ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Community and Employment Support Waiver Services: Unable to Provide for Member's Identified Needs-AR PASSE-AD-1422	02/01/2026
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

Community and Employment Support Waiver Services: Unable to Provide for Member's Identified Needs

B. Background

Pursuant to Title XIX of the Social Security Act and Arkansas Act 775, CareSource PASSE organizes and manages the delivery of services for certain Medicaid beneficiaries with complex behavioral health and intellectual and developmental disability service needs. PASSE members receive services tailored to meet personal goals and preferences, thus engaging the members and caregivers or family/representative in shared decision-making.

The Community and Employment Supports (CES) waiver allows members to receive supportive living services in the home and/or community as an alternative to institutionalization. CES providers are allowed to specify the maximum number of members served, the services provided, and the service levels that are offered based on staff availability. PASSE members have the freedom of choice to choose a provider, and a selected provider cannot refuse to provide services unless the provider cannot assure the health, safety, or welfare of the member. If a provider is unable to make these assurances, a set protocol is to be followed.

C. Definitions

N/A

D. Policy

I. All services delivered under the CES waiver must be documented in the member's PCSP. If a member selects an approved CES provider within the member's geographic location, the CES provider is required to provide the identified services.

II. If a CES provider becomes unable to assure the health, safety, or welfare of a member, the provider must notify CareSource within 2 business days and submit a formal letter to DHS. **[Note: Providers are reminded that they are required to submit an Incident Report to CareSource and to DHS for any event regarding the member that meets the criteria for a reportable event, such as a member experiencing harm while receiving services from the provider.]**
   A. If the provider is unable to provide services due to staffing, the notification will include the efforts to employ and retain qualified personnel and the outcome.
   B. If services are unable to be provided due to inadequate housing, the provider should develop and propose alternative housing arrangements within the member's resources. If the member is unable or unwilling to accept a proposed alternative, the provider must document the refusal of available resources and immediately notify CareSource.

III. If a CES provider is unable to adequately meet the needs of a member that is not due to the immediate health or safety of the member, at least 30-days notice must be

provided to CareSource. 60-days notice is required if the provider is providing residential supports to maintain living. The inability to serve the member must be based on the provider's limitation. CareSource prohibits providers or partners from refusing to treat, serve, or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (ie, intersex, transgendered, transsexual), or disability. In consideration of cultural differences, including religious beliefs and ethical principles, CareSource will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

IV. When a provider is unable to continue services for any reason, the provider will help ensure a smooth transition process and continuous delivery of care until the transition to a new provider is complete.
   A. After contacting CareSource, the provider will send a written notice to the member, family member, or authorized representative.
      1. The written notice will include the reason for transitioning care, the effective date, and a statement regarding the member's appeal rights with a copy of DDS Policy # 1076 regarding appeal procedures.
      2. The provider will also CC the written notice to carecoordination@caresourcepasse.com. A copy of the written notice must be placed in the member's service record.
   B. The provider will be responsible for conducting a transfer or discharge planning conference with the member, family, care coordinator, legal representative, and advocate, as applicable, to help support a smooth transition.
   C. The provider will complete a written discharge summary to include, at a minimum, the health, developmental, behavioral, and social issues and the member's nutritional status to be provided to the newly selected provider.

V. If the member files a timely appeal, the member may remain with the provider and not be transferred until a decision is rendered on the appeal.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Nonmedical Community Supports and Services
Person-Centered Services Plans (PCSP)

G. Review/Revision History

	DATE	ACTION
Date Issued	02/14/2024	New Policy. Approved at Committee
Date Revised	10/22/2025	Annual review, approved at Committee.
Date Effective	02/01/2026	
Date Archived		

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

H. References

1. Amendment to the Community and Employment (CES) 1915(c) Waiver; the CES Provider Manual and the CES Certification Standards, 016.05.17 ARK. CODE R. § 004 (2017).
2. Arkansas Department of Human Services, Division of Developmental Disability Services. Appeals. Policy No. 1076. Accessed August 25, 2025. www.humanservices.arkansas.gov
3. *Community and Employment Support (CES) Waiver Provider List*. Arkansas Dept of Human Services; 2025. Accessed August 25, 2025. www.humanservices.arkansas.gov