POLICY AND PROCEDURE

POLICY NAME: Supportive Living Criteria	**POLICY ID: ARTC.CC.20**
BUSINESS UNIT: Arkansas Total Care	**FUNCTIONAL AREA:** Care Coordination and Waiver Provider Support Utilization Management
EFFECTIVE DATE: 04-01-2023	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE:	
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:
To provide criteria on which to review requests for supportive living services for CES-Waiver members residing in the community for Arkansas Total Care (ARTC) line of business.

PURPOSE:
To provide criteria on which to review requests for the Arkansas Total Care (ARTC) line of business supportive living services for CES-Waiver members residing in the community. ARTC's supportive living services policy supports the utilization management review process for the CES-Waiver benefits and management of service coverage and limitations as described in the current CES-Waiver and ARTC Provider Waiver Services Manual.

SCOPE:
Arkansas Total Care's Care Coordination and Waiver Provider Support "WPS" departments.

POLICY:
Supportive living services are a covered benefit for ARTC members who have an active CES-Waiver slot or Tier IV status with approved ICF determination when the service is necessary for the health, welfare, and safety of the member. The services provided in the home and/or community must be appropriate for the member and enable the member to function with greater independence in the community. Without these supportive living services, the member would otherwise be institutionalized.

Supportive living services must be prior authorized by Arkansas Total Care. These services are covered only for ARTC members with an active CES-Waiver slot or Tier IV status with approved ICF determination on the date(s) the service is provided.

DESCRIPTION OF BENEFITS AND LIMITATIONS:

The following is a description of ARTC CES-Waiver covered supportive living services, and any applicable limitations covered by this policy:

Benefit:
Supportive living is an array of individually tailored habilitative services and activities to enable members to reside successfully in their own home, with family or in an alternative living setting (apartment, or provider owned group home). Supportive living services must be provided in an integrated community setting.

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:

- 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.
- Money management, including training and assistance in handling personal finances, making purchases, and meeting personal financial obligations.
- 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.
- 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.
- Community integration experiences, including activities intended to instruct the member in daily living and community living in integrated settings, such as shopping, church attendance, and sports.
- 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.
- Communication, including training in vocabulary building, use of augmentative communication devices, and receptive and expressive language.
- Behavior shaping and management, including training and assistance in appropriate expression of emotions or desires, compliance, assertiveness, 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.
- Reinforcement of therapeutic services, including conducting exercises reinforcing physical, occupational, speech, behavioral or other therapeutic programs.
- 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; and
- Health maintenance activities, which include tasks that members would otherwise do for themselves or have a family member do, except for injections and IV medication administration. It is not considered administration, except for injections and IV medications, when the paid staff assist the client by getting the medication out of the bottle or blister pack. Supportive living may be provided in clinic setting (i.e. physician office visit, wound clinic etc.) to facilitate appropriate care and follow-up. If 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 approved prior authorized rate for the service in place prior to hospitalization. If provided in acute care hospital, supportive living must meet following criteria:

a) be provided to meet needs of the individual that are not met through the provision of acute care hospital services.
b) must be in addition to and may not substitute for the services the acute care hospital is obligated to provide.
c) must be identified in the individual's PCSP and
d) service must ensure smooth transition between the acute care setting and community-based setting to preserve the individual's functional abilities. ARTC will conduct retrospective reviews to ensure these criteria are met.

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

- Supportive living cannot cover room and board expenses, including general maintenance, upkeep, or improvement to the home
- Supportive living may not substitute for the services the acute care hospital is obligated to provide during member's hospitalization.
- 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 but is not limited to personal care services, ADDT and EIDT.
- If a guardian is an owner for the Supportive Living provider serving the member, they cannot also act as a direct paid staff to avoid potential conflicts of interest.

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

- All supportive living services are limited to the amount, duration and scope of services authorized by Arkansas Total Care.
- All supportive living services must be provided by a qualified direct support professional working under the scope of a CES-Waiver or appropriately certified CSSP Provider who is credentialed with ARTC at time-of-service provision.
- For members under the age of 18, who reside with their parent/guardian without complex physical health/mental health or co-occurring needs, the maximum number of hours of Supportive Living will be 60 hours/week.
- If Supportive Living is provided in a hospital setting while the individual is receiving medical care, it cannot exceed 14 consecutive days nor exceed approved prior authorized rate for the service in place prior to hospitalization. Supportive living must meet following criteria
    - Be provided to meet needs of the individual that are not met through the provision of acute care hospital services.
    - Must be in addition to and may not substitute for the services the acute care hospital is obligated to provide.
    - Service must ensure smooth transition between the acute care setting and community-based setting to preserve the individual's functional abilities.
- If there is technology available that offers the same or higher level of care required, then technology 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.

PROCEDURE:
A. Identification of Need for Supportive Living Services

There are multiple ways that the potential need for supportive living services exists. Those are described below:

The member and/or an authorized representative may identify the need for supportive living services. In addition, a member's treating physician, medical representative or CES Waiver provider may identify that the member may benefit from covered services, including supportive living services.

In any of the above situations, the ARTC Care Coordinator "CC" will assist the member/guardian with identifying and selecting an in-network supportive living provider of their choice. The ARTC CC will ensure the provider understands the prior authorization process and assist where appropriate and needed.

B. Coordination of Benefits

ARTC will coordinate with member to confirm there is not another source of payment through these sources as CES-Waiver is the payer of last resort.

C. Prior Authorization Request

Eligibility criteria set by DDS for CES-Waiver services must be met prior to the request for 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.

Documentation needed:

The following documentation should be submitted with the prior authorization request in order to determine that the member requires the supportive living service to safely maintain him/her in the overall community.

Initial, Revision or Concurrent Requests:

- Current budget sheet/schedule reflecting the most current proposed hours of supportive living and schedule.
- Current Treatment Plan.
- Documentation of the last 3 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 time period of progress notes may be requested.
- Days and hours that parental/guardian supports and/or natural supports are in place if applicable.
- Days and hours that other services including but not limited to ADDT, EIDT and Personal Care are in place if applicable.
- Justification for the number of units being requested.
- Completed "SL Provider Level 2 & Level 5 Rate Request" and "Physician/Clinician Recommendation for Level 2 & Level 5 Rate Request" forms including justification for the rate level being requested including but not limited to documentation from provider (PCP, behavioral health clinician, specialist, etc.), incident reports, medical

records, overview of additional training/licensure/certification required for staff, or other pertinent information.
    - Specific plan for how Level 2 or Level 5 rate will be used to support member's complex needs including how/when training will occur, schedule/hours staff with specialized certification/training will be working with member, plan to reduce risk and/or complex needs, etc.
- Information on any additional resources that have been explored.
- Any additional pertinent information that could be used in a determination.

Additional Items Required for Revision or Concurrent Requests:

- Behavioral Prevention & Intervention Plan or Positive Behavioral Support Plan if behaviors are identified as a risk on member's PCSP.
- Copy of active medication management plan that was developed and is overseen in conjunction with the prescribing physician for any member receiving prescription medications.
- Documentation of the last 3 months of all supportive living progress notes remitted by all DSP staff. An extended time period of progress notes may be requested.
- Evidence of how the Level 2 or Level 5 rate was utilized to support member's complex needs if applicable over previous authorized time period as well as plan for concurrent review request.
    - Specific details on how Level 2 or Level 5 rate were used to support member's complex needs including training that occurred, schedule/hours staff with specialized certification/training worked with member, progress made from plan to reduce risk and/or complex needs, etc.

Additional documentation may be requested if required to determine level of need and/or progress that may include but is not limited to; additional progress notes, assessments, incident reports and supporting medical documentation.

Prior Authorization Review

These three components will be evaluated on the determination of need

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. Requires the level of care provided in an ICF/IID
C. Would be institutionalized in an ICF/IID in the near future, but for the provision of Waiver services.
D. Meets eligibility criteria set by DDS for HCBS Waiver
    a. Verification of a categorically qualifying diagnosis.
    b. Age of onset is established to be prior to age 22.
    c. 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; and

d. The disability and deficits are expected to continue indefinitely.

E. Physician prescribes home and community-based services 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 that the benefits to receiving the treatment outweigh any potential harm.
G. Less intensive services would not be adequate to assist the member in reaching identified treatment goals.
H. Have an active CES-Waiver slot or Tier IV status with approved ICF determination through Arkansas 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, which 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 treatment team agrees on treatment goals, objectives, and interventions.

Levels of Supportive Living

Supportive living rate criteria are based on member needs. Staff overtime, other administrative/business needs or living expenses cannot be used as justification for a higher-level rate.

Supportive Living – one on one staffing – Level 1 Criteria

<u>Intellectual Disabilities</u>:

- Meets the criteria for institutional level of care as defined by the state
- Must have an approved and documented proof of CES-Waiver slot, with documented proof by DHS/DDS (ARTC WPS team will verify), formally approved Tier 4 Dual status through Arkansas DHS, or formally approved Tier 4 Enhanced Care Coordination status with an active ICF determination.

Supportive Living – one on one staffing – Level 2 Criteria

Member must also meet criteria for Level 1

<u>Complex Medical/Health Conditions</u>

Member has complex medical/health conditions that require additional license, certification, or training for staff. Below are several examples but is not a comprehensive list.

- Tube Feeding
- Trach care
- Tasks and activities that can be performed only by a licensed specialist

Complex Behavioral Health Needs

Member has behavioral needs that require additional license, certification, or training for staff. Below are several examples but is not a comprehensive list.

- Significant/Extreme physical aggression
- High potential (or rapid readmit within the last 12 months) for rapid readmission, as evidenced by utilization of Acute Placement/ED usage, within 3–6-month span
- Tasks and activities that can be performed only by a licensed specialist
- Positive Behavior Support Plan is in place with regular review and training for Direct Care Support Staff

Complex Intellectual Disabilities

- At least (2) more ID diagnoses 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 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
Member must also meet criteria for Level 1 & Level 2

Complex Medical/Health Conditions

Requests must be reviewed by the Medical Director to ensure justification for a custom rate. Examples are listed below but this is not a comprehensive list.

- Members who have received multiple Unable to Serve notices from providers based on members needs or behaviors that require a high level of support.
- High potential (or rapid readmit within the last 12 months) for rapid readmission, as evidenced by utilization of Acute Placement/ED usage, within 3–6-month span where other levels of interventions have been attempted and failed to meet member's needs.
- Requires the need for 2:1 Direct Care with Incident Reports to support justification

**The number of units approved will be determined through ARTC's utilization management process while the rate determination will be determined in*

conjunction with ARTC'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 supported living in congregant home settings of no more than eight (8) 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 ration required to meet each member's needs as provided in their treatment plan, prior authorization and PCSP and to ensure member and staff health and safety but under no circumstances may there be less than a four-to-one (4:1) member to staff ration in the home at any time.

Discharge Criteria
Criterion A, B or C must be met to satisfy criteria for discharge.

A. The member does not meet eligibility criteria set by DDS for CES-Waiver services CES-Waiver slot or Tier IV status with approved ICF determination by DHS.
B. The member no longer meets continued stay criteria (e.g., treatment goals have been completed).
C. The member has failed to engage in services, despite assertive outreach efforts that are documented in the member's treatment record.

REFERENCES:
ARTC Waiver Provider Services Manual
CES-Waiver

ATTACHMENTS:
SL Provider Level 2 & Level 5 Rate Request
Physician/Clinician Recommendation for Level 2 & Level 5 Rate Request

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.