200 for 20 individuals annually.

**Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)**

Encounter data will be filed daily for each day services are rendered to the individual. Provider would collect and report/provide access through sharing of the health record to all encounter data. At a minimum, this would include time spent on direct and indirect service.

**Description of Monitoring Activities:**

LME/MCO will monitor admissions and concurrent stay through Utilization Management and Review processes.

LME/MCO Network Management will monitor providers delivering STRS for compliance. Ongoing monitoring of complaints, incident reports, quality of care concerns, audits etc. will occur as needed.