

# Orientation for Prospective Agency Providers of DD Community-Based Services

**Division of Developmental Disabilities**

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# Orientation Overview

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This orientation is for prospective and newly-certified agency providers of Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver services.

Orientation is provided by:

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

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# Department of Health and Human Services (DHHS)

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Nebraska DHHS has five divisions:

- [Behavioral Health \(DHHS-BH\)](#)
- [Children and Family Services \(DHHS-CFS\)](#)
- [Medicaid & Long-Term Care \(DHHS-MLTC\)](#)
- [Public Health \(DHHS-PH\)](#)
- [Developmental Disabilities \(DHHS-DD\)](#)

To learn more about any of the divisions, click on the division name above.

To learn more about DHHS, visit [dhhs.ne.gov](https://dhhs.ne.gov).

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# Division of Developmental Disabilities

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Nebraska DHHS, Division of Developmental Disabilities (DHHS-DD) 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 [§83-1217](#)*

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# DHHS Responsibilities

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The purpose of Medicaid HCBS DD waiver services is to provide essential habilitation (training and support) for eligible Nebraskans with developmental disabilities so they can live, work, and more fully participate in their communities.

- DHHS-PH certifies agency providers for DD services.
- DHHS-DD provides funding and oversight of services to ensure participant needs are met.

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# Specialized vs. Non-Specialized Services

## Agency (Specialized) Services

- Provided by community-based agency providers certified by DHHS-Public Health.
- The agency is responsible for administration, including hiring, training, and dismissing direct-care staff.
- The agency provider schedules staff and bills for services.
- The agency is responsible for assuring all their staff have education, experience, and other requirements.

## Independent (Non-Specialized) Services

- Provided by independent providers hired, trained, and dismissed directly by the participant.
- The participant is responsible for ensuring the provider can meet their needs.
- The independent provider is responsible for keeping their own schedules and billing for services.

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# Becoming an Agency Provider

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Vital components to become a successful agency provider:

- Administrative background;
- **Organizational skills and practices to operate a functional business;**
- Knowledge, education, and experience working with people who have developmental disabilities.

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# Frequently Asked Questions (FAQs) #1

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What regulations do I have to follow as a provider?

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# FAQ #1 Regulations

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- Regulations are called regs, Titles, or NAC.
- The Nebraska Administrative Code (NAC) has two titles specifically about DD services:
  - [Title 403 - Medicaid Home and Community-Based Waiver Services for Individuals with Developmental Disabilities](#) - Governs Medicaid home and community-based waiver services for people with DD.
  - [Title 404 - Community-Based Services for Individuals with Developmental Disabilities](#) - Governs community-based services for people with DD
- In addition, providers must follow applicable local, state, and federal codes, laws, ordinances, and regulations.
- Providers are responsible for identifying and following the most current regulations at all levels.

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# FAQ # 1 Regulations

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403 NAC includes 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

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404 NAC includes the following chapters:

1. Scope and Authority
2. Definitions
3. Eligibility and Authorization
4. Core Requirements for Specialized Providers of Services
5. Individual Support Options
6. Provider Operated/Controlled Community-Based Residential and Day Service Options
7. (Reserved)
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

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State statutes and regulations referenced in 403 and 404 NAC 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 463 NAC)
- Statutes and regulations relating to reporting child and adult abuse, neglect, and exploitation.
- The federal Health Insurance Portability and Accountability Act (HIPAA)

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# FAQ # 1 Regulations

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404 NAC 4-003.03 includes a reference to state statute:

- Local Governing Board or Advisory Committee: The agency 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 members.

*When addressing regulations and statutes, note plurals. In this case, committees/governing boards must have at least 6 members.*

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# FAQ # 1 Regulations

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Clarifying information about state statutes or regulations in 404 NAC:

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

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# FAQ # 1 Regulations

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## Other regulations referenced in 404 NAC include:

- Centers for the Developmentally Disabled (CDDs) are living arrangements where four or more people with developmental disabilities live together.
  - In addition to 403 and 404 NAC, CDDs are governed by 175 NAC—Chapter 3.
  - CDDs are monitored by DHHS-PH. (You must be a certified provider to become a CDD.)
- When serving a child who is a state ward, a provider must follow 390 NAC and 395 NAC, as these govern Child Welfare and Juvenile Services.
- When completing medical tasks, a provider must follow 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

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- DHHS-DD's federal funding comes through Medicaid HCBS Waivers.
  - 403 NAC 2-001, 404 NAC 4-003.01, and 471 NAC 2-000
- All community-based DD service 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 before enrolling providers.
  - NE Medicaid contracts with MAXIMUS Health Services, Inc. to comply with these requirements.

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# Frequently Asked Questions (FAQs) #2

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How do I become certified as an agency provider?

Follow the steps in the NAC 404 [Chapter 4](#)  
*(also described on the following slides)*

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# FAQ #2 Steps to Become an Agency Provider

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Step 1: Attend orientation

Step 2: Complete an application with a letter of intent. The application is provided by DHHS-DD after you attend orientation and includes:

- Scope of services you intend to provide as outlined in 403 NAC Ch 4 and 5:
  - Chapter 4 defines the DD Day Services Waiver for Adults.
  - Chapter 5 defines the Comprehensive Developmental Disabilities Services Waiver.
  - Services are defined and determined by the Waiver service definitions, which are more updated than 403 NAC and supersede regulations.
- Location (city/cities) where you will provide service(s)
- Other pertinent information.

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# FAQ #2 Steps to Become an Agency Provider

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- New regulations were approved July 16, 2018
  - New providers must enroll per 404 NAC.
  - Service names and codes are found in 403 NAC.
  - [DHHS-DD's website](#) will help you understand the changes.
- The [DD Policy Manual](#) summarizes DD waiver services in chapter 8.
  - The service definitions and limits outlined in the manual do not include all details and requirements.
  - Providers should refer to the Medicaid HCBS DD Waivers for full service information
- Subscribe to the [Provider Bulletin webpage](#) to receive updates.

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# Changes to DD Services

Service listed in 403 Regulations	New Service, per 2019 HCBS Waiver Amendment
Residential Habilitation – 9844 – crosswalks to the five services to the right	<u>Continuous Home - Residential Habilitation - 3992</u>
	<u>Host Home - Residential Habilitation - 9293</u>
	<u>Medical In-Home Habilitation - 9220</u>
	<u>Behavioral In-Home Habilitation - 1796</u>
	<u>Shared Living - Residential Habilitation - 1472</u>
In-home Residential Habilitation – 2611 – crosswalks to the two services to the right	<u>Independent Living - 2639</u>
	<u>Supported Family Living - 7494</u>
Adult Companion Service - 4479 Adult Companion Service In-Home – 2546 – these two services crosswalk to the two services to the right	<u>Independent Living - 2639</u>
	<u>Supported Family Living - 7494</u>
Crisis Intervention Support – 4428 – crosswalks to Consultative Assessment	<u>Consultative Assessment Service - 7783</u>

# Residential Habilitation Changes

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Additional explanation of 2019 Waiver Amendment changes impacting definitions in 403 NAC: Residential Habilitation - 9844 - crosswalked to five services:

- Continuous Home – Residential Habilitation – 3992
  - Provider-controlled shift staff
- Host Home – Residential – 9293
  - Provided in the home of an agency provider employee. Must live with the employee and share daily life with the family in the home and community.
- Shared Living – Residential Habilitation – 1472
  - Provided in the home of an agency provider contractor. Must live with the contractor and share daily life with the family in the home and community.
- Medical In-Home Habilitation – 9220
  - Short-term service when there is a severe medical event that keeps a participant from normal day activities.
- Behavioral In-Home Habilitation – 1796
  - Short-term service when there is a severe mental health event or behavior that keeps a participant from normal day activities.

# In-Home Residential Changes

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Additional explanation of 2019 Waiver Amendment changes impacting definitions in 403 NAC: In-Home Residential Habilitation 9844, Adult Companion Service 4479 and Adult Companion Service In-Home crosswalked to these two services:

- Independent Living - 2639
  - Provided in Participant's home, teaching skills for living independently and doing things in the community.
- Supported Family Living – 7494
  - Provided in Family home, teaching skills for living independently and doing things in the community.
- Crisis Intervention Services 4428 are rolled into Consultative Assessment Services – 7783
  - Helps a participant stay in current services while keeping the participant, and others, safe. Services may include a functional behavior assessment by a qualified health care provider. Behavioral interventions are developed, used, evaluated, and revised as needed.

# FAQ #2 Steps to Become an Agency Provider

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Step 3: Electronically submit a complete application with your agency provider's policy and procedure (P&P) manual.

- *All submissions must be electronic; DHHS does 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 by DHHS to demonstrate how your P&P meet the rules and regulations. This worksheet is sent with the application/letter of intent form.
- Be sure to proofread your submissions, ensuring page numbers are correct and match your worksheet.

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# FAQ #2 Steps to Become an Agency Provider

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Step 4: DHHS 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!* Your 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 say you have an advisory board; *how will the advisory board function? Consider: what will they do? what do they address?*

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# FAQ #2 Steps to Become an Agency Provider

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The initial review of the P&P covers 11 core areas in 404 NAC:

- 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.*

# FAQ #2 Steps to Become an Agency Provider

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- DHHS *cannot* consult with you to develop your P&P.
  - We are only allowed to review your P&P and determine whether it is acceptable.
  - DHHS does not “Approve” or “Reject” P&Ps.
  - When we review a P&P and determine the core areas are not acceptable, we send it back to be revised.
- DHHS-PH may schedule an administrative review at any time.

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# FAQ #2 Steps to Become an Agency Provider

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Step 5: When revisions are required, you can choose to make revisions and resubmit your P&P to DHHS for review.

- There is no official limit on how many attempts you have to get your P&P accepted.
- Be sure to proofread your revisions, ensuring page numbers are correct and match your worksheet.
- 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.
- *When information submitted is clearly not in line with provision of Medicaid HCBS DD Waiver services, your certification may be denied.*

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# FAQ #2 Steps to Become an Agency Provider

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How long does it take to become an agency provider?

- It usually takes several months to become certified as a provider of Medicaid HCBS DD services.
- The time it takes is dependent upon how long it takes your agency to fully complete an application and P&P manual fully describing *how* your agency and staff will comply with 403 and 404 NAC in daily operations.

Can I get start-up funding?

- No, new agency providers should not anticipate start-up funding through the State of Nebraska.
- You are responsible for start-up costs and should plan accordingly.

# New Business Resources

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## Resources for new businesses (not all-inclusive):

- 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://nebraskacommunitycolleges.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/>

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# Frequently Asked Questions (FAQs) #3

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How does a person receive DD services and choose a provider?

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# FAQ #3 Services and Choice

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## Eligibility and Funding Offers:

- A person submits an application for developmental disabilities services.
- DHHS-DD determines eligibility:
  - When eligible, the person is offered a Service Coordinator (SC).
  - When the person has no Medicaid and requests SC, Ability to Pay is determined.
- The eligible person is added to the Wait List.
- When a person on the wait list meets priority status, he/she receives funding:
  - In order to maximize funding, person must apply for and accept Medicaid and other benefits.
  - The person accepts waiver services and becomes a participant of services.
  - A SC is assigned, when the person had not requested one before.
- An objective assessment (ICAP) is completed to determine the participant's annual Individual Budget Amount (IBA).

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# FAQ #3 Services and Choice

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## Funding Process and Beginning Services:

- The participant's annual Individual Budget Amount (IBA) is what is available to him/her to purchase services.
- The SC meets with the participant and discusses possible services and provider options. The SC gives the participant a list of agency providers.
- SC sends referrals to providers via Therap (<https://www.therapservices.net>)
  - Therap is the state-mandated web-based case management system for DD providers.
  - Referrals may be sent statewide or just to one provider.
  - Participant choose providers for referral to be sent to; choice may be based on: geography, knowledge of program, or other reasons.
- When a provider accepts a referral, a back and forth begins, including possible meet and greet meeting, tours, and trial periods.
- Once the participant chooses a provider, their individual support plan (ISP) team will meet

# FAQ #3 Services and Choice – Most Important

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Services are to be person-centered, in accordance with the participant's hopes, dreams, and goals and the location they prefer.

Services must be:

- Safe
- Person-centered
- Habilitative (includes habilitation programs)
- Focused on contributing to an increased quality of life for participants
- Well-administered and in compliance with waiver guidelines

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# FAQ #3 Services and Choice

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## CMS Room and Board Definition:

- **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** means three meals a day or any other full nutritional regimen (snacks, as needed).

*DHHS does not pay for room and board.*

*Room and Board is paid by the participant, possibly with his/her SSI payment.*

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# FAQ #3 Services and Choice – CMS Rule

The Centers for Medicare and Medicaid Services (CMS) **Final Rule**: all home and community-based settings (HCBS) which receive Medicaid Waiver funds have to ensure people live in the community and have opportunities to access their community and receive services in the most integrated settings.

- Final Rule was effective March 17, 2014.
- Existing agencies must be in compliance by March 17, 2022.
- New agencies must comply immediately.
- What this means for ALL settings: A setting is selected by the participant from options including non-disability-specific settings and options for privacy in residential settings (such as having a private room).

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# FAQ #3 Services and Choice – CMS Rule

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What the final rule means for participants (not a complete list):

- Participants must have *informed* choice of providers, services, and settings and their choice must be documented in a person-centered plan.
- Participants 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.

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# FAQ #3 Services and Choice – CMS Rule

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What the final rule means for residential services (not a complete list):

- Each participant 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 participant must have privacy in their sleeping or living unit, with a lock and key controlled by the participant and appropriate staff.
- Each participant 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.
- Participants sharing a living unit must have choice of roommate.

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# FAQ #3 Services and Choice – CMS Rule

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What the final rule means for non-residential services (not a complete list):

- *Informed* choice of *meaningful* activity for the 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 (such as PT, OT, medications, diet) are kept in a private area, away from general operating areas of the setting.

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# Final Rule Resource

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Resource to help you comply immediately with the Final Rule:

- <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>

# Additional Resources and Notes

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Some places to find answers to your questions:

- NAC 403 and 404 regulations, monitored by the DHHS-DD and DHHS-PH.
- DHHS-DD webpages for provider information, Provider Bulletins, regulations and waivers
- Ask other community-based agency providers who have years of experience.
  - *A helpful resource is the DD Provider Directory on the DHHS-DD website.*
- Contact Todd Greene, 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>
  - *Agency providers must register with the Secretary of State as a business to enroll in Medicaid.*

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# Questions?

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# Provider Medicaid Enrollment

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- Enrollment is completed after the provisional certification by Public Health.
- Enrollment begins with a referral to the web portal developed by Medicaid and contracted to Maximus Health Services, Inc.
- Provider must supply information to the DHHS-DD Program Coordinator:
  - Services to be provided – specifically, what HCBS waiver do these fall under?
  - Name of agency provider
  - Federal Tax ID Number
  - Zip plus four – can be learned at the USPS website:  
<https://tools.usps.com/go/ZipLookupAction!input.action>

Sign up for more information and to receive [Medicaid provider bulletins](#)

# Background Check Requirements

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- 404 NAC requires you to acquire Adult Protective Services/Child Abuse and Neglect (APS/CAN) background checks for employees *before they start providing services*.
- When you are an owner or member of management and you provide direct care support in an emergency, you must have all the background checks and training required of any direct-care employee.
- The website with information on using the Child and Adult Abuse Registry: <http://dhhs.ne.gov/Pages/Abuse-and-Neglect-Central-Registry.aspx>

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# Insurance Requirements

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In addition to complying with statutory and regulatory requirements, the [Policy Manual](#) includes additional provider requirements such as:

- 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

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- DHHS-DD Program Coordinator notifies DD Service Coordination Supervisors statewide when all provider enrollment documentation is received.
- Your agency provider will be listed as an option when Service Coordination speaks with participants.
  - Service Coordination will *not* advocate for your agency provider.
- Service Coordination will notify the DHHS-DD Program Coordinator when a participant chooses your agency provider for services.
- Once a participant starts services, your agency must follow the [Medicaid HCBS DD Waivers](#), all pertinent [regulations](#), and the [DD Policy Manual](#).

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# Billing Guidelines

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- Services and supports must be delivered as documented in each participant's person-centered plan. This plan is called the Individual Support Plan (ISP).
- Services billed must be provided in accordance with all statutory, regulatory, and provider agreement requirements, and in accordance with the approved [Medicaid HCBS DD Waivers](#).
- No payments will be made for room and board, start-up costs, cost of provider-controlled property maintenance, upkeep, or improvement.

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# Claims Processing

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- Providers can only claim services provided during the period shown on the Service Authorization.
- Claims are normally processed in 3-5 business days; however, please allow up to 10 business days for payment.
- Nebraska Prompt Payment Act, Neb. Rev. Stat. §81-2401 through 81-2408, says we have 45 days to make payment on claims.
- All billing goes through Therap.
  - Therap's training video on the billing process:  
<http://www.therapservices.net/nebraska/nebraska-billing-integration-training/>

# Using the State-Mandated Case-Management System

Many Therap modules are mandated for use by DHHS:

- Referrals
- Service Authorizations
- Medication Administration
- General Event Reports (GERs)
- Individual Support Plans (ISP)
- ISP Programs
  - Programs must be written and run in accordance with the Habilitation Plan Overview:  
<http://dhhs.ne.gov/Guidance%20Docs/DD%20Habilitation%20Plan%20Overview.pdf>
- Attendance
- Billing

You can learn more at: <https://help.therapservices.net/app/nebraska>

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# 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 DHHS-DD.
3. **Application Review:** DHHS-DD processes application and forwards to DHHS-PH when complete.
4. **DHHS-PH Review(s):** P&P review to evaluate NAC 403 & 404 compliance.
5. **DHHS-PH Interview:** Provider's opportunity to demonstrate knowledge and ability to apply P&P.
6. **Correction of Identified Issues:** Provider writes responses outlining needed corrections.
7. **Provisional Certificate:** Issued after *all* concerns have been corrected by provider.
8. **Maximus Enrollment Referral:** Referral from DHHS-DD to DHHS-MLTC.
9. **Initial Referral Accepted:** Provider must notify DHHS-PH & DHHS-DD within one business day.
10. **On-Site Pre-Service Review:** DHHS-PH evaluates actual readiness to serve individuals' health and safety needs.
11. **Home & Community Based Service Final Rule Assessment:** DHHS-DD completes for provider-operated sites.
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. When the provider has not demonstrated compliance after a third review, the application is denied.*

# Naming your Agency Provider

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Before naming your agency and registering with the Secretary of State, consider what the name you choose says about you and your business.

The following websites have information about people-first language:

- [https://www.inclusionproject.org/nip\\_userfiles/file/People%20First%20Chart.pdf](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](https://www.sccoe.org/depts/students/inclusion-collaborative/documents/person-First_Language_Article.pdf)

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# How Can I Succeed?

- Make sure you are eligible to be an agency provider (see 404) and to obtain a Medicaid number *before* you begin the certification process.
- Be *certain* you *really* want to be an agency provider instead of an independent provider or 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.
  - It's is NOT enough to know if you can address and meet all of them because you have worked for a provider, have a family member with disabilities or “scanned” 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 P&Ps.
  - Make sure they reflect your agency's work and structure.

*You are attempting to demonstrate to DHHS that you are a prepared, professional, and qualified business, ready to offer quality services and meet all requirements at the time you submit your application.*

# Things to Consider

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- Documentation is everything!
  - No documentation means no evidence that your agency is maintaining regulatory compliance.
  - Document *everything!*
- As a regulatory oversight source, DHHS cannot provide consultation services.
  - When you want to engage business consultation services, you need to obtain those from another source.
- The agency provider is responsible for any actions and services provided by a subcontractor for the provider.
  - See Title 404 NAC Chapter 11.
  - Examples of subcontractors: EFH, nurse, transportation, behavior specialist

# Initial Certification and Plans of Improvement

- Once a provisionally-certified agency provider has a participant receiving DD services, an initial certification review is conducted. The review includes:
  - Site visits, observations, and examination of documentation; and
  - Interviews with administration, staff, and participants.
- A written certification report is issued to the agency provider.
- The report requires a plan of improvement (POI) be submitted, accepted, and implemented.
  - Upon acceptance of a POI and evidence 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 DHHS-PH as specified in the letter.

# Reports, Citations, and Responses

- Reports issued to agency providers are public documents. The public has access and can see reports on your agency.
  - Do not use names in responses and ensure responses are written professionally, as they reflect your agency.
- Citations can come from complaint reviews. Like certification reviews, a written report is issued to the agency provider and a POI is required. These are also public documents.
  - Citations often come from poorly written policies that do not give staff guidance for *how* the agency will operationalize compliance.
- To be “in compliance,” you must follow all regulations, laws, and state statutes applicable to the service and setting
  - This includes things such as local zoning laws, fire marshal requirements, and covenants.

# Continued Certification

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- You must maintain current certification to bill for Medicaid HCBS DD Waiver services.
- Certification reviews are done by multiple reviewers over multiple days.
- The agency provider is responsible for providing information and documents requested in a timely manner.
  - When DHHS does not see it, we assume it does not exist.
- Maintaining certification requires maintaining compliance with the regulations and fully implementing all POIs accepted by DHHS.
- Citations issued from complaint investigations can and have been considered in determining certification status.

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# Citation Components

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Each citation has of three parts:

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

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# Plans of Improvement (POI) per 404 NAC

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 Agency Providers

Are you *fully* prepared to manage staff and run a business *before* you begin?

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

# Common Problems - Continued

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- Knowing the DD world, but not the business world.
- Knowing how to run a business, but not human services work.
- Not having enough start-up funding available.
- Underestimating the time and work needed to get started.
- Failure to implement what your P&P said you would do (such as background checks, training, competency testing, or assessments).
- Failure to read and follow 403 and 404 NAC.
- Failure to know and follow other legal and regulatory requirements, such as IRS, local codes, and ADA.
- Expecting someone else to tell you what to do, how to do it, and when to do it.

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# Questions?

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# Self Evaluation Checklist – part 1

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- Know your business plan:
  - Do you want to run your own business? If so, you can become an agency provider.
  - Do you want to work under an existing provider? If so, you can be an employee or a subcontractor.
  - Do you want to work independently? If so, you can become an independent 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?
  - Implementing services 24/7

# Self Evaluation Checklist – part 2

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- 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?

# Katie Weidner & Kim McFarland

DHHS-DD Provider Relations

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DHHS-DD toll-free: 877-667-6266

DHHS-DD Reception: 402-471-8501



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[dhhs.ne.gov](http://dhhs.ne.gov)

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