

New & Prospective Specialized Provider Agencies of Community-Based Services

ORIENTATION

Division of Developmental Disabilities

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Overview:

This orientation is for prospective and newly certified specialized community-based service provider agencies by the

**Division of Developmental Disabilities
And
Division of Public Health
Department of Health and Human Services
State of Nebraska**

Revised April 2019

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Department of Health and Human Services (DHHS)

Five Divisions:

- [Behavioral Health \(DBH\)](#)
 - [Children and Family Services \(CFS\)](#)
 - [Medicaid & Long-Term Care \(MLTC\)](#)
 - [Public Health \(DPH\)](#)
 - [Developmental Disabilities \(DDD\)](#)
- To learn more about DHHS or any of the divisions, click [here](#), or on each individual Division above. (dhhs.ne.gov)

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Division Responsibilities:

The Department of Health and Human Services (DHHS), Division of Developmental Disabilities (DDD) is charged by statute with contracting for “specialized services and shall only contract with specialized programs which meet certification and accreditation requirements”. The MC-19 Medicaid Provider Agreement serves as the contract.

Nebraska Revised Statute (NRS) [§83-1217](#)

Division Responsibilities:

DHHS certifies Agency providers of **specialized community-based developmental disabilities services** to provide **essential habilitation (training and support)** services for Nebraskans with developmental disabilities so that they can live, work, and more fully participate in the community.

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Specialized vs. Non-Specialized Services

- Agency (Specialized) Services
 - Provided by certified community-based agencies
 - The agency hires, trains, fires, keeps time sheets, etc.
 - **The agency is responsible for assuring all their staff meet education/experience, and other requirements.**
- Independent (Non-Specialized) Services
 - Provided by Independent Providers hired directly by the individual, their family, or their guardian
 - The independent provider is responsible for keeping their own timesheets, doing billing, etc.

Becoming a Provider Agency:

3 vital components are needed in order to become a successful provider agency:

1. Administrative background;
2. **Organizational skills and practices to operate a functional business;**
3. Knowledge, education, and/or experience in working with individuals who have developmental disabilities.

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Becoming a Provider Agency

Frequently Asked Questions (FAQs):

1. What regulations do I have to follow as a provider?

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FAQ #1 Regulations

- [Title 404](#) and [Title 403](#) of the Nebraska Administrative Code (NAC)—Community-Based Services for Individuals with Developmental Disabilities
- Often referred to as “403 or 404 Regulations” or “403 or 404 Regs”

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FAQ # 1 Regulations

- In addition to 403 and 404 Regulations, **every provider of services must follow all applicable local, state, and federal codes, laws, ordinances, and regulations.**
- **Providers are responsible for identifying and following the most current regulations at all levels of the process.**

FAQ # 1 Regulations

Title 403 NAC regulations include the following chapters:

1. Administration and Definitions
2. Application, Eligibility, Funding, Waitlist and Appeals
3. Participant Self-Direction
4. DD Day Services Waiver for Adults*
5. Comprehensive DD Services Waiver*

* Chapters 4 and 5 require policies and procedures

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FAQ # 1 Regulations

Title 404 NAC regulations include the following chapters:

1. Scope and Authority of Title 404 NAC
2. Definitions pertinent to providing services
3. Eligibility and authorization of funds
4. Core requirements for specialized providers of DD Services
5. Individual Support Options (ISO) –Residences that are NOT owned/operated by an agency

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FAQ # 1 Regulations

Title 404 NAC regulations include the following chapters (cont.):

6. Provider Operated/Controlled Community Based Residential and Day Services
7. Reserved for future use
8. Respite Services
9. Non-Specialized Services
10. Children's Waiver Family Services
11. Specialized DD Provider Contracting

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FAQ # 1 Regulations

Additional, related state statutes and regulations are also cited/referenced throughout 403 and 404 NAC. These include:

- Statutes regarding contracting, certification/accreditation, reimbursement, criminal history, and governing board/advisory committees
- Federal Verification System (E-Verify)
- Adult Protective Services Act (§28-348 through §28-387 and Title 463 NAC)
- Statutes and regulations relating to reporting child and adult abuse, neglect, and exploitation.

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FAQ # 1 Regulations

Additional, related state statutes and regulations are also cited/referenced throughout 404 NAC. For example:

- 404 NAC 4-003.03—Local Governing Board or Advisory Committee: The specialized provider must comply with Neb. Rev. Stat. §83-1217 and 83-1218.
 - §83-1217 (7): The local Governing Board or Advisory Committee must consist of more than one member of each: (a) Persons with developmental disabilities, (b) family members or legal guardians of persons with developmental disabilities, and (c) persons who are interested community
- When addressing regulations and statutes, note plurals. In this case, committees/governing boards must have at least 6 members.

FAQ # 1 Regulations

Clarifying information regarding State Statutes or Regulations cited/referenced in 404 NAC:

- ▶ Criminal History Check – 4-004.03E applies instead of 4-004.03B 1 and 2; contact Program Coordinator for current list of vendors. Vendors must be registered and in good standing with the Secretary of State to do business in Nebraska.
- ▶ 4-008 5.b. Incident Reporting System - <http://support.therapservices.net>
- ▶ All providers are required to use Therap for GERs, referrals, and billing.

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FAQ # 1 Regulations

Additional, related state statutes and regulations are also cited/referenced throughout 404 NAC. For example:

- Centers for the Developmentally Disabled (CDDs) are living arrangements where four or more individuals with developmental disabilities live together. You must first be a certified DD agency to become a CDD.
 - In addition to 403 and 404 NAC, CDDs are governed by Title 175 NAC—Chapter 3.
 - These regulations are monitored by the DHHS Division of Public Health.
- Title 390 and 395 NAC are regulations referring to children whom are state wards (“Child Welfare and Juvenile Services”)

FAQ # 1 Regulations

Additional, related state statutes and regulations are also cited/referenced throughout 404 NAC. For example:

- [Title 172](#) NAC:
 - Chapter 95—Administration of Medications by Medication Aides and Medication Staff
 - Chapter 96—Medication Aide Registry
 - Chapter 99—Provision of Nursing Care
 - Chapter 101—Practice of Nursing
 - Chapter 102—Practice of Licensed Practical Nurses-Certified

FAQ # 1 Regulations

- DDD's federal funding comes through Medicaid Waivers
 - Title 403 NAC 2-001 and Title 404 NAC 4-003.01 and 471 NAC 2-000
- Because of this, all Community-Based DD providers, MUST be Medicaid Providers and be thoroughly familiar with Medicaid provider requirements
- A Medicaid Provider number is required once provisional certification is obtained
- Federal regulations (42 CFR 455, Subpart E) require State Medicaid Agencies to conduct specific screening activities prior to the enrollment of providers.
 - NE Medicaid has contracted with MAXIMUS Health Services, Inc. to aid DDD and MLTC in becoming compliant with these requirements.

FAQ # 1 Regulations

- Health Insurance Portability and Accountability Act (HIPAA)
- If serving children who are state wards, [Title 390](#) “Child Welfare and Juvenile Services”

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Becoming a Provider Agency

Frequently Asked Questions (FAQs):

2. How do I become certified as a specialized provider agency?
 - Follow the steps outlined in the NAC 404, [Chapter 4](#) (also described on the following slides)

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FAQ #2 Steps to becoming a provider

1. Attend orientation

2. Complete an application/letter of intent:

- ▶ Form is provided by DDD following orientation attendance

Includes:

- ▶ Scope of services you intend to provide as outlined in the 403 Regulations
- ▶ Location (city/cities) where you will provide the service(s)
- ▶ And other pertinent information.

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FAQ #2 Steps to becoming a provider

New regulations were approved July 16, 2018 therefore new providers must enroll per 404 NAC, but the names and codes of the services may be found in 403 NAC. The Division's [website](#) will help you to understand the changes.

The [DD Services Directory](#) is a summary of the waiver services

Provider [Bulletins](#), subscribe to this page to receive updates

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FAQ #2 Steps to becoming a provider

Scope of Services – Service Options – 403 NAC Chapters 4 and 5
Defined and Determined by the Waiver

Chapter 4 defines the DD Day Services Waiver for Adults

Chapter 5 defines the Comprehensive Developmental Disabilities
Services Waiver (both Adult and Children)

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FAQ #2 Steps to becoming a provider

3. Electronically submit a complete 403 and 404 NAC application form with your agency's policy and procedure (P&P) manual. All submissions need to be electronic; we do not accept hard copies.
 - ▶ P&P manual **must** provide clear references to specific regulations addressed by the policy section. You are required to use a worksheet (provided) to demonstrate how your policies and procedures meet the rules and regulations. This will be sent with the application/letter of intent form. Be sure to proofread your submissions, ensure page numbers are correct and match your worksheet including any changes you make.

FAQ #2 Steps to becoming a provider

4. The Department will review your application/letter of intent and P&P to determine if everything is complete and make a decision to:

- ▶ Ask for revisions; or
- ▶ Pass the information to the Program Coordinator for next steps.

Regurgitation of the rules and regulations is not sufficient!

- ▶ P&P must clearly spell out how you will implement the rules and regulations
 - ▶ Example: How will you report critical incidents?
 - ▶ Example: Not enough to state you have an advisory board; how will the advisory board function – what will they do, what do they address, etc.

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FAQ #2 Steps to becoming a provider

The initial review of the P&P will encompass eleven core areas of the regulations:

- ▶ Criminal History Check 4-004.03b, 4-004.03c
- ▶ Positive Behavioral Supports 4-005.03
- ▶ Incident Reporting System 4-008-Do they utilize Department approved method - Therap
- ▶ Abuse and Neglect 4-010
- ▶ Quality Assurance/Quality Improvement 4-014, 4-014.01, 4-014.02, 4-014.03
- ▶ Restriction of Rights/Restrictive Measures 5-003.02c, 6-004.01a, 6-006, 6-006.01
- ▶ Rights Review Committee 4-011
- ▶ Entry to Services 4-003.05
- ▶ Staff Training 4-004
- ▶ Disaster Preparedness 4-005.07
- ▶ Habilitation 4-005

All other sections are required to be present and in compliance and may be reviewed at any time.

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FAQ #2 Steps to becoming a provider

- The Department cannot consult with you to develop content for your P&P. We are only allowed to review the P&P and determine if it is acceptable.
- The Department does not “Approve” or “Reject” P&P’s. If we review a P&P and determine that the core areas are not acceptable, we will send it back to be revised.
- DHHS-Public Health may schedule an administrative review at any time.

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FAQ #2 Steps to becoming a provider

5. If revisions are required, you can choose to make revisions and resubmit your P&P to the Department for review.

- ▶ While there is no official limit on how many attempts you can have to get the P&P accepted, we reserve the right to pause the certification process if an excessive number of reviews have been required or the requested revision is not adequate.
- ▶ **If the documentation submitted is clearly not in line with provision of community based DD services, your certification may be denied.**

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FAQ #2 Steps to becoming a provider

How long does it take?

It usually takes several months to become certified as a provider of specialized DD services

The time it takes is dependent upon how long it takes your agency to fully complete an application and policies and procedures manual that fully describe **how** your agency and staff will comply with 403 and 404 NAC in daily operations

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FAQ #2 Steps to becoming a provider

Start Up Funding?

New provider agencies should not anticipate start-up funding through the State of Nebraska, and plan accordingly.

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New Business Resources

This list is not all inclusive, but does provide some resources for new businesses:

- Nebraska Business Resources: <http://research.unl.edu/industryrelations/nebraska-business-resources/>
- NE Department of Economic Development: <https://opportunity.nebraska.gov/>
- Omaha Small Business Network: <http://www.osbnbtc.org/>
- Nebraska Business Development Center: <http://www.nbdc.unomaha.edu>
- Nebraska Community Colleges: <http://nebraskacomunitycolleges.org/system/area-map/> for locations and contact information
- Northeast Nebraska Economic Development District: <http://www.nenedd.org>
- Economic Development for Western Nebraska: <http://tcdne.org/local-business-services/ecenter/>

FAQ #3 Services and choice

3. How do individuals receive services and choose providers?

- Funding and Placement Process
- Eligibility is determined
- Ability to Pay is determined
- Date of need is selected
- Added to the Registry of Needs/Wait List
- Individuals receive funding, come off registry/wait list

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FAQ #3 Services and choice

Funding and Placement Process (Cont.)

- Maximizing Funding – agreement that individual and/or their family will apply for and accept any Federal Medicaid or other eligible benefits
- Service Coordinator (SC) is assigned
- Assessment (ICAP) is completed to determine Individual Budget Amount (IBA)
- SC meets with individual and their family to discuss service options and discuss possible provider options
- Referrals are sent to providers via Therap, potentially statewide or just to one agency. This referral may be filtered by the individual in several ways – geography, knowledge of program, etc.

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FAQ #3 Services and choice

Funding and Placement Process (Cont.)

- Therap is the web-based Electronic Documentation System provided by DHHS for providers' use.
 - <https://www.therapservices.net/>
- If the provider accepts the referral, a back and forth begins, including possible meet and greet meeting, tours, and trial periods.
- Once individual chooses an agency, the team will meet
- **The Department does not pay for room and board. Room and Board is paid by the individual's SSI payment or by the individual, depending on circumstances.**

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CMS ROOM AND BOARD DEFINITION

ROOM:

- The term 'room' means shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services.
 - This includes: a bedroom, bed with mattress (on a frame), pillow, linens, blankets (as appropriate to the season) and a dresser or closet for storage

BOARD:

- The term 'board' means three meals a day or any other full nutritional regimen (snacks, as needed).

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FAQ #3 Services and choice

- Individuals choose providers from a list provided by the Service Coordinator, or from their own experiences
- Services are to be person-centered, in accordance with the individual's hopes, dreams and goals and in the location they prefer

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FAQ #3 Services and choice - CMS Rule

The Centers for Medicare and Medicaid Services (CMS) established a new rule that became effective March 17, 2014 and all existing agencies must be in compliance by March 17, 2022. New agencies must comply immediately.

- This rule states that all home and community-based settings (HCBS) that receive Waiver (Medicaid) funds have to ensure that people live in the community and have opportunities to access their community and receive services in the most integrated settings.

What this means for ALL settings:

- The setting is selected by the individual from options that include non-disability specific settings and options for privacy in residential settings (i.e. a private room.)

FAQ #3 Services and choice - CMS Rule

- Individuals must have informed choice of providers, services and settings and that choice must be documented by a person-centered plan.
- People have optimal opportunity for independence in making life choices without regimented daily activities, can access their physical environment and may interact with family and friends, just as people who are not receiving home and community based services do.

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FAQ #3 Services and choice - CMS Rule

What this means for residential services (not a complete list):

- Each individual must have the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws. If such laws do not apply, a lease or other legally binding agreement is in place to provide those protections.
- Each individual must have privacy in their sleeping or living unit, with a lock and key controlled by the individual and appropriate staff.
- Individuals must be allowed to furnish and decorate their own sleeping and living areas, to have access to food at any time, and to have visitors of their choosing at any time.
- Individuals sharing a living unit must have choice of roommate.

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FAQ #3 Services and choice - CMS Rule

What this means for non-residential services (not a complete list):

- Informed choice of MEANINGFUL activity for period of time determined by the participant
- Interests of participants are the primary focus when establishing schedules
- The setting is located in the community, and facilitates integration
- Tasks and activities are comparable to those who do not receive services
- The setting allows for a mix of service delivery
- The setting offers a location for everyone to securely store their belongings
- All schedules for PT, OT, medications, diet, etc. are kept in a private area, away from general operating areas of the setting

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FAQ #3 Services and choice - CMS Rule

To help you to comply immediately with the Final Rule, please see links below:

Final Rule, Detailed Summary <https://www.medicaid.gov/medicaid/hcbs/downloads/final-rule-slides-01292014.pdf>

Residential Settings assessment tool:

<https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-re-settings-characteristics.pdf>

Non-Residential settings assessment

tool: <https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-non-residential.pdf>

General information about settings that isolate:

<https://www.medicaid.gov/medicaid/hcbs/downloads/settings-that-isolate.pdf>

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RESOURCES AND NOTES

Some places to find answers

- NAC 403 and 404 for Community Based Services regulations that are monitored by the DHHS Developmental Disabilities Division “DDD” and DHHS Public Health “DPH.”
- DHHS Developmental Disabilities Division website for Provider Bulletins, draft regulations, new waiver information
- Ask other Specialized Community-Based Certified Providers who have years of experience. A helpful resource is the DD Provider Directory on the DDD website.
- Contact Kate Bolz, Director of the Nebraska Association of Service Providers at: <http://neserviceproviders.org/>
- Nebraska Secretary of State Business Services at: <http://www.sos.ne.gov/dyindex.html#boxingName>
 - Agencies must be registered with the Secretary of State as a business to be enrolled in Medicaid

CHANGES ARE COMING

- Waiver amendments with new service codes and requirements effective Summer, 2019. Watch for updates: http://dhhs.ne.gov/developmental_disabilities/Pages/RegulationsAndWaivers.aspx
- New subcontracting policy requirements effective Summer, 2019: <http://dhhs.ne.gov/Guidance%20Docs/DD%20PB%2018-06%20Contracting%20for%20Services.pdf>

Most Important

Services must be:

- Safe
- Person-centered
- Habilitative
- Focused on contributing to an increased quality of life for individuals
- Well-administered and in compliance with waiver guidelines

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Questions?

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Provider Medicaid Enrollment

Medicaid Provider Enrollment

- After the provisional certification by Public Health
- Via referral to the web portal developed by Medicaid and contracted to Maximus Health Services, Inc.
- Provide information to Program Coordinator

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Medicaid Provider Enrollment, Cont.

Referral information needed by Program Coordinator:

- ▶ Services to be provided – specifically, what waiver do these fall under?
- ▶ Name of agency
- ▶ Federal Tax ID Number
- ▶ Zip plus four – can be ascertained at USPS web site:
<https://tools.usps.com/go/ZipLookupAction!input.action>

For more information and to receive [Medicaid provider bulletins](#)

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Additional requirements before providing services

- You must acquire APS/CPS background checks for employees **before they start providing services** as a requirement under NAC 404 regulations. If you are an owner or member of management for an agency and you provide direct care support in an emergency, you must have all the background checks required of any employee.
- The website with information on using the new Child and Adult Abuse Registry may be found here: <http://dhhs.ne.gov/Pages/Abuse-and-Neglect-Central-Registry.aspx>

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Provider requirements

In addition to complying with statutory and regulatory requirements, the Provider Handbook includes additional provider requirements such as:

- ▶ Insurance – certification of insurance required on or before first date of service
 - ▶ Worker’s Compensation as required by state law
 - ▶ Commercial motor vehicle liability coverage
 - ▶ Professional liability coverage
 - ▶ General liability

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Referral to services

- Program Coordinator notifies Service Coordination Supervisors statewide when all provider enrollment documentation is received
- Service Coordination will NOT advocate for your agency, but will list your agency as another option when speaking with individuals and their families/guardians.
- Service Coordination will notify Program Coordinator when an individual chooses your agency as a provider
- Once the individual starts services the HCBS Waivers, all pertinent regulations, and the Provider Handbook must be followed.

Billing Guidelines

- Services and supports delivered as documented in each individual's person centered plan which may also be referred to as: Individual Support Plan (ISP), or Individual and Family Support Plan (IFSP)
- Services billed must be provided in accordance with all statutory, regulatory and provider agreement requirements and in accordance with the approved Home and Community Based Services (HCBS) Medicaid waivers.

Billing Guidelines

- No payments will be made for room and board, start-up costs, cost of provider-controlled property maintenance, upkeep and/or improvement
- [DD Provider Handbook](#) is your reference.

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Claims Processing

- Providers can only claim for services provided during the period shown on the Service Authorization
- All billing goes through Therap. Refer to the following link for a video training on the billing process:

<http://www.therapservices.net/nebraska/nebraska-billing-integration-training/>

Additional Information

- Many Therap modules are mandated for use by DHHS-DDD
 - Referrals
 - Service Authorizations
 - Medication Administration
 - Individual Support Plans (ISP)
 - ISP Programs
 - Programs must be written and executed in accordance with DD Habilitation Plan Writing Guide found here:
<http://dhhs.ne.gov/Guidance%20Docs/DD%20Habilitation%20Plan%20Overview.pdf>
 - Attendance
 - Billing
 - You can learn more by going to this link:
<https://help.therapservices.net/app/nebraska>

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Additional Information

- Before naming your agency and registering with the Secretary of State, consider what the name is saying about you and your business.
 - Use 'People First' language:
https://www.inclusionproject.org/nip_userfiles/file/People%20First%20Chart.pdf
 - https://www.sccoe.org/depts/students/inclusion-collaborative/documents/person-First_Language_Article.pdf

Questions?

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New Agency Provider Certification Steps

1. **Orientation**: Prospective provider registers for and attends Orientation
2. **Application Request**: Prospective provider requests from Developmental Disabilities.
3. **Application Review**: DD processes Application Packet, forwards to DPH if complete
4. **DPH Review(s)**: P&P review to evaluate NAC 403 & 404 compliance
5. **DPH Interview**: Your opportunity to demonstrate knowledge and ability to apply your P&P
6. **Correction of Identified Issues**: Provider written responses outlining corrections
7. **Provisional Certificate Issued**: After **all** concerns have been corrected by provider
8. **Maximus Enrollment Referral**: Referral from DDD to MLTC
9. **Initial Referral Accepted**: Provider must notify DPH & DDD within one business day
10. **On-Site Pre-Service Review**: evaluate actual readiness to serve individuals' health and safety needs
11. **Home & Community Based Service Final Rule Assessment**: DD completes
12. **Initial Certification Review**: After the first person starts services

*The application may be denied at any point in the process based on failure to meet requirements or demonstrate compliance. If the provider has not demonstrated compliance after a third review, the application for certification will be denied.

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How can I succeed?

- Be CERTAIN you really want to be an agency provider instead of an independent provider, employee for someone else, consider the requirements of being a business owner along with the perks! <http://dhhs.ne.gov/Pages/DD-Prospective-Provider.aspx>
- Read, study, and know the Title 403 and 404 NAC regulations. Working for a provider in the past, having a family member with disabilities, or “scanning” the regulations is NOT enough to know if you can address and meet all of them. <http://dhhs.ne.gov/Pages/DD-Regulations-and-Waivers.aspx>
- Be professional in your submissions. Proofread, format, use updated software, respond in a timely manner to requests for corrected or additional information. Follow all directions (highlight changes, label forms and appendices)
- Be prepared to describe and explain your policy and procedure submissions. Make sure the P&P you submit reflect your agency’s work and structure.
- Make sure you are eligible to be an agency provider (see 404) and eligible to obtain a Medicaid number BEFORE you begin the certification process to conserve your time and efforts.

Things to consider . . .

- The reports issued to provider agencies are public documents. This means the public has access and can see reports on your agency.
- Do not use names in responses and ensure responses are written professionally as you wish to have them reflect on your agency
- Citations can also come from complaint reviews. Like certification reviews, a written report is issued to the provider and a POI is required. These are also public documents.
- The provider agency is held responsible for any actions and services provided by a subcontractor of specialized services for the provider agency. See Title 404 NAC Chapter 11.
 - Examples of subcontractors – EFH, nurse, transportation, behavior specialist, etc.

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Things to consider . . .

- Citations often come from poorly written policies that do not give staff the guidance for how the agency will operationalize compliance.
- Documentation is everything! No documentation means no evidence that your agency is maintaining regulatory compliance. Document EVERYTHING!
- As a regulatory oversight source, we cannot provide consultation services. If you want to engage business consultation services, you need to obtain those from another source.
- You are attempting to demonstrate to DHHS that you are a prepared, professional, and qualified business, ready to offer quality services and meet all regulatory requirements at the time you submit your initial application
- To be considered to be “in compliance”, you must comply with all regulations, laws and state statutes as applicable to the service and/or setting
 - This may include local zoning laws, fire marshal requirements, covenants, etc.

Initial Certification

- Once a provisionally certified provider is engaged in service delivery, an initial certification review will be conducted
- It will include site visits, observations, interviews with administration, staff, persons receiving services, and examination of documentation
- Written certification report will be issued to the provider and will require a plan of improvement (POI) be submitted, accepted, and implemented
- Upon acceptance of a POI and evidence that emergent issues have been addressed, certification will be issued, normally for a 1 year period
- The POI will be evaluated for implementation with reports of progress submitted to DPH as specified in the citation letter

Continued Certification

- You must maintain a current certificate to bill for waiver funded services
- Certification reviews will encompass multiple days and multiple reviewers
- The agency is responsible for providing information and documents requested in a timely manner; if we don't see it, we will assume it doesn't exist
- Maintaining certification requires maintaining compliance with the regulations and fully implementing all POIs accepted by the Department for citations.
- Citations issued from complaint investigations can and have been considered in determining certification status

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Citation Components

Each citation consists of three parts:

- ▶ 1. The Title 403 and/or 404 NAC regulation(s) with which the provider is not in compliance
- ▶ 2. A statement of what part(s) of the regulation the provider is not in compliance with
- ▶ 3. Evidence for the deficiency

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Plans of Improvement (POI)

4-002.10B Plan of Improvement: The provider must submit an acceptable plan of improvement to continue certification. Within 20 days of receipt of the Department's written results, the provider must submit an acceptable plan of improvement to address areas found to be out of compliance. The plan of improvement must:

1. Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;
2. Include an expected date for completion of the plan of improvement that is timely, taking into consideration the nature of the violation;
3. Identify a means to prevent a recurrence;
4. Identify who is responsible for implementing the plan of improvement and ensuring all areas are corrected and maintained; and
5. Be signed and dated by the director of the entity or designee.

Common Problems for New Providers

Are you fully prepared to manage staff and a business BEFORE you begin?

- ▶ 4-004 (Staff Requirements) including E-verify and APS/CPS registry & background checks **completed & documented**, not just submitted or in process. You must register with CFS before you can be authorized to complete some of these checks.
- ▶ External requirements for businesses like IRS guidelines, payroll & HR systems. You need to research and meet requirements that are not part of the Handbook, billing guidelines or NAC 404.
- ▶ 4-004.07 and .08 which include direction to comply with NAC 172 95, 96, & 99 for medication aides. Ensure you have a written agreement in place for monitoring medication aides and medication aides are current on their certification. **You** are held responsible for their work.
- ▶ Read the regulations carefully; example “**persons**” is plural

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Common Problems - Continued

- People know the DD world but not the business world
- People know the business world but not the DD/human services work
- Not enough start up funding available
- Underestimating the time and work needed to get started
- Failure to implement what your policies and procedures said you would do (background checks, training, competency testing, assessments as examples)
- FAILURE TO READ AND FOLLOW THE TITLE 404 NAC REGULATIONS
- Failure to know and follow other legal and regulatory requirements – IRS, local codes, ADA
- Expecting someone else to tell you what to do, how to do it, when to do it

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Questions?

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Self Evaluation Checklist

- Do you want to run your own business? (become a provider); work under an existing provider? (be an employee or a subcontractor); or work independently? (independent service provider)
- Do you have experience or an experienced partner for processing payroll, tax withholding, writing policies AND procedures that meet regulatory standards, hiring, training, and managing staff and implementing services 24/7?
- Do you have adequate
 - Financial resources for start up costs for several months? To reimburse individuals for theft, mismanagement, repairs to property for damages, insurance deductibles, background check costs?
 - Secure computer systems and internet
 - Business space (meetings, reviews, equipment)
 - Office equipment and supplies (copiers, phone system)
 - Insurance
 - Medication oversight
- Are you willing to
 - Work days, evenings, nights, weekends, and holidays?
 - Be "on call" 24/7/365?
 - Go to work when issues can't be resolved by phone?
 - Do the work when staff are sick, quit without notice, etc.?
 - Go without paying yourself when cash flow doesn't exceed expenses?

Helpful contacts

DD toll free # 877.667.6266

DD Reception # 402.471.8501

Community-Based Services email:

DHHS.DDDCommunityBasedServices@Nebraska.gov

DHHS website: <http://dhhs.ne.gov>

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