P.O. Box 25010
Little Rock, AR 72221

1915(i) and 1915(c) Waiver Services Manual Contents

P.O. Box 25010
Little Rock, AR 72221

P.O. Box 25010
Little Rock, AR 72221

P.O. Box 25010
Little Rock, AR 72221

P.O. Box 25010
Little Rock, AR 72221

100.000 GENERAL PROGRAM OVERVIEW

The Medicaid Home- and Community-Based Services (HCBS) waiver program is authorized in the §1915(c) and 1915(i) waivers. The waiver programs permit a state to furnish an array of HCBS that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state, and local public programs, as well as the support that families and communities provide. The Centers for Medicare & Medicaid Services (CMS) recognize that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, the service delivery system structure, the goals and objectives of the state, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services. The Department of Human Services (DHS) is responsible for certification of all Medicaid providers. Providers must have an active certification for the date and service type performed for payment to be rendered.

101.100 1915(c) Waiver Services

The purpose of Community and Employment Support (CES) Waiver services are to support individuals of all ages who have a developmental disability, meet ICF level of care, and require waiver support services to live in the community and prevent institutionalization.

The goals of the CES Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and provide comprehensive care coordination and service delivery under the 1915(b) PASSE (Provider-Led Arkansas Shared Savings Entity) waiver program.

101.200 1915(i) Waiver Services

The program is authorized in §1915(i) of the Social Security Act and works concurrently with other §1915 authorities. The program permits a state to furnish an array of enhanced home and community based behavioral health services to better address individual needs.

The purpose of 1915(i) for HCBS is threefold: to improve the health of the population, to improve the experience of care for individuals receiving services, and to improve the quality of care while reducing the growth of health care costs.

P.O. Box 25010
Little Rock, AR 72221

101.300 Authorizations

All HCBS must be documented in the member's Person-Centered Service Plan (PCSP) and are subject to review and authorization. Please refer to the individual service description to identify if prior authorization is required.

101.400 Providers

All providers must be an approved Arkansas Medicaid provider with the appropriate Medicaid designation to render services.

200.000 COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER GENERAL INFORMATION

201.000 Overview

The CES Waiver program offers certain HCBS as an alternative to institutionalization. These services are available for eligible beneficiaries with a developmental disability who would otherwise require an intermediate care facility for the intellectually disabled/developmentally disabled (ICF/ID/DD). This waiver does not provide education or therapy services.

The purpose of the CES Waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care, and require waiver support services to live in the community and thus prevent institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision-making, employment, and community integration.

The objectives are as follows:

A. To transition eligible persons who choose the waiver option from residential facilities into the community
B. To enhance and maintain community living for all persons participating in the waiver program

CES Waiver services may require prior authorization and be based on an independent assessment, functional evaluation, or other identified assessment tools. All services must be delivered based on the approved prior authorization (if applicable), treatment plan, and align with the member's PCSP. Refer to our Pre-Auth Check tool on ArkansasTotalCare.com for more information on what services require prior authorization.

P.O. Box 25010
Little Rock, AR 72221

201.100 Providers of CES Waiver Services

CES Waiver services are limited to Arkansas and bordering state trade area cities. DDS must certify all providers as CES Waiver or Community Support System Provider (CSSP) before services may be provided for Arkansas Medicaid beneficiaries. Providers must maintain an active status.

All CES Waiver and CSSPs have the responsibility of recruiting, hiring, and training Direct Support Professional Staff. CES providers will ensure the member/parent/guardian have a say in the decision-making process, should they choose. CES providers are responsible for ensuring ongoing training and support is provided to all Direct Support Professionals.

201.200 Records and Documentation Requirements

CES Waiver and CSSPs must keep and properly maintain written records. Providers must ensure that all service specific documents outlined in this manual, the Arkansas Total Care provider manual, your Arkansas Total Care provider contract, as well as any licensing regulatory agency requirements, are included in the member's record.

201.300 Pass-Through Providers Requirements

Pass-through billing is utilized when a covered and needed CES Waiver service must be completed by an entity that is not a Medicaid provider and therefore, Arkansas Total Care cannot reimburse directly. In these situations, a CES Waiver or CSSPs can act as a "pass through" by subcontracting with said entity to provide the needed service. The primary use of pass-through is with consultation, adaptive equipment, environmental modifications, supplemental support, and specialized medical supply services.

Any CES Waiver or CSSPs acting in a pass-through role must guarantee that any sub-contractor they work for abides by all Medicaid regulations and the CES Waiver/CSSP assumes all liability for contract noncompliance. The provider must also have a written contract that sets forth specifications and assurances that work will be completed in a timely and satisfactory manner for the member being served, is documented appropriately, and is billed appropriately as outlined in the related prior authorization. The provider is responsible for ensuring that services were delivered to standard and proper documentation, including a signed customer satisfaction statement, has been submitted prior to billing Arkansas Total Care.

CES Waiver/CSSPs must develop and maintain sufficient written documentation to support each service for which pass-through billing occurs. This documentation, at a minimum, must consist of the following:

A. Certification statements, narratives, and proofs that support the cost-effectiveness and medical necessity of the service to be provided as outlined in this manual.

P.O. Box 25010
Little Rock, AR 72221

B. A copy of the prior authorization related to the service for which pass-through billing is occurring, including any amendments.
C. Contract with entity providing the services that outlines the specific services rendered.
D. The start date/time and end date/time services were rendered.
E. The name and credentialing (e.g., license number of certified contractor), if applicable, of the entity who provided the service.
F. The relationship of the service to the treatment regimen of the member's PCSP.
G. Updates describing the beneficiary's progress or lack thereof. Updates should be maintained daily, or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the DSP staff who delivered the service, the CES Waiver provider, the supervisor, and the authorized designee/member/parent/guardian.
H. Proof that services were rendered to quality/standards supported by prior authorization and the contract, including but not limited to a signed customer satisfaction attestation from member/guardian, photos, etc.

Additional documentation and information may be required depending on the service being provided.

201.400 Unable to Serve Notice Requirements

CES Waiver and CSSPs may submit an Unable to Serve notification in situations where they are no longer able to ensure the health and safety of the member, their other consumers, or their staff. Upon reasonable notice, and after stabilization of the member's condition, the provider must send a formal letter to the Arkansas Total Care Incident Report Box (Incident@ArkansasTotalCare.com) detailing the rationale and supporting justification for no longer being able to serve the member. The letter must include information on the transfer of medical records and care, as well as emergency and interim care. When determining a plan for the transition of care, the HCBS provider should ensure the following are taken into consideration:

A. If the member is residing in provider-owned or operated housing, all tenant and lease laws and regulations are being followed.
B. The transition plan allows for adequate time to transfer the member's care to a new provider.
C. The transition plan does not put the member at unnecessary risk.
D. The transition plan addresses all the members' needs, both service- and non-service-related.

201.500 Risk Mitigation Plans

Effective April 1, 2024, PASSE Care Coordinators will begin incorporating a Risk Assessment & Mitigation Plan into all PCSPs as they are initiated or revised. The Risk Assessment &

P.O. Box 25010
Little Rock, AR 72221

Mitigation Plan will have two sections: general risk and behavioral risk. The general risk section will be completed for all PASSE members. The behavioral risk section will only be completed for PASSE members with an open CES-waiver slot. From this, a behavioral risk score will be determined as either no risk, low, medium, or high.

For members identified as having a low or medium behavioral risk, their Supportive Living provider will be responsible for completing a Behavioral Prevention and Intervention Plan (BPIP) and sharing it with the PASSE Care Coordinator. For members identified as having a high behavioral risk, their PASSE Care Coordinator will identify a consultation provider to complete a Positive Behavior Support Plan (PBSP) that will be shared with the PASSE Care Coordinator and all providers working with the member. The member's CES-waiver provider will collaborate with the consultation provider to implement the PBSP.

210.000 PROGRAM COVERAGE

211.000 Description of Services

CES services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

A. Supportive living
B. Respite services
C. Supported employment
D. Adaptive equipment
E. Environmental modifications
F. Specialized medical supplies
G. Supplemental support
H. Consultation
I. Community transition
J. Care coordination

212.000 Supportive Living

Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in an integrated community setting. If operating a Complex Care Home under Supportive Living Services, the provider must ensure all state and federal regulations are met including the CSSP manual requirements.

P.O. Box 25010
Little Rock, AR 72221

Supportive living includes activities that directly relate to achieving goals and objectives set forth in the member's treatment plan and PCSP. It excludes room and board expenses, including general maintenance, upkeep, or improvement to the home.

Supportive living is designed to assist the member with acquiring, retaining, or improving skills in a wide variety of areas that directly affect the person’s ability to reside as independently as possible in the community. The habilitation objective to be served by each activity should be documented in the member's treatment plan and align with their PCSP. Examples of supportive living include:

A. Decision making, including the identification of and response to dangerous/threatening situations, making decisions and choices affecting the member's life, and initiating changes in living arrangements or life activities.
B. Money management, including training and assistance in handling personal finances, making purchases, and meeting personal financial obligations.
C. Daily living skills, including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medication (to the extent permitted by state law), proper use of adaptive and assistive devices and household appliances, training on home safety, first aid, and emergency procedures.
D. Socialization, including training and assistance in participating in general community activities and establishing relationships with peers. Activity training includes assisting the member with continued participation on an ongoing basis.
E. Community integration experiences, including activities intended to instruct the member in daily living and community living in integrated settings, such as shopping, church, and sports.
F. Mobility, including training and assistance aimed at enhancing movement within the member’s living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community.
G. Communication, including training in vocabulary building, use of augmentative communication devices, and receptive and expressive language.
H. Behavior shaping and management, including training and assistance in appropriate expression of emotions or desires, compliance, assertiveness, and acquisition of socially appropriate behaviors or reduction of inappropriate behaviors. The Supportive Living Provider is responsible for developing and overseeing the Positive Behavior Support Plan or Behavioral Prevention and Intervention Plan depending on the member’s risk level identified in the Risk Mitigation Plan as part of the PCSP process.

P.O. Box 25010
Little Rock, AR 72221

I. Reinforcement of therapeutic services, including conducting exercises reinforcing physical, occupational, speech, behavioral, or other therapeutic programs.
J. Companion activities and therapies, or the use of animals as modalities to motivate members to meet functional goals established for the member's habilitative training, including language skills, increased range of motion, socialization, and the development of self-respect, self-esteem, responsibility, confidence, an assertiveness.
K. Health maintenance activities, including tasks that members would otherwise do for themselves or have a family member do, apart from injections and IV medication administration. It is not considered administration, apart from injections and IV medications, when paid staff assist the member by getting the medication out of the bottle or blister pack.

Supportive living may be provided in a clinic setting (e.g., physician office visit, wound clinic, etc.) to facilitate appropriate care and follow-up. If a health maintenance activity is performed in a hospital setting for supportive care of the individual while receiving medical care, supportive living cannot exceed 14 consecutive days nor exceed the approved prior authorization rate for the service in place prior to hospitalization. If provided in an acute care hospital, supportive living must a) be provided to meet needs that are not met through the provision of acute care hospital services; b) be in addition to, and not substitute, for the services the acute care hospital is obligated to provide; c) be identified in the individual's PCSP; and d) ensure smooth transition between the acute care setting and community-based setting to preserve the individual's functional abilities. Arkansas Total Care will conduct retrospective reviews to ensure these criteria are met.

Persons residing in supportive living arrangements are eligible for the same services and service level as any other waiver participant. Staff working in such arrangements must have hours of compensation prorated according to the number of individuals, waiver and non-waiver, residing in the supportive living arrangement. Additional one-on-one staffing may be provided when the need is justified, and prior authorization is in place.

For Complex Care Homes, the provider is required to maintain the member-to-staff ratio needed to meet each member's needs as provided in their treatment plan, prior authorization, PCSP, and to ensure member and staff health and safety. Under no circumstances may there be less than a four-to-one member-to-staff ratio in the home at any time.

212.100 Benefit Limits & Exclusions for Supportive Living

Limitations for supportive living services include, but are not limited to, the following:

A. All supportive living services must be prior authorized and are limited to the amount, duration, and scope of services authorized by Arkansas Total Care.

P.O. Box 25010
Little Rock, AR 72221

B. All supportive living services must be provided by a qualified direct support professional working under the scope of a CES Waiver, or by an appropriately certified CSSP who is credentialed with Arkansas Total Care at time-of-service provision.
C. For members under 18 who reside with their parent/guardian without complex physical health/mental health or co-occurring needs, the maximum number of supportive living hours will be 60 hours per week.
D. If supportive living is provided in a hospital setting while the individual is receiving medical care, it cannot exceed 14 consecutive days nor exceed the approved prior authorization rate for the service in place prior to hospitalization. Supportive living must meet the following criteria:
    i. Supportive living must be provided to meet needs not met through acute care hospital services.
    ii. Supportive living must be in addition to, and not a substitute for, the services the acute care hospital is obligated to provide.
    iii. The service must ensure a smooth transition between the acute care setting and community-based setting to preserve the individual's functional abilities.
E. If there is technology available that offers the same or higher level of care required, then it will be utilized over a direct support provider unless justification for the need for supportive living is provided. A combination of technology and direct support staff may also be utilized when appropriate.
F. Beneficiaries may access both supportive living and respite on the same date if the two services are distinct and do not overlap that each service was provided. Arkansas Total Care monitors this provision through retrospective annual review with providers responsible for maintaining adequate time records and activity case notes or activity logs that support the service deliveries. Controls in place to ensure payments are made only for services rendered include: requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe, with such activities linked to the PCSP objectives; supervision of staff by the direct care supervisor with sign-off/sign-on timesheets maintained weekly; audits and reviews conducted by Arkansas Total Care at random; random visits to the home; and oversight by the chosen and assigned Care Coordinator.

Exclusions for supportive living services include but are not limited to the following:

A. Supportive living cannot cover room and board expenses, including general maintenance, upkeep, or improvement to the home.
B. Supportive living may not substitute for the services the acute care hospital is obligated to provide during the member's hospitalization.

P.O. Box 25010
Little Rock, AR 72221

C. Supportive living cannot be provided and billed for while other services that would be considered duplicative are also being provided and billed for. This includes personal care services ADDT and EIDT.
D. If a guardian is an owner for the supportive living provider serving the member, they cannot also act as a paid direct staff to avoid potential conflicts of interest.

212.200 Supportive Living Prior Authorization Request Criteria

Eligibility criteria set by DDS for CES Waiver services must be met before requesting supportive living services. Prior authorization is required for all supportive living services and must be approved before services can begin. All supportive living prior authorization requests are considered "standard" requests for timeliness of decision-making purposes.

These three components will be evaluated when reviewing for service requests:

A. Severity of the functional impairment
B. Appropriate intensity of services
C. Least restrictive or intrusive services necessary

Initial Request Criteria *Eligibility Criteria A–H must be met.*

A. Placement and participation in supportive living services shall be based on the needs of the recipient as documented in the standardized Independent Assessment, Treatment Plan, and PCSP.
B. The level of care must be provided in an ICF/IID.
C. The member would be institutionalized in an ICF/IID in the near future, but for the provision of waiver services.
D. The member meets the eligibility criteria set by DDS for the HCBS waiver:
    i. There is verification of a categorically qualifying diagnosis.
    ii. The age of onset is established to be prior to age 22.
    iii. Substantial functional limitations in activities of daily living (adaptive functioning deficits) are present and are because of the categorically qualifying diagnosis. Adaptive functioning deficits are defined as an individual's inability to function in three of the following six categories as consistently measured by standardized instruments administered by qualified professionals: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
    iv. The disability and deficits are expected to continue indefinitely.
E. The physician prescribes HCBS to meet the assessed needs of the individual. The DDS 703 form is used to submit this information.
F. The level of care provided is determined by the clinician to be the least restrictive, and the benefits to receiving the treatment outweigh any potential harm.

P.O. Box 25010
Little Rock, AR 72221

G. Less intensive services would not be adequate to assist the member in reaching identified treatment goals.
H. The member has an active CES Waiver slot or Tier IV status with approved ICF determination through DHS.

Continued Stay Criteria *Criteria A–E must be met to satisfy criteria for continuation of services.*

A. Intensity of service guidelines and initial request criteria are met.
B. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the description of services.
C. If progress has not been made, the provider will indicate in writing the modifications they plan to make to the treatment plan to address current needs or justify the need for continued care at this level.
D. The member can be expected to benefit from HCBS, and such services remain appropriate to meet the member's needs.
E. The member and others identified by the treatment plan process are active participants in the creation of the treatment plan and discharge plan and are actively participating in treatment. The member has designated others and the treatment team agrees on treatment goals, objectives, and interventions.

Levels of Supportive Living

Supportive Living — One-on-One Staffing — Level 1 Criteria

Intellectual Disabilities:

A. The member meets the criteria for institutional level of care as defined by the state.
B. The member must have an approved and documented proof of CES Waiver slot, with documented proof by DHS/DDS (Arkansas Total Care WPS team will verify), formally approved Tier IV Dual status through DHS, or formally approved Tier IV Enhanced Care Coordination status with an active ICF determination.

Supportive Living — One-on-One Staffing — Level 2 Criteria
The member must also meet criteria for Level 1.

Complex Medical/Health Conditions:
The member has complex medical/health conditions that require additional licensing, certification, or training for staff. Examples are included below:

A. Tube feeding
B. Trach care

P.O. Box 25010
Little Rock, AR 72221

C. Tasks and activities that can be performed only by a licensed specialist

Complex Behavioral Health Needs:
The member has behavioral needs that require additional licensing, certification, or training for staff. Examples are included below:

A. Significant/extreme physical aggression
B. High potential (or rapid readmit within the last 12 months) for rapid readmission, as evidenced by utilization of acute placement/ED usage, within a three- to six-month span
C. Tasks and activities that can be performed only by a licensed specialist
D. Positive Behavior Support Plan in place with regular review and training for Direct Care Support Staff

Complex Intellectual Disabilities:
The member has received diagnoses for at least two more IDs and two of the above combined, under Complex Medical/Health Conditions and/or Behavioral Health.

**Rate determination will be based on the type of additional supports needed to best support member and might incorporate blended rates. For concurrent reviews, evidence that the initial plan submitted for Level 2 funding was enacted or an alternative plan was established based on a change in member's needs.*

Supportive Living — One-on-One Staffing — Level 5 Criteria
The member must also meet criteria for Level 1 and Level 2.

Complex Medical/Health Conditions:
Requests must be reviewed by the Medical Director to ensure justification for a custom rate. Examples are included below:

A. Members who have received multiple Unable to Serve notices from providers based on needs or behaviors that require a high level of support
B. High potential (or rapid readmit within the last 12 months) for rapid readmission, as evidenced by utilization of acute placement/ED usage, within a three- to six-month span where other levels of interventions have been attempted and failed to meet the member's needs
C. Requires the need for two-to-one direct care with incident reports to support justification

**The number of units approved will be determined through Arkansas Total Care's utilization management process while the rate determination will be determined in conjunction with*

P.O. Box 25010
Little Rock, AR 72221

Arkansas Total Care's Contracting Team. Rate determination will be based on the type of additional supports needed to best support member and might incorporate blended rates. For concurrent reviews, evidence that initial plan submitted for Level 5 funding was enacted or an alternative plan was established based on a change in member's needs.

Supportive Living — Complex Care Home
Member must also meet criteria for Level 1 & Level 2

Members who receive supportive living and require a higher level of care due to acuity may receive supportive living in congregant home settings of no more than eight unrelated persons. Each person residing in the Complex Care Home must be diagnosed with an intellectual disability and a significant co-occurring deficit, which includes "without limitation" individuals with an intellectual disability and significant behavioral health needs or physical health needs.

The Complex Care Home provider is required to maintain the member to staff ratio required to meet each member's needs, as provided in their PCSP and prior authorization, and to ensure member and staff health and safety. Under no circumstances may there be less than a four-to-one member-to-staff ratio in the home at any time.

212.300 Documentation Required for Supportive Living Requests
The following documentation should be submitted with the prior authorization request to determine that the member requires the supportive living service to safely maintain them in the overall community.

Initial, Revision, or Concurrent Requests:

A. Budget sheet/schedule reflecting the most current proposed hours of supportive living and schedule
B. Current treatment plan
C. Documentation of the last three months of all supportive living progress notes remitted by all DSP staff if supportive living services are already in place and being approved through a separate funding source. An extended progress note period may be requested.
D. Days and hours that parental/guardian support and/or natural support are in place, if applicable
E. Days and hours that other services, including but not limited to ADDT, EIDT, and personal care, are in place, if applicable
F. Justification for the number of units being requested
G. Completed "SL Provider Level 2 & Level 5 Rate Request" and "Physician/Clinician Recommendation for Level 2 & Level 5 Rate Request" forms with justification for

P.O. Box 25010
Little Rock, AR 72221

the rate level being requested, including but not limited to documentation from the provider (PCP, behavioral health clinician, specialist, etc.), incident reports, medical records, overview of additional training/licensure/certification required for staff, or other pertinent information

i. Specific plan for how the Level 2 or Level 5 rates will be used to support the member's complex needs, including how/when training will occur, schedule/hours staff with specialized certification/training will be working with the member, a plan to reduce risk and/or complex needs, etc.

H. Information on any additional resources that have been explored
I. Any additional pertinent information that could be used in a determination

Additional Items Required for Revision or Concurrent Requests:

A. Behavioral Prevention & Intervention Plan, or Positive Behavioral Support Plan if behaviors are identified as a risk on the member's PCSP
B. Copy of active medication management plan developed and overseen in conjunction with the prescribing physician for any member receiving prescription medications
C. Documentation of the last three months of all supportive living progress notes remitted by all DSP staff. An extended progress note period may be requested.
D. Evidence of how the Level 2 or Level 5 rates were utilized to support the member's complex needs, if applicable, over the previous authorized time period, as well as a plan for concurrent review request
    i. Specific details on how Level 2 or Level 5 rates were used to support the member's complex needs, including training that occurred, schedule/hours that staff with specialized certification/training worked with the member, progress made from the plan to reduce risk and/or complex needs, etc.

Additional documentation may be requested if required to determine the level of need and/or progress that may include additional progress notes, assessments, incident reports, and supporting medical documentation.

NOTE: Failure to satisfactorily document activities according to Arkansas Total Care requirements may result in non-payment or recoupment of payment of services.

213.000 Respite Services

Respite services are provided on a short-term basis for beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Receipt of respite services does not necessarily preclude a beneficiary from receiving other services on the same day. For example, a beneficiary may receive day services, such as supportive employment, on the same day as respite services.

P.O. Box 25010
Little Rock, AR 72221

When respite is furnished for the relief of a therapeutic foster care provider, therapeutic foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite may be provided in the following locations:

A. Beneficiary's home or private place of residence
B. The private residence of a respite care provider
C. Foster home
D. Group home
E. Licensed respite facility
F. Other community residential facility approved by the state, not a private residence
G. Licensed or accredited residential mental health facility
H. Licensed Human Development Center (HDC)

213.100 Benefit Limits & Exclusions for Respite Services

Prior authorization is required for all respite services and must be approved before services can begin. When respite is provided in an HDC setting, it should not exceed 90 days.

213.200 Documentation Requirement for Respite Service Requests

A. Updated budget sheet and treatment plan reflecting the most current proposed hours
B. Documentation as to why respite is required and why natural supports cannot support this need
C. Any additional pertinent information that could be used for determination
D. Documentation as to which respite activities will be performed during the time services are rendered

214.000 Supported Employment

Supported employment is a tailored array of services that offers ongoing support to beneficiaries with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred or has been interrupted or intermittent because of a significant disability, and who need ongoing supports to maintain their employment.

Supported employment services may include any combination of the following services:

A. Vocational/job related discovery and assessment
B. Person-centered employment planning
C. Job placement
D. Job development

arkansas total care

P.O. Box 25010
Little Rock, AR 72221

E. Negotiation with prospective employers
F. Job analysis
G. Job carving
H. training and systematic instructions
I. Job coaching
J. Benefits support
K. Training and planning
L. Transportation
M. Asset development
N. Career advancement services
O. Extended supported employment supports
P. Other workplace support services, including services not specifically related to job skill training, that enable the waiver client to be successful in integrating into the job setting

The service array may also be utilized to support individuals who are self-employed. Transportation between the member's place of residence and the employment site is included as a component of supported employment services when there is no other resource for transportation available.

214.100 Benefit Limits & Exclusions for Supported Employment

Prior authorization is required for all supported employment services and must be approved before services can begin. Supported employment is limited to a weekly maximum of 40 hours with an annual limit of 2,080 hours.

Payment for supported employment services excludes:

A. Incentive payments made to an employer of waiver beneficiaries to encourage or subsidize an employer's participation in the program
B. Payments that are passed through to waiver beneficiaries
C. Payments for training that are not directly related to the waiver beneficiary's employment
D. Reimbursement if the beneficiary is not able to perform the essential functions of the job. The functions of a job coach are to coach, not to do the work for the person.
E. CES Waiver-supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.
F. Services provided in a sheltered workshop or similar type of vocational service furnished in a specialized facility

P.O. Box 25010
Little Rock, AR 72221

214.200 Documentation Requirements for Supported Employment Service Requests

Supported employment requires related activities to be identified and included in outcomes with an accompanying work plan submitted as documentation of need for service.

Documentation must include:

A. Demonstrate the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individual with Disabilities Education Act (20 U.S.C. 1401 et. seq)
B. Include proof from the funded provider where services were exhausted to include the Arkansas Rehabilitation Services letter of closure
C. Include a job development plan or transition plan for job supports
D. Include the beneficiary's work schedule
E. Include the beneficiary's remuneration statement (paycheck stub)

215.000 Adaptive Equipment

Adaptive equipment is a piece of therapeutic or augmentative equipment, or product system, that is used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily tasks that would not be possible otherwise. Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the member. All items must meet applicable standards of manufacture, design, installation, and the Americans with Disabilities Act (ADA).

Adaptive equipment includes enabling technology, such as safe home modifications, that empowers members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance, while still providing monitoring and response as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice. Before enabling technology will be provided, it must be documented that an assessment was conducted, and a plan was created to show how the enabling technology will meet those requirements.

Adaptive equipment also includes a Personal Emergency Response System (PERS), which is a stationary or portable electronic device used in the member's place of residence that enables the member to secure help in an emergency. The PERS is connected to a response center staffed by trained professionals who respond to activation of the device. The member may also wear a portable "help" button to allow for mobility. PERS services are limited to members who are without paid support for significant parts of the day and have no regular paid support for

P.O. Box 25010
Little Rock, AR 72221

extended periods of time and who would otherwise require extensive routine supervision. PERS services may include the assessment, purchase, installation, and monthly rental fee.

Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment that allows the member increased control of their environment to gain independence or to protect their health and safety. Supplies are not covered.

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the beneficiary more appropriately than a communication board. Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Adaptive equipment needs for supportive employment are included. This service may include specialized equipment such as devices, controls, or appliances that will enable the person to perceive, to control, or to communicate with the environment in which they are competitively employed.

The care and maintenance of adaptive equipment and PERS are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service could be denied for a minimum of two plan years. Any unauthorized use or selling of aids by the beneficiary or legally responsible person shall mean the aids will not be replaced using waiver funding.

Vehicle modifications are adaptations to an automobile or van to accommodate the special needs of the beneficiary. Vehicle adaptations are specified by the service plan as necessary to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare, and safety of the beneficiary.

Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made.

Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification, is a fraudulent activity. All suspected fraudulent activity will be reported to the Office of Medicaid Inspector General for investigation.

P.O. Box 25010
Little Rock, AR 72221

Reimbursement for a permanent modification cannot be used or considered as a down payment for a vehicle.

Lifts that require vehicle modification and the modifications themselves are, for purposes of approval and reimbursement, one project and cannot be separated by plan-of-care years to obtain up to the maximum amount allowed.

The age and condition of the vehicle will be considered when being reviewed for modification.

215.100 Benefit Limits & Exclusions for Adaptive Equipment

The adaptive equipment is based on medical necessity and/or adaptive functioning and need. Arkansas Total Care must prior authorize adaptive equipment. Adaptive equipment may only be covered if not available to the beneficiary from any other source. An appropriate licensed professional must ensure that the equipment will meet the needs of the beneficiary when the purchase exceeds $500. The licensed professional's field of practice should align with the beneficiary's condition for which the equipment is needed.

All adaptive equipment must be solely for the waiver beneficiary. All purchases must meet the conditions for desired quality at the least expensive cost. Any modifications over $1,000 will require three bids with the lowest bid with comparable quality being awarded; however, Arkansas Total Care may require three bids for any requested purchase. All adaptive equipment is limited to the amount, duration, and scope of services described in the member's PCSP, plan of care, and as authorized by Arkansas Total Care.

Exclusions for adaptive equipment include but are not limited to the items noted below.

A. Swimming pools (in-ground or above-ground) and hot tubs are not allowable as either an environmental or adaptive equipment.
B. Therapeutic tools like those therapists employ during therapy are not included.
C. Educational aids are not included.
D. Computers will not be purchased to improve socialization or educational skills.
E. Computer supplies are excluded.
F. Computer desks or other furniture items are not covered.
G. Medicaid-purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.
H. Items such as toys, gym equipment, sports equipment, etc. are excluded as they do not meet the service definition.

Exclusions and limitations for adaptive equipment specific to vehicle modifications include but are not limited to the following:

P.O. Box 25010
Little Rock, AR 72221

A. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the beneficiary.
B. Purchase, down payment, monthly car payment, or lease cost of a vehicle.
C. Regularly scheduled upkeep and maintenance of a vehicle and the modification to the vehicle.
D. Vehicle modifications to leased vehicles (the vehicle must be owned and not leased or be in the process of being purchased and proof of ownership is required).
E. All vehicle modifications must be completed by a qualified professional licensed under applicable Arkansas statutes and in accordance with applicable state and local building codes as well as the ADA.

215.200 Documentation Requirements for Adaptive Equipment Requests

Documentation must include:

A. How adaptive equipment will increase, maintain, or approve functional capabilities of the member to perform daily tasks that would not be possible otherwise.
B. Details of how the equipment will ensure the member's health and safety.
C. Three separate bids if the request exceeds $1,000. Arkansas Total Care may require three bids for any requested purchase.
D. Documentation of an appropriate licensed professional to ensure that the equipment will meet the needs of the member when the purchase exceeds $500.
E. Letter of necessity from the prescribing provider, including clinical justification for the request.
F. Any additional pertinent information that could be used in a review.
G. Documentation of other avenues that were explored for accessing these items prior to requesting to be covered under the CES Waiver.
H. If making a vehicle modification, proof that the vehicle is not a leased or company owned vehicle.

216.000 Environmental Modifications

Environmental modifications are physical adaptations to the member's home that are documented in the member's plan of care and PCSP, which are necessary to ensure the health, welfare, and safety of the member, or which enable the member to function with greater independence in the community. Without the modification, the member would not be able to remain in the community. Such modifications may include the installation of lifts, ramps, grab-bars, widening of doorways, modifications of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies, which are medically necessary for the welfare of the member.

P.O. Box 25010
Little Rock, AR 72221

Environmental modification services are a covered benefit for Arkansas Total Care members who have an active CES Waiver slot when adaptation to the member's home is necessary for the health, welfare, and safety of the member. The modification to the home or vehicle must be appropriate for the member and enable the member to function with greater independence in the community. Without the modification, the member would otherwise be institutionalized.

Expenses for the installation of the environmental modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be relocated with the beneficiary, and that have written consent from the property owner or legal representative, will be considered. Requests for modifications must include an original photo of the site where modifications will be done; to-scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion, and expected outcomes; labor and materials breakdown; and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the waiver provider. Payment to the contractor is to be withheld until the work meets specifications, including a signed customer satisfaction statement.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted at one time and another part submitted at another time.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000 will require three bids, with the lowest bid with comparable quality being awarded. However, Arkansas Total Care may require three bids for any requested modification.

Environmental modifications may only be funded through the CES Waiver if not available to the beneficiary from any other source. If the beneficiary may receive environmental modifications through the Medicaid state plan, a denial by utilization review will be required prior to approval for funding through the waiver.

216.100 Benefit Limits & Exclusions for Environmental Modifications

Arkansas Total Care requires prior authorization for all environmental modifications. Final determinations and approvals will be for specific cost amounts. Any additional or unexpected costs would need to be submitted for further review and be in alignment with all other aspects outlined in this policy. There is an annual capitated amount of $10,000 per member. Arkansas Total Care reserves the right to approve a "rolling cap" that allows for the incorporation of the upcoming year's capitated amount in situations where justification is provided that the needed

modification is medically necessary and will exceed the annual capitated amount. Modifications of the same or similar type will only be permitted to occur once every five years unless there are extenuating circumstances that are out of the control of the member and member's family/support system, such as loss of property due to a natural disaster.

Exclusions include, but are not limited to, those adaptations or improvements to the home that are:

A. Of general utility and/or aesthetic in nature and are not of direct medical or remedial benefit to the member, such as carpeting or central air conditioning/heat, or general maintenance/repair of the home.
B. Adaptations that add to the total square footage of the home.
C. Adaptations for medical conditions that are temporary in nature, such as broken bones and recoveries from surgery where the member is expected to be back to their prior level of functioning after a predetermined period of time.
D. Home modifications in a group home, adult family care home, rehabilitation facility, or any other facility in which a member resides.
E. Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services.
F. If the member resides in a home covered by any federally funded housing assistance program, they are not eligible for home modifications. Under the Fair Housing Act and Section 504 of the Rehabilitation Act of 1973, HUD and HUD-assisted agencies must make reasonable accommodations for the known physical or mental limitations of a qualified applicant. All HUD programs are obligated except for the mortgage insurance and loan guarantee programs.
G. Spas, hot tubs, in-ground, and above-ground pools are excluded.
H. Walk-in tubs are excluded.
I. Home modifications are intended to improve access for the member. They are not intended to improve the overall value, appearance, or structural deficiencies of the home.
J. Reimbursement for a permanent modification cannot be used or considered as a down payment for a home.
K. Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded.
L. Expenses for remodeling or landscaping that are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable.
M. The moving of modifications, such as fencing, ceiling tracks, and adaptive equipment that may be permanently affixed to the structure or outside premises, is not allowable.

The following is a list of limitations:

A. All home accessibility adaptations must be provided by a qualified independent,

general, residential, or building contractor licensed under applicable Arkansas statutes and in accordance with applicable state and local building codes as well as the ADA.

B. Final determinations and approvals will be for specific cost amounts. Any additional or unexpected costs would need to be submitted for further review and be in alignment with all other aspects outlined in this policy.
C. All environmental modification services are limited to the amount, duration, and scope of services described in the member's PCSP, plan of care, and as authorized by Arkansas Total Care.
D. If the member lives in a mobile home or manufactured home, construction limitations may prohibit an approved home modification from occurring. The general contractor selected by Arkansas Total Care is the subject matter expert that will be relied upon to determine whether an approved home modification can be completed without causing structural damage to the mobile home or manufactured home.
E. The modification(s) must be performed within any applicable Arkansas zoning or coding ordinances.
F. Modifications of the same or similar type will only be permitted to occur once every five years unless there are extenuating circumstances that are out of the control of the member and member's family/support system, such as loss of property due to a natural disaster.
G. There is an annual capitated amount of $10,000 per member. Arkansas Total Care reserves the right to approve a "rolling cap" that allows for the incorporation of the upcoming year's capitated amount in situations where justification is provided that the needed modification is medically necessary and will exceed the annual capitated amount.

216.200 Documentation Requirements for Environmental Modification Requests

The following documentation should be submitted with the prior authorization request to determine that the member requires the environmental modification service to safely maintain them in the home environment and the overall community.

A. Justification that the requested modification is needed for safety of the member, which includes the safe entry and exit to the home and ability to carry out the activities of daily living.
B. Justification that the modification to the home will enable the member to function with greater independence in the home and community.
C. Justification that without the adaptation to the home, the member would not be able to remain in the community.
D. Applicable assessments of the member's physical needs indicate that the requested service will safely meet the needs of the member and will support the member in carrying out activities of daily living.

P.O. Box 25010
Little Rock, AR 72221

E. Documentation of how the modification will increase, maintain, or improve functional capabilities if a member performs daily tasks that would not be possible otherwise.
F. For home modifications, a proposed sketch of the space to be modified and original photos of the site to be modified.
G. A total of three bids if the modification exceeds $1,000. Arkansas Total Care may require three bids for any requested modification.
H. Identification of other specifications relative to materials, time for project completion and expected outcomes, labor and materials, and assurance of compliance with local building code.
I. If making a home modification, proof of home ownership or approval from the applicable homeowner. See the Homeowner Verification section for more details.
J. If making a home modification, homeowner association or property owner association (HOA and POA) status as approval from any HOA or POA will be required before modification can begin and is a requirement for Arkansas Total Care to approve and fund home modification.

217.000 Specialized Medical Supplies

A physician must order or document the need for all specialized medical equipment. All items must be included in the PCSP. All specialized medical supplies should also be documented in the prescribing physician's chart as related to the medical condition for which the item(s) are being requested. Specialized medical equipment and supplies include:

A. Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.
B. Durable and non-durable medical equipment not available under the Arkansas Medicaid state plan that is necessary to address beneficiary functional limitations.
C. Necessary medical supplies that are not available under the Arkansas Medicaid state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design, and installation. The most cost-effective item will be considered first.

Additional supply items are covered as a waiver service when they are considered essential and necessary for home and community care. Covered items include:

A. Nutritional supplements
B. Non-prescription medications
    i. Excludes alternative medicines that are not approved by the Food and Drug Administration (FDA)

P.O. Box 25010
Little Rock, AR 72221

C. Prescription drugs, not including the cost of Medicare Part D covered medications for dual-eligible beneficiaries

When the items are included in Arkansas Medicaid state plan services, a denial of extension of benefits by Arkansas Total Care's utilization review will be required prior to approval for waiver funding.

Arkansas Total Care may request medical records from the prescribing provider to ensure the medical necessity of specialized medical supplies. Arkansas Total Care expects the following information to be contained in the medical records:

A. Signed progress note(s) for all dates of service
B. Medical condition(s) for which each product has been prescribed
C. Referrals to specialty providers for diagnosis and treatment of conditions
D. Lab test reports clearly indicating the lab result(s) and date(s) of service, if applicable
E. Documented baseline in member condition and how the member has benefited from using this product over the past year
F. Quantity prescribed per month
G. Other documentation from the face-to-face encounter, if applicable

217.100 Benefit Limits & Exclusions for Specialized Medical Supplies

Arkansas Total Care requires prior authorization for all specialized medical supplies. Arkansas Total Care reserves the right to find comparable products to meet the needs of the member.

217.200 Documentation Requirements for Specialized Medical Supplies Requests

A. Name and description of the item, along with other identifying information, if applicable. For nutritional supplements and OTC medications, include the National Drug Code (NDC). For other products, include the Universal Product Code (UPC) if available.
B. Expected supplier of the item.
C. Justification that the item(s) are necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary for proper functioning of such items.
D. Letter of medical necessity from the prescribing provider, including clinical justification for the request as well as quantity.
E. Supporting documentation indicating that this item is covered by the FDA.
F. Documentation on how the member has benefited from using this product this past year, if applicable.
G. Any additional information that could be used in making a determination.
H. Proof of lack of other available resources.

P.O. Box 25010
Little Rock, AR 72221

218.000 Supplemental Support Service

The supplemental support service helps improve or enable the continuance of community living. Supplemental support service will be based on demonstrated needs as identified in a beneficiary's PCSP as unforeseen problems arise that, unless remedied, could cause disruptions in the beneficiary's services or placement, or place them at risk of institutionalization. Waiver funds will be used as the payer of last resort.

218.100 Benefit Limits & Exclusions for Supplemental Support Services

This service can be accessed only as a last resort. Lack of other available resources and funding options must be documented and proven. All supplemental services require prior authorization from Arkansas Total Care.

Benefit limits and exclusions for supplemental support services include but are not limited to the below.

A. Payment for housing or room and board is excluded.
B. Generators will only be considered if a member is on a life-sustaining device that requires electricity and is limited to the support of this device and not other household items.
C. Generators will be limited to a single purchase per lifetime with a capitated cost of $1,000.
D. Ongoing maintenance and fuel costs for generators are excluded.

218.200 Documentation Requirements for Supplemental Support Service Supplies Requests

Documentation must include a description of how the specific service being requested under supplemental supports will improve and enable the member's continuance of community living and assurance of health and safety and prevent disruption of community placement, including evidence to support this.

219.000 Consultation Services

Consultation services are clinical and therapeutic services that assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's PCSP.

Consultation activities may be provided by professionals who are licensed as:

A. Psychologists
B. Psychological examiners
C. Mastered social workers
D. Professional counselors
E. Speech pathologists

P.O. Box 25010
Little Rock, AR 72221

F. Occupational therapists
G. Physical therapists
H. Registered nurses
I. Certified parent educators or provider trainers
J. Certified communication and environmental control specialists
K. Dietitians
L. Rehabilitation counselors
M. Recreational therapists
N. Qualified Developmental Disabilities Professionals (QDDP)
O. Positive Behavior Support (PBS) specialists
P. Behavior analysts

These services are direct in nature. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. These activities include, but are not limited to:

A. Provision of updated psychological and adaptive behavior assessments
    i. Allowable providers include psychologists, psychological examiners, speech therapists, physical therapists, and occupational therapists within the scope of their practice area.
B. Screening, assessing, and developing CES Waiver services treatment plans
    i. Allowable providers include QDDPs, psychologists, psychological examiners, speech therapists, physical therapists, occupational therapists, dietitians, PBS specialists, licensed clinical social workers, professional counselors, RNs, certified communication and environmental control specialists, and board-certified behavior analysts (BCBAs) within the scope of their practice area.
C. Training of direct services staff or family members in carrying out special community living services strategies identified in the member's PCSP as applicable to the consultation specialty
D. Providing information and assistance to the persons responsible for developing the member's PCSP as applicable to the consultation specialty
E. Participating on the interdisciplinary team when appropriate to the consultant's specialty
F. Consulting and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the member's PCSP specific to the consultant's specialty
G. Assisting direct services staff or family members to make necessary program adjustments in accordance with the member's PCSP and applicable to the consultant's specialty

P.O. Box 25010
Little Rock, AR 72221

H. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers, and software consistent with the consultant's specialty
I. Training or assisting members, direct services staff, or family members in the set up and use of communication devices, computers, and software consistent with the consultant's specialty
J. Training of direct services staff or family members by a professional consultant in:
    i. Activities to maintain specific behavioral management programs applicable to the member
    ii. Activities to maintain speech pathology, occupational therapy, or physical therapy program treatment modalities specific to the member
    iii. The provision of medical procedures not previously prescribed but now necessary to sustain the member in the community
K. Training or assisting by advocacy consultants to members and family members on how to self-advocate
L. Rehabilitation counseling
M. Screening, assessing, and developing PBS plans, and assisting staff in implementation, monitoring, reassessment, and plan modifications
    i. A PBS plan is required when a high level of behavioral-related risk is identified in the PASSE's risk mitigation plan. Allowable providers include psychologists, psychological examiners, PBS specialists, BCBAs within the scope of their practice area, licensed clinical social workers, and licensed professional counselors.
N. Training and assisting members, direction services staff, or family members in proper nutrition and special dietary needs

Additionally, the PASSE is responsible for developing a risk mitigation plan for each client that outlines risk factors and action steps that must be taken to mitigate the risk. CES Waiver clients who are at low risk of displaying behaviors that can lead to harm of self and/or community members must have a behavior prevention and intervention plan that is overseen and implemented by the client's supportive living provider. The goal is to keep the member in their place of residence and avoid an acute placement.

Supportive living staff developing, overseeing, and implementing behavioral prevention and intervention plans must receive training in verbal de-escalation, trauma-informed care, and verbal intervention training. Behavioral prevention and intervention plan development must be performed by staff who meet the minimum qualifications of a PBD specialist in accordance with CES Waiver standards.

P.O. Box 25010
Little Rock, AR 72221

219.100 Benefit Limits & Exclusions for Consultation Services

Arkansas Total Care requires prior authorization for all consultation services.

219.200 Documentation Requirements for Consultation Service Requests

A. Justification for clinical and therapeutic services that assist the waiver member, parents, guardian, legally responsible individual, and services provider in carrying out the member's PCSP
B. Name of the licensed professional providing the service and the service to be provided
C. Documentation of how the service will be a part of the individual objectives for the member as applicable to the consultation specialty
D. Justification on how training of direct services staff and family members will carry out this request in the PCSP as applicable to the consultation specialty
E. Cost, resource, justification, desired outcome, and how this will be monitored and reported
F. Schedule and frequency of the training(s)
G. Credentials of the trainer and supporting documentation of how this training has provided outcomes for this service as relating to the person's disability
H. Any additional information that could be used in a determination

220.000 Community Transition Services

Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institution or another provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the beneficiary or their guardian is directly responsible for their own living expenses. Waiver funds can be accessed once it has been determined that the waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

A. Security deposits that are required to obtain a lease on an apartment or home
B. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens
C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water
D. Services necessary for the beneficiary's health and safety, such as pest eradication and one-time cleaning prior to occupancy
E. Moving expenses

P.O. Box 25010
Little Rock, AR 72221

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the PCSP development process, clearly identified in the PCSP, and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Duplication of environmental modifications will be prevented through control of prior authorizations for approvals.

Costs for community transition services furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver are considered to be incurred and billable when the person is determined to be eligible for the waiver services. The beneficiary must be reasonably expected to be eligible for, and to enroll in, the waiver. If for any unseen reason the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid.

220.100 Benefit Limits & Exclusions for Community Transition Services

Arkansas Total Care requires prior authorization for all community transition services. Community transition services may not include payment for room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes (televisions, cable access, streaming services, DVD players, etc.). Community transition services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

220.200 Documentation Requirements for Community Transition Service Requests

A. Detailed itemization to demonstrate how the dollars requested will be spent
B. Proof or attestation that items/services cannot be obtained from other sources
C. Any additional information that could be used in making a decision

221.000 Care Coordination Services

Care coordination services are the responsibility of Arkansas Total Care and are no longer a covered service when provided by a CES Waiver provider.

P.O. Box 25010
Little Rock, AR 72221

230.000 PRIOR AUTHORIZATION

CES Waiver services require prior authorization by Arkansas Total Care. **In the absence of prior authorization, reimbursement will be denied and may not be approved retroactively.**

See the Arkansas Total Care Provider Manual for instructions on how to submit authorization for service requests to Arkansas Total Care. This manual is available at ArkansasTotalCare.com.

240.000 REIMBURSEMENT

241.000 Method of Reimbursement

The reimbursement rates for CES Waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure. Providers can locate our fee schedule at ArkansasTotalCare.com under the Provider Resources tab.

250.000 BILLING PROCEDURES

251.000 Introduction to Billing

CES Waiver providers use the CMS-1500 claim form to bill Arkansas Total Care. See the Arkansas Total Care Provider Manual for instructions on how to submit claims for services rendered to Arkansas Total Care. This manual can be found at ArkansasTotalCare.com.

300.000 1915(i) WAIVER GENERAL INFORMATION

301.000 Overview

Arkansas Total Care is committed to ensuring that all members have access to the services needed. The goal is to create a flexible array of services that will allow members to reach their maximum level of wellness. Arkansas Total Care is committed to ensuring that all behavioral health services under the 1915(i) HCBS state plan amendment are provided with the intention to prevent or delay entry into an institutional setting, or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely and successfully in their own home or in the community. These services are aligned with the member's PCSP goals/objectives and services.

301.100 Providers of 1915(i) Waiver Services

1915(i) waiver services are limited to Arkansas and bordering state trade area cities. DHS must certify all providers before services may be provided for Arkansas Medicaid members.

P.O. Box 25010
Little Rock, AR 72221

All providers must be participating with Medicaid to provide services to Arkansas Total Care members.

310.000 PROGRAM COVERAGE

311.000 Scope

The 1915(i) waiver program offers certain HCBS care. Services within the 1915(i) must be appropriate to address the individual's identified functional deficits due to their behavioral health diagnosis and are rehabilitative in nature.

The purpose of the 1915(i) waiver is to support beneficiaries of ages four and up to address their behavioral health needs in a home- or community-based setting.

All 1915(i) waiver services must be prior authorized unless otherwise stated below. All services must be included in the member's PCSP.

312.000 Description of Services

The 1915(i) state plan amendment for HCBS is intended to improve the health of the population, the experience of care of individuals receiving services, and the quality of care, while reducing the growth of healthcare costs.

Services provided under this program can be provided by two provider types: Outpatient Behavioral Health (OBH) Agencies or Community Services/Supports Provider (CSSP). If provided as a CSSP, the services are broken out in three levels. In this manual they will be broken out by the CSSP levels. The levels/services are as follows:

Base Level

A. Supportive housing
B. Supportive life skills development
C. Adult life skills
D. Supportive employment
E. Respite
F. Therapeutic host homes
G. Pharmacological counseling by an RN

Intensive Level

A. Behavioral assistance
B. Peer support
C. Family support partners
D. Child and youth support services

P.O. Box 25010
Little Rock, AR 72221

E. Crisis stabilization intervention
F. Aftercare recovery support (for substance abuse) services

Enhanced Level

A. Adult rehabilitative day service
B. Therapeutic communities
C. Residential community reintegration
D. Substance abuse detox (observational)
H. Partial hospitalization

312.100 Program Requirements

In addition to the requirements for each service, to provide HCBS under the 1915(i) waiver, Arkansas Total Care has the following requirements:

1) Create a master treatment plan which is developed in cooperation with the beneficiary to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. Treatment plans must be updated annually or more frequently if circumstances or needs change significantly, or at the beneficiary's request. Treatment plans can only be developed by the following clinicians: (a) Independently Licensed Clinicians (Masters/Doctoral) (b) Non-independently Licensed Clinicians (Masters/Doctoral) (c) Advanced Practice Nurse (APN) (d) Physician

The treatment plan must use SMART goals and follow the service code definition. Any update or review to the treatment plan must include a review of the previous plan to include progress or lack thereof of each goal/objective. The plan should then be updated based on the member's progress/change in circumstances and goals and objectives should be modified based on assessment of previous plan. Goals/objectives must have completion dates that are current.

Minimum documentation requirements include:

A. Date of service (date plan is developed)
B. Start and stop times for development of plan
C. Place of service
D. Diagnosis
E. Beneficiary's strengths and needs
F. Treatment goals developed in cooperation with the beneficiary
G. Measurable objectives
H. Treatment modalities-services that will be used to meet the objectives
I. Projected schedule for service delivery including amount, scope, and duration
J. Credentials of staff who will be providing the services
K. Discharge criteria

L. Signature/credentials of staff completing the plan with date
M. Beneficiary's signature or signature of parent, guardian if beneficiary is under 18 with date of signature

2) Mental health diagnosis must be completed upon admission. Please refer to the Arkansas Department of Human Services Section II of the Counseling Services Manual for definition and documentation requirements.

3) Psychiatric assessment must be completed within 60 days of admission with an updated assessment completed when clinically appropriate or at a minimum every three years. Please refer to the Arkansas Department of Human Services Section II of the Counseling Services Manual for definition and documentation requirements.

In addition to this Waiver Manual, also see our Clinical Policy AR.CP.BH.503 for Home and Community Based Services for service specific criteria at the following link: https://www.arkansastotalcare.com/content/dam/centene/artotalcare/policies/clinical-policies/AR.CP.BH.503.pdf

See policy AR.CP.BH.503 for initial and concurrent review guidelines.

Base Level Services

313.000 Supportive Housing Services

Supportive housing is designed to ensure that members have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical-free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey.

Supportive housing includes assessing the member's individual housing needs and presenting options, assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

P.O. Box 25010
Little Rock, AR 72221

313.100 Supportive Housing Exclusions

This service is intended for adults and to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

313.200 Documentation Requirements for Supportive Housing Service Requests

The minimum documentation requirements are as listed:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of the actual encounter with collateral contact
D. Place of service (if 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how interventions address goals and objectives from the master treatment plan
G. Impact of the information received/given on the member's treatment
H. Staff signature/credentials/date of signature

313.300 Benefit Limits for Supportive Housing Services

Arkansas Total Care requires prior authorization for all units of service.

314.000 Supportive Life Skills Development Service

Supportive life skills development is a service that provides support and training for youth and adults ages 16 to 20 in a one-on-one or group setting. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Topics may include educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition. For clients with developmental or intellectual disabilities, supportive life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting.

P.O. Box 25010
Little Rock, AR 72221

314.100 Supportive Life Skills Development Exclusions

This service is intended for youth and adults ages 16 to 20. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

314.200 Documentation Requirements for Supportive Life Skills Development Services Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of the actual encounter with the collateral contact
D. Place of service (if 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how the interventions address goals and objectives from the master treatment plan
G. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
H. Plan for next contact, if any
I. Staff signature/credentials/date of signature

314.300 Benefit Limits for Supportive Life Skills Development Service

Arkansas Total Care requires prior authorization for all units of service.

315.000 Adult Life Skills Development

A service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition. For clients with developmental or intellectual disability, supportive life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting.

P.O. Box 25010
Little Rock, AR 72221

315.100 Adult Life Skills Development Exclusions

This service is intended for adults ages 18 and over. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

315.200 Documentation Requirements for Adult Life Skills Development Services Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of the actual encounter with the collateral contact
D. Place of service (if 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how the interventions address goals and objectives from the master treatment plan
G. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
H. Plan for next contact, if any
I. Staff signature/credentials/date of signature

316.000 Supportive Employment

Supportive employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the member is employed. Service settings may vary depending on individual need and level of community integration and may include the member's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

Allowable performing providers include Qualified Behavioral Health Providers (QBHPs) (BA), QBHPs (non-degreed), and RNs.

316.100 Supportive Employment Exclusions

This service must be delivered face-to-face and is intended for the adult population. A provider cannot bill any H2017 or H2015 codes on the same date of service. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

P.O. Box 25010
Little Rock, AR 72221

316.200 Documentation Requirements for Supportive Employment Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of actual encounter with collateral contact
D. Place of service (if 99 is used, specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how interventions address goals and objectives from the treatment plan
G. Information gained from collateral contact and how it relates to treatment plan objectives
H. Impact of information received/given on the member's treatment
I. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
J. Plan for next contact if any
K. Staff signature/credentials/date of signature

316.300 Benefit Limits for Supportive Employment

Prior authorization is required for all units of service.

317.000 Respite Services

Temporary direct care and supervision for a client due to the absence or need for relief of the non-paid primary caregiver. Respite can occur at medical or specialized camps, daycare programs, the member's home or place of residence, the respite care provider's home or place of residence, foster homes, or a licensed respite facility. Respite does not have to be listed in the PCSP. The primary purpose of respite is to relieve the principal caregiver of the member with a behavioral health need so that stressful situations are de-escalated, and the caregiver and member have a therapeutic and safe outlet. Respite must be temporary in nature. Any services provided for less than 15 days will be deemed temporary. Respite provided for more than 15 days should trigger a need to review the PCSP.

This service may be billed as a 15-minute unit or a per diem depending on the setting.

317.100 Respite Service Exclusions

This service is intended to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

P.O. Box 25010
Little Rock, AR 72221

317.200 Documentation Requirements for Respite Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Place of service
C. Diagnosis and pertinent interval history
D. Daily description of activities and interventions that coincide with the master treatment plan and meet or exceed minimum service requirements
E. Mental status and observations
F. Rationale and description of the treatment used that must coincide with objectives on the master treatment plan
G. Staff signature/credentials/date of signature

317.300 Benefit Limits for Respite Services

Prior authorization is required for all units of service.

318.000 Therapeutic Host Homes Services

A home or family setting that consists of high-intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting.

A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals.

The host parent should be present at the PCSP development meetings and should act as an advocate for the member.

318.100 Therapeutic Host Homes Exclusions

This service is intended to be provided face-to-face to children and youth.

318.200 Documentation Requirements for Therapeutic Host Homes Services

The minimum documentation requirements are as follows:

A. Date of service
B. Place of service
C. Diagnosis and pertinent interval history
D. Daily description of activities and interventions that coincide with the master treatment plan and meet or exceed minimum service requirements

P.O. Box 25010
Little Rock, AR 72221

E. Mental status and observations
F. Rationale and description of the treatment used that must coincide with objectives on the master treatment plan
G. Staff signature/credentials/date of signature

318.300 Benefit Limits for Therapeutic Host Homes Service Requests

Arkansas Total Care requires prior authorization for all units of service.

319.000 Pharmacological Counseling by RN

Pharmacological counseling involves a specific, time-limited one-to-one intervention by a nurse with a member and/or caregivers related to their psychopharmacological treatment. Individual pharmaceutical counseling involves providing medication information orally or in written form to the member and/or caregivers. The service should encompass all the parameters to make the member and/or family understand the diagnosis prompting the need for the medication and any lifestyle modification required. Counseling should include information relating to:

A. The purpose of taking psychotropic medication
B. Psychotropic medications, effects, side effects, and adverse reactions
C. Self-administration of medications
D. Storage and safeguarding of medications
E. How to communicate with mental health professionals regarding medication issues
F. How to communicate with family/caregivers regarding medication issues

Allowed performing providers for this service are RNs.

319.100 Pharmacological Counseling by RN Exclusions

All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

319.200 Documentation Requirements for Pharmacological Counseling by RN Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Start and stop times of the actual encounter with member
C. Place of service
D. Diagnosis and pertinent interval history
E. Brief mental status and observations
F. Rationale for and treatment used that must coincide with the master treatment plan

P.O. Box 25010
Little Rock, AR 72221

G. The member's response to treatment that includes current progress or regression and prognosis
H. Revisions indicated for the master treatment plan, diagnosis, or medication(s)
I. Plan for follow-up services, including any crisis plans
J. Staff signature/credentials/date of signature

319.300 Benefit Limits for Pharmaceutical Counseling Services

Prior Authorization is required for all units of service.

Intensive Level Services

All Intensive Level services require at least a quarterly individual/family therapy service.

320.000 Behavioral Assistance

Behavioral assistance is a specific outcome-oriented intervention provided individually or in a group setting, with the child/youth and/or their caregiver(s), that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life, and strengthen skills in a variety of life domains.

Behavioral assistance is designed to support youth and their families in meeting behavioral goals in various community settings. The service is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and support community integration. The service is tied to specific treatment goals and is developed in coordination with the youth and their family. Behavioral assistance aids the family in implementing safety plans and behavioral management plans when youth are at risk for offending behaviors, aggressions, and oppositional defiance. Staff provides supports to youth and their families during periods when behaviors have been typically problematic — such as during morning preparation for school, at bedtime, after school, or other times when there is evidence of a pattern of escalation of difficult behaviors. The service may be provided in school classrooms or on school buses for short periods of time to help a youth's transition from hospitals or residential settings but is not intended as a permanent solution to difficult behaviors at school.

Allowable performing providers include QBHPs (BA), QBHPs (non-degreed), and RNs.

P.O. Box 25010
Little Rock, AR 72221

320.100 Behavioral Assistance Exclusions

This service is intended to be provided face-to-face for children and youth ages 4-17. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

320.200 Documentation Requirements for Behavioral Assistance Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the beneficiary of all persons involved
C. Start and stop times of the actual encounter with collateral contact
D. Place of service (when 99 is used, the specific location and rationale for location must be included)
E. Client diagnosis necessitating treatment
F. Documentation of how the treatment used addresses goals and objectives from the master treatment plan
G. Information gained from contact and how it relates to master treatment plan objectives
H. Impact of the information received/given on the beneficiary's treatment
I. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
J. Plan for next contact, if any
K. Staff signature/credentials/date of signature

320.300 Benefit Limits for Behavioral Assistance

Arkansas Total Care requires prior authorization for all units of service.

321.000 Peer Support Services

Peer support is a consumer-centered service provided by individuals ages 18 and older who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach one's fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) that impact a beneficiary's functional ability. Services are provided on an individual or group basis, in either the member's home or community environment. Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques, self-

help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.

Allowable performing providers include certified peer support specialists.

321.100 Peer Support Service Exclusions

All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

321.200 Documentation Requirements for Peer Support Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of actual encounter with collateral contact
D. Place of service (if 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how the interventions address goals and objectives from the master treatment plan
G. Information gained from collateral contact and how it relates to master treatment plan objectives
H. Impact of information received/given on the member's treatment
I. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
J. Plan for next contact, if any
K. Staff signature/credentials/date of signature

321.300 Benefit Limits for Peer Support Services

Arkansas Total Care requires prior authorization for all units of service.

322.000 Family Support Partners Services

Family Support Partners is a service provided by peer counselors or family support partners (FSPs) who model recovery and resiliency for caregivers of children or youth with behavioral healthcare needs. FSPs come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach, and model appropriate child-rearing strategies, techniques, and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare

activities. It may also assist the family in securing community resources and developing natural supports.

FSPs serve as a resource for families with a child or adolescent receiving behavioral health or developmental disability services. FSPs help families identify natural supports and community resources; provide leadership and guidance for support groups; and work with families on individual and family advocacy, social support for assigned families, educational support, systems advocacy, lagging skills development, problem-solving technics, and self-help skills.
Allowable performing providers for this service are certified family support partners.

322.100 Family Support Partners Exclusions

This service is intended to be provided to children and youth. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

322.200 Benefit Limits for Family Support Partners Services

Arkansas Total Care requires prior authorization for units of service.

322.300 Documentation Requirements for Family Support Partners Service

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of actual encounter with collateral contact
D. Place of Service (if 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how the interventions address goals and objectives from the master treatment plan
G. Information gained from collateral contact and how it relates to master treatment plan objectives
H. Impact of the information received/given on the member's treatment
I. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
J. Plan for next contact, if any
K. Staff signature/credentials/date of signature

P.O. Box 25010
Little Rock, AR 72221

323.000 Child and Youth Support Services

Child and youth support services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; work with teachers/schools to modify classroom environments to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools.

Services might include an in-home case aide. An in-home case aide is an intensive, time-limited therapy for youth in the member's home or, in rare instances, a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

Allowable performing providers include QBHPs (BA), QBHPs (non-degreed), and RNs.

323.100 Child and Youth Support Exclusions

This service is intended for children and youth and to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program.

323.200 Documentation Requirements for Child and Youth Support Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Start and stop times of the actual encounter with the member
C. Place of service
D. Diagnosis and pertinent interval history
E. Brief mental status and observations
F. The member's response to treatment, including current progress or regression and prognosis
G. Revisions indicated for the master treatment plan, diagnosis, or medication(s)
H. Plan for follow-up services, including any crisis plans
I. Staff signature/credentials/date of signature

323.300 Benefit Limits for Child and Youth Support Services

Arkansas Total Care requires prior authorization for all units of service.

P.O. Box 25010
Little Rock, AR 72221

324.000 Crisis Stabilization Intervention

Crisis stabilization intervention is a scheduled face-to-face treatment activity provided to a member who has recently experienced a psychiatric or behavioral crisis that is expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, and needed accommodation for any disability and cultural framework of the member and their family. Additional needs-based criteria for receiving the service, if applicable, include the following:

A. Specify the limits (if any) on the amount, duration, or scope of this service.
B. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy client, and services must be equal for any individual within a group.

Allowable performing providers include:

A. Degreed or non-degreed QBHPs under the 1915(i) waiver, or licensed mental health professionals as stated in the counseling manual.

324.100 Crisis Stabilization Intervention Exclusions

This service is intended to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

324.200 Documentation Requirements for Crisis Stabilization Intervention Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Start and stop time of the actual encounter with the member and possible collateral contacts with caregivers or informed persons
C. Place of service
D. Specific persons providing pertinent information in relationship to the member
E. Diagnosis and synopsis of events leading up to the original crisis
F. Brief mental status and observations
G. The member's response to the intervention, including current progress or regression and prognosis
H. Development of a clearly defined crisis plan or revision to existing plan
I. Staff signature/credentials/date of signature(s)

324.300 Benefit Limits for Crisis Stabilization Intervention Service

There is a maximum of 12 units per day and 72 units per year, unless an extension of benefits (prior authorization) is requested and approved by Arkansas Total Care.

P.O. Box 25010
Little Rock, AR 72221

325.000 Aftercare Recovery Support (for Substance Abuse) Services

A continuum of care is provided to recovering members living in the community. This service includes educating and assisting the individual with accessing needed supports and services. The service assists the recovering member to direct their resources and support systems. In addition, there are transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. Meals and transportation are not included in the rate for aftercare recovery support. Aftercare recovery support can occur in the following:

A. The individual's home
B. In community settings such as school, work, church, stores, or parks
C. In a variety of clinical settings for adults, similar to adult daycares or adult day clinics

325.100 Aftercare Recovery Support Exclusions

This service is intended to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

325.200 Documentation Requirements for Aftercare Recovery Support Service Requests

The minimum documentation requirements are as listed:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of the actual encounter
D. Place of service (when 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating service
F. Documentation of how the services address goals and objectives from the master treatment plan
G. Information gained from the contact and how it relates to master treatment plan objectives
H. Impact of that information received/given on the member's treatment
I. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
J. Plan for next contact if any
K. Staff signature/credentials/date of signature

325.300 Benefit Limits for Aftercare Recovery Support Services

Arkansas Total Care requires prior authorization for all units of service.

P.O. Box 25010
Little Rock, AR 72221

Enhanced Level Services
All Enhanced Level Services have a clinical component and must have at a minimum quarterly individual/family therapy session unless more frequent services are required in the below definitions or in the HCBS Arkansas Total Care Clinical Policy.

326.000 Adult Rehabilitation Day Service
A continuum of care is provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person in learning, retaining, or improving specific job skills, and in successfully adapting and adjusting to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community.
In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities should provide a preplanned and structured group program for identified members aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment.

These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability, and must have measurable outcomes. These activities assist the member with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the individual as an active and productive member of their family, social and work community, and/or culture with the least amount of ongoing professional intervention. Skills addressed may include emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills; and any similar skills required to implement a member's master treatment plan.

The staff-to-member ratio maximum is one to 15 with the provision that the member ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status, and clinical needs.

P.O. Box 25010
Little Rock, AR 72221

326.100 Adult Rehabilitation Day Service Exclusions

All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

326.200 Documentation Requirements for Adult Rehabilitation Day Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Start and stop times of the actual encounter with collateral contact
D. Place of service (if 99 is used, the specific location and rationale for location must be included)
E. Member diagnosis necessitating intervention
F. Documentation of how the interventions address goals and objectives from the master treatment plan
G. Information gained from collateral contact and how it relates to master treatment plan objectives
H. Impact of information received/given on the member's treatment
I. Any changes indicated for the master treatment plan, which must be documented and communicated to the supervising MHP for consideration
J. Plan for next contact if any
K. Staff signature/credentials/date of signature

326.300 Benefit Limits for Adult Rehabilitative Day Service

Arkansas Total Care requires prior authorization for all units of service.

327.000 Therapeutic Communities Services

Therapeutic communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic communities employ community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within their community, and progress is measured within the context of that community's expectations.

A. Level 1 provides the highest level of supervision, support, and treatment as well as ensuring community safety in a facility of no more than 16 beds.

i. Clients who receive this level of care may have treatment needs that are severe enough to require inpatient care in a hospital but don't need the full resources of a hospital setting.
ii. The emphasis in this level is intensive services delivered using a multidisciplinary approach that includes physicians, licensed counselors, and highly trained paraprofessionals.

B. Level 2 provides supervision, support, and treatment at a lower level than Level 1 and can be used as a step down from Level 1 to begin the transition back into a community setting that will not provide 24/7 supervision, service, and support.
i. Interventions shift from clinical to addressing the client's educational or vocational needs, socially dysfunctional behavior, and the need for stable housing.
ii. Arranging for the full array of clinical and HCBS is critical for successful discharge.

Therapeutic communities must be provided in a facility that is certified by DHS.

327.100 Therapeutic Communities Exclusions

This service is intended for adults and to be delivered face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

This is a per diem service. No other Counseling Level or HCBS can be billed on the same day.

327.200 Documentation Requirements for Therapeutic Communities Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Names and relationship to the member of all persons involved
C. Place of service
D. Documentation of how the interventions address goals and objectives from the master treatment plan
E. Information gained from the contact and how it relates to master treatment plan objectives
F. Impact of the information received/given on the member's treatment
G. Staff signature/credentials/date of signature

328.000 Residential Community Reintegration Services

The Residential Community Reintegration Program is designed to serve as an intermediate level of care between inpatient psychiatric facilities and HCBS. The program provides 24-hour intensive therapeutic care provided in a small group home setting for children and youth with

emotional and/or behavior problems that cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment.

A Residential Community Reintegration Program shall be appropriately certified by DHS to ensure quality of care and the safety of members and staff. The program shall follow all certification requirements.

A Residential Community Reintegration Program shall ensure the provision of educational services to all beneficiaries in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in accordance with the Arkansas Department of Education.

328.100 Residential Community Reintegration Exclusions

This service is intended to be provided face-to-face to children and youth. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

No other counseling or HCBS may be billed on the same day.

328.200 Documentation Requirements for Residential Community Reintegration Service Requests

The minimum documentation requirements are as follows:

A. Date of service
B. Place of service
C. Diagnosis and pertinent interval history
D. Daily description of activities and interventions that coincide with the master treatment plan and meet or exceed minimum service requirements
E. Mental status and observations
F. Rationale and description of the treatment used that must coincide with objectives on the master treatment plan
G. Staff signature/credentials/date of signature

328.300 Benefit Limits for Residential Community Reintegration Services

The daily maximum of units that may be billed is one.

P.O. Box 25010
Little Rock, AR 72221

329.000 Substance Abuse Detoxification (Observational) Service

This service involves a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the member's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the member for ongoing treatment.

329.100 Substance Abuse Detoxification (Observational) Exclusions

This service is intended to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

329.200 Documentation Requirements for Substance Abuse Detoxification (Observational) Service Requests

The minimum documentation requirements are as follows:

A. Start and stop times of the actual program participation by member
B. Place of service
C. Diagnosis and pertinent interval history
D. Brief mental status and observations
E. Rationale for and treatment used that must coincide with the master treatment plan
F. The member's current progress or lack of progress toward symptom reduction and attainment of goals
G. Rationale for continued service, including necessary changes to diagnosis, master treatment plan or medication(s), and plans to transition to less restrictive services
H. All services provided must be clearly documented in the medical record
I. Staff signature/credentials

329.300 Benefit Limits for Substance Abuse Detoxification (Observational) Service

Arkansas Total Care requires prior authorization for all units of service.

330.000 Partial Hospitalization Services

Partial hospitalization is an intensive nonresidential therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment, or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less-than-24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of one to five to ensure necessary therapeutic services

and professional monitoring, control, and protection. This service shall include, at a minimum, intake, individual therapy, group therapy, and psychoeducation. Partial hospitalization shall be a minimum of five hours per day, of which 90 minutes must be a documented service provided by a mental health professional. If a member receives other services during the week but also receives partial hospitalization, the member must receive a minimum of 20 documented hours of services on no less than four days in that week.

Partial hospitalization can occur in a variety of clinical settings for adults, similar to adult daycares or adult day clinics. All partial hospitalization sites must be certified by the Division of Provider Services & Quality Assurance as a partial hospitalization provider. All medically necessary 1905(a) services are covered for EPSDT-eligible individuals in accordance with Subsection 1905(r) of the Social Security Act.

330.100 Partial Hospital Service Exclusions

This service is intended to be provided face-to-face. All other provider standards and requirements in accordance with those defined in the currently approved 1915(i) waiver program and the provider's certification should be followed.

330.200 Documentation Requirements for Partial Hospitalization Service Requests

The minimum documentation requirements are as follows:

A. Start and stop times of actual program participation by the member
B. Place of service
C. Diagnosis and pertinent interval history
D. Brief mental status and observations
E. Rationale for and treatment used that must coincide with the master treatment plan
F. The member's current progress or lack of progress toward symptom reduction and attainment of goals
G. Rationale for continued acute day service, including necessary changes to diagnosis, master treatment plan or medication(s), and plans to transition to less restrictive services
H. All services provided must be clearly documented in the medical record
I. Staff signature/credentials

330.300 Benefit Limits for Partial Hospitalization Services

Arkansas Total Care requires prior authorization for all units of service.

P.O. Box 25010
Little Rock, AR 72221

340.000 PRIOR AUTHORIZATION

1915(i) waiver services require prior authorization by Arkansas Total Care. **In the absence of prior authorization, reimbursement will be denied and may not be approved retroactively.** See the Arkansas Total Care Provider Manual for instructions on how to submit authorization for service request to Arkansas Total Care. This manual can be found at ArkansasTotalCare.com.

350.000 REIMBURSEMENT

351.000 Method of Reimbursement

The reimbursement rates for 1915(i) waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

360.000 BILLING PROCEDURES

361.000 Introduction to Billing

1915(i) waiver providers use the CMS-1500 claim form to bill Arkansas Total Care. See the Arkansas Total Care Provider Manual for instructions on how to submit claims for services rendered to Arkansas Total Care. This manual can be found at ArkansasTotalCare.com.