# Home and Community-Based Services Provider Manual

Key Guidance

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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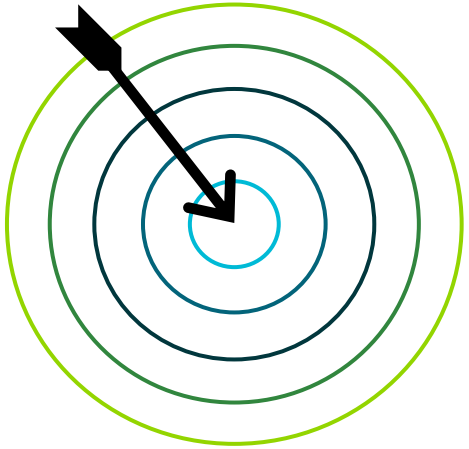
# Categories of Changes

Collectively, the changes position HCBS for alignment for federal regulations, greater consistency, reduced financial risk, and improved oversight moving forward.

1. Strengthened program integrity and oversight framework
2. Standardized billing and service delivery requirements
3. Enhanced service definitions and program expectations
4. Added two new services

# Why These Changes Were Made

Expected Outcome: More consistent service delivery, clearer provider guidance, and stronger program integrity.



**DHS Goals**

- Compile key information into one manual
- Align language to federal requirements
- Improve consistency across providers and PASSEs
- Clarify provider expectations
- Strengthen compliance and audit readiness
- Standardize documentation requirements
- Clarify service delivery requirements and levels of care

# Strengthened Compliance and Oversight Framework

Added several new sections to align with federal requirements.

1. **Incident Reporting Requirements**
   Defined “critical incidents” and established required reporting timelines and categories.

2. **Program Integrity**
   Implemented a comprehensive fraud, waste, and abuse (FWA) framework.

3. **Documentation Standards**
   Established consistent, minimum documentation requirements across all services.

4. **Billing Integrity Controls**
   Added prohibited billing activities and duplicate/ overlapping service restrictions.

Federally Required

# New Incident Reporting Requirements

Providers delivering services must report critical incidents that may impact the health, safety, welfare, or rights of a beneficiary.

**Examples of Incidents to Report**

- Death
- Abuse/neglect
- Suicide attempts
- Medication errors
- Elopement
- Serious injuries
- Rights violations

Federally Required

# Standardized Billing and Service Delivery Requirements

**Uniform Billing Rules Across Services:**

- Defines unit structures (15-minute, 30-minute, per diem)
- Adds the Eight-Minute Rule
- Emphasizes start/stop times and documentation of direct service time
- Prohibits concurrent billing of overlapping services
- Clarifies non-billable activities

**Per Diem Controls for Residential Services:**

Reinforced that per diem rates include all services and generally prohibit billing additional services on the same day.

**Clearer Roles and Responsibilities:**

Clarified that the enrolled Medicaid provider is responsible for claims submission and documentation, including subcontracted services.

Federally Required

# Overview of Enhanced Service Definitions and New Services

Enhanced several service definitions to improve clarity, consistency, and alignment with intended levels of care and added three new services.

### Moderate Changes

- Adult Rehabilitative Day Services (RDS)
- Residential Community Reintegration Program
- Supportive Living
- Therapeutic Communities (Levels 1-2)

### New Services

- Family Centered Treatment
- Therapeutic Communities 3

# Adult Rehabilitative Day Service

The definition now clearly establishes the service as a therapeutic rehabilitation program, rather than simply a recovery support program.

**Summary of Changes**

1. Increased focus on preventing higher levels of care
2. Clarified program structure (partial day or full day)
3. New staffing expectations (1:16 ratio)
4. Clarified expectation that documentation demonstrates active therapeutic rehabilitation rather than simple supervision or participation in activities

# Residential Community Reintegration Program

*Summary of Changes…*

**The Manual Establishes**

- Operational standards
- 24/7 staffing
- Maximum 16 beds
- Minimum staffing ratios
- Monthly prescriber involvement
- Required therapeutic programming

**Service Expectations**

- Minimum weekly treatment hours
- Licensed clinician involvement
- Structured therapeutic environment
- Trauma-informed care requirements

# Residential Community Reintegration Program

*Operational Requirements…*

### Staffing and Setting

- Facility must have 16 beds or fewer
- Must maintain 24/7/365 onsite staffing
- Must have at least 2 direct service staff available at all times
- Must maintain a 1:8 staff-to-client ratio when clients are present

### Clinical Requirements

- Prescriber encounter must occur at least once per month.
- Prescriber must be available to respond within 30 minutes, in person or via telehealth, when not onsite.
- Minimum 18 hours per week of individual and group services.
- Up to 5 hours may be community enrichment activities.
- Includes at least 3 treatment encounters provided by a licensed mental health professional.
- At least 1 LMHP encounter must be provided individually (not in a group setting).

# Supportive Living

The updated language makes it clear that Supportive Living is not simply supervision, monitoring, or custodial support.

**Adds Additional Documentation Guidance**

Providers Must Demonstrate:

1. Functional need
2. ADL/IADL limitations
3. Skill building
4. Community living support
5. Progress toward independence
6. Justification for intensity of services

Corrects the Supportive Living reimbursement unit from a daily rate to 15-minute units.

# Supportive Living

**What Is No Longer Sufficient?**

- ❌ Supervision only
- ❌ Observation only
- ❌ Sitting with the member
- ❌ Custodial care

**Documentation Must Show**

- ✅ Active teaching
- ✅ Coaching
- ✅ Skill development
- ✅ Community integration support
- ✅ Progress or maintenance

# Therapeutic Communities (TC)

*Summary of Changes…*

**Clinical Expectations**

1. Minimum treatment hours
2. Individual counseling requirements
3. Licensed clinician encounters

**Staffing Requirements**

1. Defined staffing ratios
2. Defined supervision expectations
3. Prescriber access requirements

**Billing Requirements**

1. Per diem billing
2. No separate billing for included services

# Therapeutic Communities 1

**Level 1 is For:** Adults with Serious Mental Illness who have severe functional impairment and need the highest level of residential support to remain stable and avoid institutional care.

**Key Requirements**

- Facility of no more than 16 beds
- High-intensity, recovery-oriented residential service
- Staff-to-client ratio of:
  - 1:4 during daytime
  - 1:6 during evening and overnight
- Minimum 35 total hours per week of individual and group services
  - Minimum 5 licensed mental health professional encounters per week
  - At least 1 individual counseling encounter
- Minimum 2 prescriber encounters per month

# Therapeutic Communities 2

**Level 2 is For:** Adults with Serious Mental Illness who need structured support but do not require the intensity of Level 1.

**Key Requirements**

- Facility or congregate living setting of no more than 16 beds
- May serve as a step-down from Level 1
- Staff-to-client ratio of:
  - 1:8 during daytime
  - At least 1 onsite staff member during evening and overnight
- Minimum 30 total hours per week of individual and group services
  - Minimum 3 licensed mental health professional encounters per week
  - At least 1 individual counseling encounter
- Minimum 1 prescriber encounter per month

# New Service: Therapeutic Communities 3

**Level 3 is NEW and is For:** Adults transitioning toward increased independence in the community.

**Key Requirements**

- Provided in a provider-owned, leased, or controlled apartment or home setting
- Must comply with federal HCBS setting requirements
- Requires daily face-to-face service or intervention
- Requires 24/7/365 on-call support
- On-call support must be able to respond within 1 hour, when appropriate
- Minimum 15 total hours per week of individual and group services
  - Minimum 3 licensed mental health professional encounters per week
  - At least 1 individual counseling encounter
  - At least 5 hours per week delivered outside of a clinic
- Minimum 1 prescriber encounter per month

# What's Different Between TC Levels?

**New Service**



| Requirement | TC1 | TC2 | TC3 |
|---|---|---|---|
| Setting | Facility | Facility | Apartment/Home |
| Staffing | Day: 1:4 Other: 1:6 | Day: 1:8 Other: 1 staff | Daily contact |
| Service Hours | 35 hours total | 30 hours total | 15 hours total |
| Prescriber Encounters | 2/month | 1/month | 1/month |
| Independence | Lowest | Moderate | Highest |

# New Service: Family Centered Treatment

## Purpose and population

- Children and youth ages 4-18
- Prevent out-of-home placement
- Stabilize families and support reunification
- Address trauma and unhealthy family patterns

## Service model

- Primarily in-home and in person
- Direct and indirect contacts
- Approximately six months, extendable for clinical complexity
- Crisis support available 24/7
- Cross-system collaboration

## Provider and billing expectations

- Follow FCT Foundation training, certification, consultation, and fidelity requirements
- Minimum 10 direct documented hours per rolling 30 days for monthly billing
- Limited daily/encounter billing circumstances

# New Modifiers for Behavior Assistance and Child and Youth Support

## Added Modifiers

**Differentiate the service delivery location**

1. Home Setting
2. School or Community Setting

**Identify provider qualifications**

1. Bachelor's-Level Provider
2. Non-Degreed Provider

## Provider Impact

1. No change to the purpose or scope of the services.
2. Providers will need to use the appropriate modifiers when submitting claims.
3. Documentation should support both the service location and the qualifications of the rendering provider.

# Medicaid-Enrolled Provider Types

### Behavioral Health Agencies

Licensed for 1915(i) services. Additional certification applies for Therapeutic Communities and Residential Community Reintegration.

### CES Waiver Providers

Licensed to provide services authorized under the CES Waiver.

### Community Support Systems Providers

Certified at Base, Intensive, or Enhanced levels, with an increasing service array and requirements.

**All billing providers must be enrolled in Arkansas Medicaid, in good standing, and credentialed with the PASSEs as an HCBS provider.**

# DPSQA Licensure Manuals And Medicaid Provider Manuals Serve Different Purposes

Providers must comply with both when both apply. One does not replace the other.

**DPSQA Licensure / Certification Manuals**

Licenses/Certifies an agency to enroll in AR Medicaid, submit claims for specified reimbursable services, and the conditions for doing so. Focus areas typically include facility and program standards, staffing, staff qualifications, safety, governance, and oversight.

**Provider Types include: CES Waiver, Behavioral Health Agency, and Community Support System Provider**

**Medicaid Provider Manual**

Defines Medicaid coverage and payment requirements. It addresses covered services, eligible populations, service definitions, documentation, billing units, claims, duplicate services, and program integrity.

# Key Takeaways

The manual standardizes baseline expectations that providers should build into policy, documentation, training, and billing controls.

### Incident reporting

Report required events using DHS processes and timelines.

### Documentation

Record date, location, intervention, participation, plan alignment, staff credentials, and required time.

### Program integrity

Report suspected FWA; maintain enrollment and disclosures; screen exclusions monthly.

### Billing

Use defined units and eight-minute thresholds; prevent overlap, concurrency, and prohibited activities.

# Questions?

We appreciate your continued partnership in serving Arkansas Medicaid beneficiaries.