ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Person-Centered Service Plans-AR PASSE-AD-1350	09/01/2023-07/31/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Person-Centered Service Plans (PCSP)

B. Background

The Patient Protection and Affordable Care Act (2010), referred to as the Affordable Care Act (ACA), supports innovative medical care delivery as part of comprehensive health care reform. Under sections 1915(C) and 1915(i), Centers for Medicare and Medicaid Services (CMS) specifies that service planning for participants in Medicaid programs must be developed through a person-centered planning process that addresses health and long-term services and supports in a manner reflecting individual preferences and goals, resulting in a person-centered service plan with personally defined outcomes in an integrated community setting that contributes to health and welfare of the individual.

Section 2402(a) (2014) of the ACA requires states to develop systems for delivery of home and community-based services and supports (HCBS) designed to respond to the changing needs of members, maximize independence, support self-direction, and achieve a more consistent and coordinated approach to the administration of policies and procedures across programs providing these services.

State systems governing this process aim to empower members receiving long-term supports and services (LTSS) in reaching goals and achieving a better quality of life. The role of staff, providers, other team members, and family members includes assisting the member in accessing paid and unpaid services, medical, and behavioral health (BH). Member self-direction allows maximum control over the amount, duration, and scope of services and supports, as well as choice of providers, which may include family or friends. Consistent with the philosophy of independent living, self-direction embraces the values of freedom, authority, autonomy, and responsibility, allowing full member participation in community life with necessary supports.

C. Definitions

- **Care Coordination** - Services that meet requirements outlined in 42 CFR § 438.208 and Ark. Code Ann. § 20-77-2701 et seq, including health education and coaching, coordination with other healthcare providers for diagnostics, ambulatory care and hospital services, and assistance with social determinants of health, such as access to healthy food and exercise and promotion of activities focused on member health.
- **Flexible Supports** - Alternative services, defined in Act 775, not included in the state plan or a waiver of the Arkansas Medicaid Program and appropriate and cost-effective services that improve the health or social determinants of a member outside the benefit package delivered at the PASSE's discretion (i.e., social activities to counter isolation, temporary supports to avoid out-of-home placement).
- **Home and Community Based Services (HCBS)** - An array of services and supports that, although largely non-medical in nature and based on goals in the PCSP, are necessary to protect the health and safety of an individual and enable the individual to live safely in a home or community-based setting.

- **Independent Assessment (IA)** - A requirement prior to PASSE enrollment conducted by a qualified individual using an assessment instrument approved by DHS that identifies members as in need of behavioral health or developmental disabilities services.
  - Tier I – Community Clinic Level of Care
  - Tiers II and III – Institutional Level of Care
  - Tier IV – Complex Care due to mental health diagnoses and/or IDD and a high need for supervision.
- **Long-Term Services and Supports (LTSS)** - Services and supports provided to members of all ages with functional limitations and/or chronic illnesses with the purpose of supporting the member to live or work in the setting of his/her choice, including the member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.
- **Natural Supports** - Unpaid supports provided voluntarily to the member in lieu of HCBS.
- **Nonmedical Community Supports** - Supports and services nonmedical in nature necessary to protect the health and safety members and enable safely living in the community. They are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Act 775 to provide such supports and services through an AR Medicaid enrolled provider as approved by a PASSE to prevent or delay entry into an institutional setting or to assist/prepare an individual to leave an institutional setting with need established by functional deficits identified on the Independent Assessment (IA) and described in the PCSP.
- **Person-Centered Service Plan (PCSP)** - The total plan of care made in accordance with the planning process as described in the 1915(c) waiver requirements for Home and Community-Based Services (42 CFR § 441.301 (c)) and 1915(i) State Plan Services (42 CFR § 441.725).
- **Service Encounter** - A standardized record of a paid or non-paid healthcare service, procedure, treatment, or therapy rendered by a licensed provider to a member.

D. Policy

I. General Provisions

A. Each member receiving services must have a PCSP that, at a minimum, complies with requirements set forth by applicable federal and state regulations in a standardized, regulator-approved format. The PCSP must be easily understood by the member and individuals important in supporting the member (i.e., written in plain language, accessible to individuals with disabilities and persons with limited English proficiency).

B. All members with an existing and current PCSP will retain and carry that plan into any newly enrolled PASSE, and that PCSP will be honored until a new PCSP is completed.

C. Members will be assigned a care coordinator (CC). The assigned CC or appropriate PASSE team member will make initial contact with the member within 15 business days of PASSE enrollment, including any contact between assignment and enrollment.

D. The CC or appropriate PASSE team member will conduct an initial services assessment of each member within thirty (30) days of enrollment. This assessment will be used to develop the PCSP, and component parts will be shared with appropriate DHS personnel, other providers, or other/previous PASSE team members to prevent duplication of activities between the entities.
E. For any member without an existing PCSP, the PASSE will have sixty (60) calendar days from the date of enrollment to develop the PCSP, which will include the initial services assessment.
F. The PCSP must be reviewed and revised under the following conditions:
    1. within 365 days of the initial PCSP date or at least every 12 months
    2. upon reassessment of functional need § 441.365(e)
    3. at the request of the member
    4. upon significant changes in member circumstances or needs, including the following (not an all-inclusive list):
        a. a change in functioning or circumstance impacting service needs, both negative and/or positive (i.e., increases or decreases in level of care, new diagnoses, sentinel events)
        b. changes in functional ability or loss of supports necessary to maintain functioning (i.e., acute illness or injury, chronic condition changes, loss of a caregiver or guardian)
        c. environmental changes that require modifications in service delivery
        d. other changes, such as legal status changes, changes in caregiver or legal guardian status, involvement with judicial systems, traumatic events

II. Minimum Standards/Requirements for the Person-Centered Service Plan (PCSP)
A. The PCSP must adhere to content requirements as found at 42 CFR § 441.301(c) and 42 CFR § 441.540 in a standardized format. The planning process and the PCSP must include, without limitation:
    1. The member's health information, including
        a. Relevant medical and mental health diagnoses;
        b. Relevant medical and social history;
        c. Primary Care Physician (PCP) and primary provider of Behavioral Health (BH) or Developmental Disability (DD) services;
        d. The individual who has legal authority to make decisions on behalf of the member; and
        e. Indication of whether or not an advance directive or living will has been created for or by the member.
    2. Reflect that the setting in which the individual resides is chosen by the individual;
    3. Reflect the member's strengths and preferences;
    4. Reflect the clinical and support needs as identified;
    5. Include individually identified goals and desired outcomes;
    6. Reflect the services and supports important for the member to meet the needs as identified through an assessment of functional need, including services and supports in the community to avoid placement in an institution;

7. Reflect the services and supports, paid and unpaid, that will assist the member in achieving identified goals and desired outcomes;
8. Reflect the risk mitigation plan;
9. Includes strategies for solving conflict;
10. Be finalized and approved in writing; and
11. Prevent the provision of unnecessary or inappropriate care.

B. The PCSP must address needs identified for the member from the ARIA, Initial Services Assessment, and the following sources, if applicable:
   1. any psychological testing results
   2. any adaptive behavior assessments
   3. any social, medical, physical or mental health histories
   4. Risk Mitigation Plans
   5. case plans for court-involved members
   6. Individualized Education Plans (IEPs)
   7. any other assessment or evaluation used by the PASSE prior to or at the time of PCSP development

C. The care coordinator (CC) is responsible for coordinating and scheduling the PCSP development meeting.
   1. The following must attend the development meeting in person:
      a. member and parent/legal guardian
      b. member's primary caregivers
      c. care coordinator
   2. The meeting should include other individuals who may attend in person, by telephone or video conferencing, including
      a. HCBS providers
      b. professionals who have conducted evaluations or assessments
      c. anyone else the member desires to attend, including family and friends who support the member
   3. If the member objects to anyone's participation in the PCSP development meeting, the CC must ensure that that individual is not allowed to participate.
   4. When developing the PCSP, those present must consider the member's preferences in regard to treatment goals, objectives, and services.
   5. The CC is responsible for engaging the member in the process and documenting member engagement, or efforts to do so, in the PCSP.
   6. It is the responsibility of HCBS service providers of NCSS to work with the CC to identify specific services needed to execute the PCSP. Unneeded services will not be provided.

III. Provider Requirements and Responsibilities

A. HCBS providers are required to participate in and adhere to PCSP processes and maintain provision of services set forth in a member's PCSP. Common HCBS programs include the following (not an all-inclusive list):
   1. Supplemental Support Services
   2. Supportive Living Services
   3. Consultation Services
   4. Therapeutic Host Homes

5. Nonmedical Community Supports and Services

B. Responsibilities as a CareSource PASSE provider are as follows:
   1. Actively participate in the PCSP process with other providers and individuals serving the member. If attendance is not possible or if a member does not want a provider to attend a PCSP meeting, provider input will be shared with the care coordination team within a week of the scheduled PCSP meeting.
   2. Implement treatment and/or programs in accordance with the PCSP.
   3. Communicate and collaborate with care coordinators about member needs.
   4. Notify care coordinators of any changes, incidents and other information of significance related to the member.
   5. Submit timely requests for services to the Utilization Management/Service Determinations teams for services aligning with the PCSP.
   6. Maintain a copy of member PCSP in member records.

IV. Member Transitions

A. Upon member transition from CareSource to another PASSE, the care coordination team will provide the following:
   1. notification to the receiving PASSE no more than one (1) business day prior to eligibility start date the special needs of the transitioning member
   2. receipt of medical records, PCSP, treatment plans, and Care Coordination files to the receiving PASSE within twenty (20) business days
   3. timely notification to member's service providers

B. Upon member transition from another PASSE to CareSource, the care coordination team will complete the following:
   1. engage the member's service providers to develop the member's CareSource PCSP
   2. ensure continuity of current services, including working with providers to transition reimbursement and/or assisting the member in choosing new providers who are in network, if necessary
   3. ensure continued reimbursement for any medically necessary services on an existing treatment plan from another PASSE
   4. coordinate services with the receiving or relinquishing PASSE, including services on an existing PCSP, ensuring continuity of care for 60 days or until the transition is completed, whichever is longer

V. Utilization Management (UM) and/or Service Determination (SD)

The development of the PCSP and Utilization Management (UM)/Service Determination are separate processes. The Utilization Management (UM) team will determine medical necessity for all physical health services, while the Service Determination (SD) team, including nurses, licensed mental health professionals and staff with experience in intellectual and developmental disabilities, review all behavioral health (BH) inpatient and outpatient requests, including HCBS services. All services are reviewed for medical necessity and/or nonmedical community supports and services.

A. All services must be documented in the PCSP. Emergent services are an exception to this rule.

B. Services on the PCSP do not guarantee authorization and do not act as a prescription.
C. The PCSP does not replace a provider's plan of care. A plan of care and additional supporting documentation is generally necessary to determine medical necessity/NCSS for a service.
D. The independent assessment (IA) identifies areas in which the member needs services or supports but is not the final determinant. A tier assignment from an IA does not guarantee a specific type or level of service.
E. Providers must verify eligibility on the date of service. CareSource PASSE will not pay claims for services provided to ineligible members. Authorization is not a guarantee of payment.
F. Authorization submissions are generally a combination of efforts between the provider and CC to ensure a complete and timely submission on the member's behalf reflective of the goals in the PCSP.
    1. The authorization process requires review of the PCSP, in addition to all other supporting documentation, to fully understand member needs.
    2. Whenever there is insufficient information included in the PCSP and supporting documentation, UM/SD staff will collaborate with Care Coordination and the provider to obtain additional information to support the request.
    3. Providers will be notified of approval or denial within required turn-around-times.

VI. Service Record Documentation

Providers must establish a service record for the member. At a minimum, the service record file must contain the following (not an all-inclusive list):

A. a copy of the PCSP
B. signed releases by any adult members who are legally competent allowing consent or declining involvement of family members regarding planning and implementing PCSP services

E. Conditions of Coverage

NA

F. Related Policies/Rules

Non-medical Community Supports and Services
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	05/24/2023	New policy. Approved at Committee.
Date Revised		
Date Effective	09/01/2023	
Date Archived	07/31/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

H. References

1. Arkansas Code Annotated. Subchapter 27 Medicaid Provider-Led Organized Care Act. § 20-77-2701 to § 20-77-2708 (2017). Retrieved March 30, 2023 from www.justia.com.
2. Arkansas Code Rule 016.06.18-012. Provider-led Arkansas Shared Savings Entity (PASSE). (2018, October 26). Retrieved March 30, 2023 from www.casetext.com.
3. Arkansas Department of Human Services (DHS). Provider-Led Shared Savings Entity (PASSE) Provider Manual. Retrieved March 30, 2023 from www.humanservices.arkansas.gov.
4. CareSource Arkansas PASSE Provider Manual. (2023). Retrieved March 28, 2023 from www.caresource.com.
5. Centers for Medicare and Medicaid Services. Home and Community Based Services. Retrieved March 30, 2023 from www.cms.gov.
6. Code of Federal Regulations. Title 42, Chapter IV. Subchapter C. Medical Assistance Programs. (2023). Retrieved March 30, 2023 from www.ecfr.gov.
7. Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement Between CareSource PASSE and The Arkansas Department of Human Services. Service Delivery Period January 1, 2023 through December 31, 2026.
8. Public Law 111-148, 124 Stat.119. The Patient Protection and Affordable Care Act (ACA). Retrieved March 30, 2023 from www.govinfo.gov.
9. US Department of Health and Human Services. About the affordable care act. Retrieved March 30, 2023 from www.hhs.gov.