

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: 05/07/2024, 04/29/2025, 04/15/2026, 06/26/2026, 10/09/2026	
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, Tier IV status with approved ICF determination, or an active CES-Waiver waitlist slot on the date(s) the service is provided and 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, Tier IV status with approved ICF determination, or an active CES-Waiver waitlist slot 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:

- 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 attendance, 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, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors. The Supportive Living Provider is responsible for developing and overseeing the Behavioral Prevention and Intervention Plan or implementing and overseeing the Positive Behavior Support Plan, depending on the member's risk level identified in the Risk Mitigation Plan as part of the PCSP process.
- 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, and assertiveness; and
- K. 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.

Determination of Supportive Living Service Hours

Supportive Living services are intended to provide individualized habilitative supports necessary to assist a member to safely reside and participate in the community. As the CES Waiver is the payer of last resort, authorization decisions shall be based on the member's remaining unmet disability-related needs after consideration of all other available resources, services, and natural supports. Consistent with current ARTC policy, Supportive Living may not duplicate services available through Personal Care, ADDT, EIDT, educational services, or other available supports.

In determining the amount, duration, and scope of Supportive Living services to authorize, ARTC will evaluate:

- A. State Plan Medicaid services available to meet the identified need;
- B. Educational and school-based services;
- C. Natural supports and unpaid caregivers;
- D. Community resources and other available supports;
- E. Assistive technology, remote supports, and environmental modifications;
- F. The member's ability to perform activities independently;
- G. Other services authorized or available during the requested time period; and
- H. The least restrictive and least intensive service necessary to safely meet the member's needs.

Supportive Living services may be authorized only for periods during which documented disability-related needs remain unmet after consideration of the above resources. Previous authorization levels, provider staffing patterns, member preference, or caregiver preference do not establish medical necessity for future service levels. Authorization decisions will be based upon the member's current assessed needs, documented risks, functional limitations, available supports, service utilization history, and demonstrated need for habilitative intervention. Historical authorization levels do not establish entitlement to future authorization levels.

Supportive Living services shall be authorized only to the extent necessary to address assessed habilitative, health, welfare, or safety needs that are not reasonably and appropriately met through another available Medicaid service, educational service, natural support, community resource, assistive technology, environmental modification, or less intensive service.

The amount of Supportive Living authorized shall be based on the member's net demonstrated need, not solely upon the number of hours requested by the member, guardian, or provider or upon the availability of paid staff.

Net demonstrated need is calculated by identifying the specific time-limited activities requiring Supportive Living and subtracting periods in which:

- A. The member is receiving another service that meets the identified need;
- B. The member is attending school, ADDT, EIDT, employment, therapy, or another structured program;
- C. A parent, guardian, household member, or other natural support is reasonably available and responsible for providing ordinary support;
- D. The member is sleeping and does not require documented active intervention;
- E. The member can safely function independently, with intermittent support, or with assistive or remote-support technology;
- F. The activity requested is custodial, recreational, educational, supervisory, or for caregiver convenience rather than habilitative; or
- G. The requested service duplicates another authorized or available benefit.

ARTC shall evaluate whether an identified need falls within the scope of another available Medicaid state-plan service or other responsible service system before authorizing Supportive Living for the same need.

When Personal Care, ADDT, EIDT, school-based services, therapy, supported employment, assistive technology, remote supports, or another covered service can reasonably and appropriately meet an identified need, Supportive Living shall not be authorized for the same task or period unless an exception is approved under the Extraordinary Need criteria.

A member's or guardian's preference not to use an otherwise available service does not, by itself, establish medical necessity for Supportive Living. However, ARTC shall consider documented barriers including provider unavailability, access limitations, contraindications, failure of the alternative service to safely meet the member's assessed need, or circumstances in which use of the alternative would conflict with the member's documented person-centered goals.

When a member or guardian declines an available service that has been determined capable of safely meeting an identified need, the hours attributable to that service shall ordinarily be excluded from the Supportive Living authorization calculation.

Before excluding hours, ARTC shall document:

1. The service or resource identified;
2. The assessed task or need it would address;
3. The expected hours or units available;
4. Evidence that the service is actually accessible within the authorization period;

5. The member's or guardian's stated reason for declining;
6. Whether a documented clinical, safety, cultural, accessibility, or person-centered barrier exists; and
7. Whether the Extraordinary Need exception applies.

Supportive Living shall not be reduced based on a theoretical service that is not authorized, not available from a qualified provider, or not capable of safely meeting the identified need.

Authorization of Supportive Living hours does not guarantee payment for all hours requested or scheduled by a provider. Services must be delivered in accordance with the member's assessed needs, authorized service level, and documented active interventions. Provider staffing patterns shall not establish medical necessity.

Members Under Age 18

For members under age eighteen (18), parents, guardians, and custodial caregivers are expected to provide the supervision, care, instruction, transportation, guidance, and assistance that would ordinarily be provided to a child of the same age without a disability.

Supportive Living services are intended to address documented disability-related needs that exceed ordinary parental responsibilities and shall not be authorized to replace routine parenting functions, childcare, after-school care, supervision for caregiver convenience, educational instruction, academic support, or other services that are the responsibility of a parent, guardian, homeschool provider, school district, or educational program.

Authorization decisions for minors shall be based upon the member's remaining disability-related needs after consideration of:

- School attendance, educational services, and educational supports;
- Age-appropriate parental responsibilities;
- Natural supports and caregiver availability;
- Other available Medicaid-covered services;
- Community resources and supports;
- Assistive technology, remote supports, and environmental modifications when applicable; and
- Periods during which the member can safely function independently.

School closures, summer breaks, holidays, scheduled school vacations, early dismissal days, virtual learning days, homeschooling arrangements, or other interruptions in educational programming do not, by themselves, establish medical necessity for additional Supportive Living services. The temporary absence of educational services does not automatically convert previously excluded school hours into reimbursable Supportive Living hours.

Requests for Supportive Living services during periods when educational services are not in session must demonstrate a documented disability-related need that remains unmet after consideration of the supports and resources identified above.

Only the remaining unmet disability-related needs may be considered for Supportive Living authorization, and any authorization shall be limited to the least restrictive amount, duration, and scope of services necessary to safely meet those needs. The amount of services authorized shall be individually determined based on the member's assessed needs and will not exceed sixty (60) hours per week unless an Extraordinary Need has been identified and approved through enhanced clinical review.

Adult Members

For adult members, authorization decisions shall be based on the member's remaining disability-related needs after consideration of:

- A. Available State Plan and waiver services;
- B. Family and community supports;
- C. Other adults residing in the home who are available to provide reasonable assistance;
- D. Community resources and informal supports;
- E. Assistive technology, remote supports, and environmental modifications;
- F. Employment, day services, therapies, and other structured activities; and
- G. Periods during which the member can safely function independently.

Supportive Living services may be authorized only for disability-related needs that cannot be safely and appropriately met through these other resources and supports.

Supportive Living Staffing:

Supportive Living services must be delivered in a manner that is safe, sustainable, and consistent with workforce best practices. Routine staff shifts are expected to occur within reasonable time limits and must not require continuous or excessive hours that would compromise staff effectiveness, individual safety, or quality of care. Except in documented emergency situations (e.g., unexpected staff call-offs, natural disasters, or immediate health and safety risks), or pre-approved exceptions based on necessity, staff may not be scheduled to provide services continuously or across extended periods that would reasonably be interpreted as 24-hour or near-continuous coverage by one individual. Program staffing models must ensure adequate relief, handoff, and continuity of care through appropriate scheduling and use of multiple staff as needed.

Requests exceeding these thresholds require enhanced clinical review and documentation demonstrating why non-family providers, natural supports, or other available resources are insufficient to safely meet the member's needs.

Individuals with a direct financial interest in the provision of Supportive Living services may participate in the person-centered planning process; however, requests for service levels, staffing arrangements, schedules, or authorizations shall not be based solely on information provided by financially interested parties. ARTC may require supporting documentation from independent sources when determining medical necessity and service intensity.

Providers must notify the Care Coordinator and ARTC Care Coordination team within ten (10) business days of any permanent or long-term change in staffing, caregiver assignments, living

arrangements, household composition, or service schedules that may affect the member's needs, natural supports, or authorized service levels.

The availability of unpaid family members, household members, and other natural supports shall be considered when determining the amount, duration, and scope of Supportive Living services to be authorized.

Shared Staffing:

When shared staffing is utilized, all individuals receiving the service must be physically located within the same defined service setting and within an approved proximity that ensures continuous access to staff support and immediate, in-person intervention as needed.

- A. For purposes of shared staffing, “approved proximity” is defined as:
 - a. Individuals must be located within the same residential site or immediately adjacent area (e.g., within the same home, building, or apartment complex designated as the service setting); and
 - b. Direct support staff must be able to reach any individual receiving services within a response time not to exceed three (3) minutes except in the instance in which another member in the shared staffing group requires additional staff attention for an emergency/critical incident; and
 - c. The distance between staff and any individual must remain within a walkable range that does not require the use of a vehicle to provide support, supervision, or intervention.
 - d. Shared staffing shall not be billed when individuals are located in separate sites or in any arrangement that prevents staff from providing immediate, face-to-face response. This includes, but is not limited to, individuals located in non-contiguous properties, separate neighborhoods, or any location requiring vehicular travel.
 - e. If an individual being served separates from the group/leaves the approved proximity of the group (e.g., leaves the apartment complex, chooses not to participate in offsite activity with the group), the provider must immediately discontinue shared staffing billing for that individual for the duration of time the individual separated from the group. Services delivered during this time must be provided and documented in accordance with the member’s authorized service level (e.g., one-to-one staffing, if applicable).
 - f. Providers are responsible for demonstrating compliance with shared staffing requirements through documented policies/procedures/workflows, including:
 - i. Maintaining real-time awareness of each individual’s location within the approved service setting
 - ii. Ensuring staff are continuously available and able to respond without delay to identified health, safety, or behavioral needs
 - iii. Maintaining documentation that clearly supports compliance with proximity, supervision, and response time requirements

- iv. Ensuring service delivery aligns with the individual's person-centered service plan and assessed needs
- g. Failure to meet these requirements will result in services being determined out of compliance and will lead to recoupment or denial of reimbursement.

Quality Oversight:

Supportive Living providers must maintain written quality assurance and safety oversight policies and procedures designed to ensure the health, welfare, and safety of individuals receiving services in accordance with PASSE requirements, HCBS settings rule standards, and the member's person-centered service plan.

- A. These policies and procedures must, at a minimum, address:
 - a. Ongoing monitoring of service delivery, including compliance with authorized service levels and staffing requirements
 - b. Oversight of staff performance and adherence to Supportive Living service standards
 - c. Monitoring of member outcomes, health, safety, and overall well-being
- B. Quality assurance and safety practices must include regularly scheduled onsite visits conducted by qualified supervisory or oversight personnel who are not the member's assigned direct support staff. These visits must assess service quality, member health and safety, staff performance, and compliance with applicable PASSE, HCBS, and contractual requirements.
 - a. Providers must have formally documented policies and processes that define:
 - i. The frequency and scope of onsite oversight visits
 - ii. Qualifications of staff conducting the visits
 - iii. Required elements to be reviewed during each visit
 - iv. Documentation standards for recording visit findings, corrective actions, and follow-up activities
- C. Documentation of onsite visits and related quality assurance activities must be maintained in a manner that is auditable and readily available upon request. Arkansas Total Care (ARTC) reserves the right to request, review, and audit all related policies, procedures, and documentation to ensure compliance with Supportive Living service requirements, PASSE standards, and HCBS regulations.
- D. Failure to maintain required policies, conduct oversight visits as defined, or produce requested documentation will result in findings of non-compliance and corrective action, up to and including recoupment or other remedies as permitted under the provider agreement.

Extraordinary Circumstances / Extraordinary Need:

Extraordinary Need means a documented, disability-related circumstance in which failure to authorize additional Supportive Living services would create a substantial and imminent risk of institutionalization, hospitalization, serious injury, exploitation, or inability to meet an essential health or safety need, and no appropriate alternative service, support, resource, natural support, or state plan benefit is reasonably available to safely address the need.

The presence of an Extraordinary Need does not automatically qualify a member for additional Supportive Living hours. Rather, it may warrant additional review when determining whether other services, supports, resources, or natural supports are insufficient to safely meet the member's needs.

Factors that may indicate the presence of an Extraordinary Need include, but are not limited to:

- A. Complex medical needs requiring active intervention by specially trained staff;
- B. Current serious behavioral risks documented in a Positive Behavior Support Plan (PBSP), Behavioral Prevention and Intervention Plan, or Risk Mitigation Plan;
- C. Recent documented incidents demonstrating a likelihood of serious harm;
- D. A time-limited transition from an institutional, inpatient, crisis, or residential setting;
- E. Sudden loss of a primary caregiver/natural support/family/household member due to hospitalization, death, abandonment, or another verified emergency;
- F. Temporary unavailability or inability to access services, supports, or resources that would otherwise be expected to meet the identified need;
- G. A short-term health or safety crisis that places the member at risk of institutional placement; or
- H. A documented clinical determination that the member cannot safely utilize an otherwise appropriate service or support.

These circumstances will be evaluated as part of the overall medical necessity determination and do not guarantee authorization of additional Supportive Living hours. Any authorization will be limited to the amount, duration, and scope necessary to address the documented unmet need and may be subject to enhanced clinical review.

Circumstances That Do Not Alone Establish Extraordinary Need:

The following circumstances, by themselves, do not establish medical necessity for additional Supportive Living hours:

- A. Parent or guardian employment;
- B. Provider staffing shortages or staffing preferences;
- C. Desire to maintain a historical service schedule;
- D. Member or guardian preference for a specific provider or service type;
- E. General caregiver stress or burnout;
- F. Lack of informal supports without a corresponding documented disability-related need;
- G. Loss of a paid caregiver when other qualified providers are available;
- H. Convenience, companionship, or generalized supervision needs;
- I. A provider's reliance on 12-hour or 24-hour staffing models; or
- J. The fact that similar service levels were previously authorized.

Overnight Supportive Living Services

Overnight Supportive Living services are intended to address documented health, welfare, and safety needs requiring active overnight intervention. Overnight services will not be authorized for general supervision, monitoring, companionship, caregiver convenience, staff availability, or standby response to a potential emergency outside of any exceptions noted below.

All overnight Supportive Living services must be provided by awake, alert, and actively engaged staff. Sleeping staff, on-call staff, passive supervision, or staff who are merely available in the event assistance may be needed are not reimbursable. Existing policy requirements regarding awake, alert, and actively engaged staff apply to all overnight services.

A. Members Under Age 18

Overnight Supportive Living services for members under age eighteen (18) residing with a parent, guardian, or custodian will not be authorized unless the member has a documented complex medical condition requiring active overnight intervention by staff with specialized training, certification, licensure, or demonstrated competency related to the member's medical needs.

Overnight services shall not be authorized for routine parental responsibilities, childcare needs, behavioral monitoring alone, general safety oversight, sleep disturbances, or guardian preference.

B. Adult Members Residing with Another Adult

Overnight Supportive Living services will not be authorized when the member resides with another adult who is physically and cognitively capable of responding in the event of an emergency or providing reasonable overnight assistance.

The presence of such an individual will address the need for general health and safety support in the event of an emergency.

C. Adult Members Without Available Overnight Supports

For adult members who do not reside with another adult capable of providing emergency assistance, overnight Supportive Living may be authorized only when at least one of the following criteria is met:

- a) The member has a documented complex medical condition requiring active overnight intervention by staff with specialized training or competency and the identified risk cannot be safely mitigated through technology, natural supports, environmental modifications, or less intensive services;
- b) The member is unable to independently ambulate, transfer, evacuate, or otherwise respond to an emergency situation without assistance, and the identified risk cannot be safely mitigated through technology, natural supports, environmental modifications, or less intensive services; or
- c) The member has severe, current behavioral needs that create a substantial risk of harm to self or others during overnight hours and:
 - a. A current Positive Behavior Support Plan (PBSP) or Behavioral Prevention and Intervention Plan is in place;

- b. The provider demonstrates active implementation of the plan; and
- c. Documentation supports the need for overnight intervention beyond general supervision or monitoring.

D. Shared Staffing Exception

The above overnight criteria do not prohibit overnight Supportive Living services delivered through approved shared staffing arrangements in provider-operated residential, group home, or other approved residential settings. However, all overnight shared staffing services remain subject to requirements related to staffing ratios, proximity, supervision, documentation, and the requirement that staff remain awake, alert, and actively engaged throughout the service period.

E. Documentation Requirements

Requests for overnight Supportive Living services must include:

- a. A description of the overnight need;
- b. Frequency and type of overnight interventions required;
- c. Supporting medical, behavioral, or incident documentation;
- d. Available natural supports within the residence;
- e. Other adults residing in the home that can assist in the event of an emergency;
- f. Alternative supports, technology, or environmental modifications that were considered; and
- g. For concurrent reviews, documentation demonstrating that overnight interventions were actually required and provided during previously authorized overnight hours.

Exclusions and Limitations:

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 member's hospitalization.
- 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 but is not limited to personal care services, respite, ADDT and EIDT.
- D. 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.
- E. Supportive Living services must not be academic, educational, or instructional in nature, and may not replace, duplicate, or supplement educational services required or provided through a school system. Supportive Living services cannot be delivered in a school or educational setting, including during the school day or as part of an academic program. Services provided in school facilities or environments where the primary purpose is education are not eligible for reimbursement under the Supportive Living benefit.

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

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

- B. 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.
- C. 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
 - 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. Service must ensure smooth transition between acute care setting and community-based setting to preserve the individual's functional abilities.
- D. 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 or resources 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.

Previous authorization levels are not, by themselves, evidence of ongoing medical necessity. At each review, ARTC will conduct an individualized assessment of the member's

current needs and service utilization. When a member consistently utilizes substantially fewer units than previously authorized, ARTC may determine that a different amount, duration, scope, or schedule of services more accurately reflects the member's demonstrated needs while continuing to support health, welfare, safety, community integration, and identified treatment goals.

Authorization decisions will be based upon documented need at the time of review and will not be based solely upon historical service levels or provider requests. Historical authorization levels do not establish entitlement to future authorization levels.

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.
- Detailed daily schedule that includes all services (including but not limited to supportive living, ADDT, EIDT, personal care, etc.) member is receiving, days and hours that parental/guardian supports and/or natural supports are in place if applicable, independent hours, education hours, work hours and anything else pertinent to the individual's schedule.
- Justification for the number of units being requested.
- If overnight hours are being requested, justification must be included.
- 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.

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
- D. Other available services, supports and resources

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 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 remains 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.

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.
- D. Providers are required to adhere to all standards outlined at a State and Federal level including Unable to Serve standards outlined in the Arkansas CES Agency Standards.

REFERENCES:

ARTC Waiver Provider Services Manual
CES-Waiver
CES Agency Standards

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
Annual Review	No updates	05/07/2024
Annual Review	Removed note submission requirement for initial and concurrent reviews, clarified language for Tier IV status, clarified level criteria related to PBSP being required from RMP, removed Complex Care Homes as it is not an approved service in the CES Waiver.	04/29/2025
Annual Review	Added clarification regarding service limitations, staffing expectations and provider quality oversight.	05/06/2026
Off-Cycle Review	Updated shared staffing language and expanded on related policy and quality requirements.	06/26/2026
Off-Cycle Review	Followed up on previous updates and expanded on operational details.	10/09/2026

POLICY AND PROCEDURE APPROVAL

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