Community Living Facilities and Support (CLFS)

Procedure code: License: (ICF-IID) Codes with Modifiers
T2016 U1 U5 – LEVEL 1, T2016 U2 U5 – LEVEL 2
T2016 U3 U5 – LEVEL 3, T2016 U4 U5 – LEVEL 4
T2016 U5 – LEVEL 5

DESCRIPTION:

Community Living Facilities and Supports (CLFS) 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.

CLFS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities. CLFS for individuals with intellectual disability is an alternative definition in lieu of ICF-IID under the Medicaid 1915(b) benefit. This service enables Trillium to provide comprehensive and individualized active treatment services to adults to maintain and promote their functional status and independence. This is also an alternative to home and community-based services waivers for individuals that potentially meet the ICF/IID level of care.

Individuals who choose CLFS 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 their lease for the room in the home along with the choice of the agency or other people who support them. Each of these people will need an independent care coordinator who can provide them with information about affordable housing options, sources of financial support such as Supplementary Security Income (SSI), and oversight of their overall behavioral healthcare and long term service needs. For many adults CLFS is best practice and is far more cost effective than ICF-IID and more readily available than the current Innovations Waiver with limited slots. Many of these people may end up in institutions without this alternative.

Each participant in CLFS must either stay in homes they own, their family owns or have a lease in the community. The participant must be able to control where they live. CLFS does not include room and board payments. CLFS must be provided at the least restrictive level based on the assessed needs and health and safety of the individual.

1. Information About Population to be Served:

POPULATION	AGE RANGES	PROJECTED NUMBERS	CHARACTERISTICS
Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports.	Age 22-expiration	• As of 1-7-17 there are 840 people on the Registry of Unmet needs in the Trillium service area- 730 are adults. • 346 adults are Medicaid eligible to receive a residential service but none are available • 384 adults are Medicaid eligible for a day service but none are available	• Available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. • Medicaid eligible • Meet NC GS 122c definition for Developmental Disability

2. Treatment Program Philosophy, Goals and Objectives:

CLFS 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. CLFS is a comprehensive community living support benefit for eligible IDD adults with Medicaid.

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

CLFS 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 of care. The service needs are based on an evaluation and the person centered plan (PCP) is developed by the person with input from their chosen provider agency and team.

There are Five Levels of CLFS:

- CLFS Level 5 is Group Living (New group homes with 4 or less people with overnight staffing or virtual monitoring existing 6 beds facilities will be grandfathered in for coverage with this benefit) and meaningful person centered Day Services minimum of 6 hours per day with different staff.

- CLFS Level 4 is Supervised Living (3 or less people no overnight staffing required but may include virtual monitoring) and Day Service or Supported Employment minimum of 6 hours per day Monday-Friday with different staff.
- CLFS Level 3 is Companion Living (paid roommate or alternative family living) and Day Service or Supported Employment minimum of 6 hours a day with different staff.
- CLFS Level 2 Independent Living (living in own apartment no overnight staff but may include virtual monitoring) and
- Day Service or Supported Employment minimum of 6 hours per day.
- CLFS Level 1 Home Living (living at home with family or no supports) and attend a Day Service to maintain and develop skills of active treatment.

The service includes:

- Choosing direct support professionals and/or housemates;
- Acquiring household furnishings; for new members
- 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 through meaningful day services separate from the residential setting and,
- Managing personal financial affairs, as well as other supports.

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; and
- 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, collaboration with other systems. However, the majority of contacts are direct – with the individual.

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

3. Expected Outcomes:

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

Many CLFS 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 collectively often referred to as day programs. The CLFS provider is responsible for all activities, including day programs. The concept of active treatment is that all aspects of support and service to the individual are coordinated towards specific individualized goals in the PCP.

Any person that is living in a licensed facility, group home, supervised living setting, alternative family living arrangement or any other setting that they nor their family own must have a lease agreement in place with the owner/provider.

4. Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:

Direct Support professionals working in CLFS Level 1-5 must have a minimum of GED or a high school diploma. Completion of individualized training necessary based on the PCP of the people the agency supports. Supervision and person centered planning for consumers who participate in CLFS is completed by a Qualified Professional with experience with the population. Supervision is available daily as needed for direct support professional staff. All services are provided under the direction of a Qualified Developmental Disabilities Professional (QDDP). All direct care staff are trained to work with challenging behaviors in general as well as specific for each Level of CLFS. Staff are trained to manage medical needs. Each level of CLFS can have access to nursing services, if needed, based on the needs of the person.

5. Unit Of Service: Per Diem (/ Daily Rate)

6. Anticipated Units of Service per Person: 365 Per Year In Levels 2-5 And 250 in LEVEL 1

7. Targeted Length of Service: Yearly Re-Evaluation of Level of Care Eligibility

UTILIZATION MANAGEMENT

Prior authorization is required for this Service. The maximum length of service is 365 units per year for Levels 2-5; and 250 units for Level 1. Six-month re-evaluations occur for level of care eligibility.

1. Required Documents:

Initial/Annual - Person Centered Plan (See PCP Instructional Manual), Psychological Evaluation, NC SNAP/SIS, and Progress Summary, if applicable. Comprehensive Crisis Plan as needed. (Comprehensive Crisis Plan Instructions – "The revised comprehensive plan will be required for individuals who meet criteria defined as being at higher risk for a crisis incident (see Plan Criteria tab). All other individuals that receive enhanced services are to continue to have the current one page Person-Centered Crisis Plan developed".)

Revision – Revised/Updated Person Centered Plan, Progress Summary.

Service Order Requirement

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of each beneficiary's needs. They are required for each individual service and may be written by a medical doctor (MD), doctor of osteopathic medicine (DO), licensed psychologist, nurse practitioner (NP), or physician assistant (PA).

- Backdating of service orders is not allowed.
- Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service is ordered.
- A service order must be in place prior to or on the day that the service is initially provided in order to bill Medicaid or NCHC for the service. Even if the beneficiary is retroactively eligible for Medicaid the provider shall not be able to bill Medicaid without a valid service order.

Service orders are valid for one year from the date of last required signature entered on a Person Centered Plan (PCP). 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 services orders, signatures, and the date of plan.)

Medical Necessity

There is a mental health or substance use diagnosis or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3(12a).

The member was grandfathered into the service from previously funded group living, supervised living, alternative family living, adult day vocational services or day activity.

OR

The member who is grandfathered in should be eligible for ICF-IID Level of Care with an Intellectual and/or Developmental Disability as defined in GS 122C-3 (12a);

AND

NC SNAP (CLFS Level 1-2, minimum 1; CLFS Level 3-5, minimum 3) or Supports Intensity Scale (CLFS Level 1-2, Level A-C; CLFS Level 3-5, Level D-G)

AND

Member is experiencing difficulties in at least one of the following areas:

- Functional impairment
- Crisis intervention/diversion/aftercare needs, or
- At risk for placement outside the natural home setting.

AND

The member'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 as a result 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 member's current residential placement meets any one of the following:

- The member 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

Continuation/Utilization Review Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's service plan or the consumer continues to be at risk based on history or the tenuous nature of the functional gains or any one of the following apply:

- Member has achieved initial service plan goal and additional goals are indicated. Member is making satisfactory progress toward meeting goals.
- Member is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the member's premorbid level of functioning are possible or can be achieved, this is not a long term maintenance service but active treatment.
- Member 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.
- Member is regressing; the service plan must be modified to identify more effective interventions or appropriate level of care.

AND

If the recipient is functioning effectively with this service for 6 months or longer, a step down plan should be considered and transition plan created to assure that the person lives in the least restrictive environment. The decision should be based on any one of the following:

- Evidence that gains can be maintained in a lower level of support is documented in the service record or through evaluation of supports needed.

OR

- In the event there are epidemiologically sound expectations based on independent evaluations that symptoms will persist and lower levels of care but lower levels of care have been tried and failed because of the level of needs and that ongoing treatment interventions are needed to sustain functional gains, the presence of a DSM-5 (or any subsequent editions of the reference material) diagnosis would necessitate a disability management approach.

Discharge Criteria

Member's level of functioning has improved with respect to the goals outlined in the service plan, or no longer benefits from this service. This decision should be based on one of the following:

- Member has achieved service plan goals; discharge to a lower level of care is indicated or ok with edits member 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
- Member is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted and/or the member 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 not ok with this edit, important to stated not receiving benefit from active treatment
- Member no longer desires service

Service Maintenance Criteria

If the recipient is functioning effectively with this service and discharge would otherwise be indicated, the service may be maintained to support a transition period when it can be reasonably anticipated that the person can step down to a less restrictive level within CLSF and regression is likely to occur if the transition is not well coordinated or withdrawn. The decision should be based on any one of the following:

- Evidence that gains can be maintained in a lower level of support is documented in the service record or through evaluation of supports needed

OR

- In the event there are epidemiologically sound expectations based on independent evaluations that symptoms will persist and lower levels of care ok with edit have been tried but failed because of the level of needs and that ongoing treatment interventions are needed to sustain functional gains, the presence of a DSM-5 (or any subsequent editions of the reference material) diagnosis would necessitate a disability management approach

Exclusions: Members receiving CLFS are excluded from receiving any State Funded Services. Members receiving CLFS are excluded from receiving Medicaid state plan personal care or other Medicaid benefits included in this bundled service.

****Therapeutic Leave – See CCP #8E**