ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Person-Centered Service Plans-AR PASSE-AD-1350	10/01/2025
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), the 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 (LTSS) in a manner reflecting individual preferences and goals, resulting in a person-centered service plan (PCSP) with personally defined outcomes in an integrated community setting that contributes to the health and welfare of the individual.

Section 2402(a) (2014) of the ACA requires states to develop systems for the delivery of home and community-based services (HCBS) and supports 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 empower members receiving 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) services. Member self-direction allows maximum control over the amount, duration, and scope of services and support, 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 of 42 C.F.R. § 438.208 and ARK. CODE ANN. § 20-77-2701.
- **Flexible Services** – Alternative, appropriate and cost-effective services outside the benefit package, not included in the state plan or a waiver improving member health or social determinants delivered at the PASSE's discretion (eg, social activities, temporary supports to avoid out-of-home placement).
- **Home and Community Based Services (HCBS)** – An array of services and supports, largely non-medical in nature, based on goals in the PCSP, necessary to protect the health and safety of an individual and enable safe living 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 AR Dept of Human Services (DHS) that identifies members as in need of BH or developmental disabilities (DD) services.

- **Long-Term Services and Supports (LTSS)** – Services and supports provided to all ages with functional limitations and/or chronic illnesses to support the member to live or work in the setting of 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 in lieu of HCBS.
- **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 C.F.R. § 441.301(c)) and 1915(i) State Plan Services (42 C.F.R. § 441.725).
- **Service Encounter** – A standardized record of a paid or non-paid healthcare service, procedure, treatment, or therapy by a licensed provider to a member.

D. Policy
   I. General Provisions
      A. The PCSP, at a minimum, will indicate the following:
         1. medical services that achieve goals/desired outcomes identified on the assessment of functional need in accordance with 42 C.F.R. 441.725
         2. HCBS services including, if appropriate, LTSS services
         3. member strengths, needs, and preferences
         4. a crisis plan for the member
      B. All medical services provided must be medically necessary for each member, and all HCBS and LTSS must be documented on the PCSP, unless an emergency or crisis stabilization service.
      C. Each member receiving services must have a PCSP that is easily understood by the member and individuals supporting the member (eg, written in plain language, accessible to individuals with disabilities and persons with limited English proficiency).
      D. All members with an existing, current PCSP will retain and carry that plan into any newly enrolled PASSE, including CareSource, which will be honored until a new PCSP is completed.
      E. Members will be assigned a care coordinator (CC) or an appropriate team member who will make initial contact within 15 business days (BDs) of enrollment, including any contact between assignment and enrollment.
      F. The CC or appropriate team member will conduct an initial services assessment within 30 days of enrollment to develop the PCSP. Component parts will be shared with appropriate DHS personnel, other providers, or other/previous PASSE team members to prevent duplication of activities.
      G. For any member without an existing PCSP, CareSource will have 60 calendar days (CDs) from the date of enrollment to develop the PCSP, including the initial services assessment.
      H. 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
         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 (eg, increases or decreases in level of care, new diagnoses, sentinel events)
    b. changes in functional ability or loss of support necessary to maintain functioning (eg, 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 (eg, 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 42 C.F.R. § 441.301(c) and 42 C.F.R. § 441.540, be written in a standardized format and document member preferences for the delivery of service and supports. Commensurate with the level of member need and the scope of services and supports available, the plan must include
        1. member health information, including
            a. relevant medical and BH diagnoses
            b. relevant medical and social history
            c. Primary Care Physician (PCP) and provider(s) of BH and DD services
            d. individual with legal authority to make decisions on behalf of the member
            e. advance directives or living wills created for/by the member or refusal to do so
        2. reflection that residential setting is chosen by the member
        3. member's strengths and preferences
        4. clinical and support needs identified via an assessment of functional need
        5. individually identified goals and desired outcomes
        6. services and support, paid and unpaid, that will assist in achieving identified goals and desired outcomes, including natural supports
        7. risk mitigation or crisis plan and individualized backup plans, as necessary
        8. the individual or entity responsible for monitoring the plan
        9. be finalized and approved in writing
        10. 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 or assessments, if necessary
        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 to be attended, in person, by the member, parent/

legal guardian, primary caregivers, and care coordinator. The meeting should include other individuals who may attend in person, by telephone or video conferencing, including HCBS providers, professionals who have conducted evaluations or assessments, and anyone else the member desires to attend, including family and friends who support the member.

1. If the member objects to any individual's participation in the development meeting, the CC must ensure that that individual is not allowed to participate.
2. When developing the PCSP, those present must consider the member's preferences in regard to treatment goals, objectives, and services.
3. The CC is responsible for engaging the member in the process and documenting member engagement, or efforts to do so, in the PCSP.
4. It is the responsibility of HCBS service providers 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 the provision of services in the PCSP.

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 CCs 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 the 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 1 BD prior to the 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 20 business days
3. timely notification to the member's service providers

B. Upon member transition from another PASSE to CareSource, the CareSource CC team will complete the following:

1. engage the member's service providers to develop the CareSource PCSP
2. ensure continuity of current services, including transitioning reimbursement or assistance 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 90 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 UM team will determine medical necessity for all physical health services, while the SD team, including nurses, licensed mental health professionals and staff with experience in IDD(s), review all 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, except emergent services.
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 guarantee of payment.
F. Authorization submissions are a combination of efforts between the provider and CC to ensure a complete and timely submission on the member's behalf reflective of 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 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.

E. Conditions of Coverage
NA

F. Related Policies/Rules
Medical Necessity Determinations
Non-medical Community Supports and Services

G. Review/Revision History

	DATE	ACTION
Date Issued	05/24/2023	New policy. Approved at Committee.

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

Date Revised	05/08/2024 06/18/2025	Annual review. Updated sections F & H, deleted VI. Approved at Committee. Annual review. Updated references. Approved at Committee.
Date Effective	10/01/2025	
Date Archived		

H. References

1. *CareSource PASSE Provider Manual*. CareSource. Accessed June 10, 2025. www.caresource.com
2. About the Affordable Care Act. US Dept of Health and Human Services. Accessed June 10, 2025. www.hhs.gov
3. Assessment of Functional Need, 42 C.F.R. § 441.535 (2024).
4. Coordination and Continuity of Care, 42 C.F.R. § 438.208 (2017).
5. Home and community-based services. Centers for Medicare and Medicaid Services. Accessed June 10, 2025. www.cms.gov
6. Home and Community-Based Services: Waiver Requirements, 42 C.F.R. §§ 441.300-.310 (2023).
7. Medicaid Provider-Led Organized Care Act, ARK. CODE ANN. §§ 20-77-2701 to 2708 (2017).
8. Person-Centered Service Plan, 42 C.F.R. § 441.540 (2024).
9. Provider-Led Arkansas Shared Entity (PASSE), 016-06-18 ARK. CODE R. § 12 (2018).
10. Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement Between CareSource PASSE and The Arkansas Dept of Human Services. Service Delivery Period January 1, 2023 through December 31, 2026. Accessed June 10, 2025. www.humanservices.arkansas.gov
11. *Provider-Led Shared Savings Entity (PASSE) Provider Manual, Part II*. Arkansas Dept of Human Services. Accessed June 10, 2025. www.humanservices.arkansas.gov
12. The Patient Protection and Affordable Care Act. Public Law 111-148, 124 Stat.119. Accessed June 10, 2025. www.govinfo.gov