# Division of Developmental Disabilities

| District | Date |
|---|---|
| District 1 | July 11, 2019 |
| District 2 | July 8, 2019 |
| District 3 | July 24, 2019 |

# Service Coordination & Provider Meeting 3rd Quarter 2019

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# Agenda

- Welcome & Introductions
- Distribution of District Contact Information
- Service District & Provider Focus Areas
- Policy & Provider Relations Team:
  - Waiver Amendments
  - Appendix K – Disaster
  - Policy Guide
  - Regulations
  - Updated GER Guide
  - Completing MARs
  - DD & VR
  - Rights & Restrictions
  - Shared Living – Maximus Enrollment
  - Provider Requirements – DD Notification/Medicaid Requirements
  - Claims Processing
  - State Transition Plan (STP)
  - Independent Provider Orientation
- Quality Team:
  - National Core Indicators
  - GER/Reportable Incidents – CMS Performance Measure
  - Post-Payment Claims Reviews
- Service Coordination Team:
  - ISP Quality Reviews
  - ICAP Agency Liaisons
  - ICAP Appeals
  - Therap Referrals
  - Open Discussion

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# Service District & Provider Focus Areas

- Increased ISP Reviews – How are they going?
  - Reminder to send follow-up within timelines

- Annual ISP Meetings
  - Can reduce the time spent in the meeting if everyone comes prepared with their documents (Medical, ISP Program Data, Assessments & Summaries, etc…)

- LE Contact – Ensure SC's are notified timely. This includes participants who are victims and those participants who call LE themselves on a roommate.

- Thank You! Positive feedback is being received from SCs that Providers are reaching out to them directly with questions and relationships are improving.

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# Waiver Amendments

- The Waiver amendments were submitted to CMS on March 21, 2019.
- DHHS-DD received an informal "Request for Additional Information" (RAI) from CMS on May 10, 2019 for both the Adult Day and Comprehensive waivers.
- DHHS-DD submitted the updated waiver applications and responses to the RAI on June 7, 2019
- As a result of the RAI, the planned effective date of the waiver amendments was revised to September 1, 2019.
- No other significant revisions were made based on the RAI.
- DHHS-DD received a formal RAI from CMS on June 19, 2019.
  - A formal RAI restarts the 90-day clock that CMS has to review the waiver amendments.

# Appendix K
# Emergency Preparedness and Response

- As you are aware, Nebraska experienced major flooding and blizzard conditions in the western part of the state in March 2019.
- Governor Ricketts declared a state of emergency in 81 of 93 counties in Nebraska.
- DHHS-DD submitted a standalone Emergency Preparedness and Response (Appendix K) to the waivers to be utilized for this emergency, with a request for a retroactive implementation date.
- Appendix K was approved by CMS on May 21, 2019 for retroactive implementation effective March 13, 2019 and ending September 13, 2020.
- DHHS-DD is beginning to process claims that have been submitted thus far.
- The deadline for submission of claims for retainer payments is August 31, 2019.

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# Policy Guide

- Division Policy staff are in the final stages of drafting a Policy Guide as a companion to the waivers and regulations.
- The projected implementation date for the Policy Guide is September 1, 2019, to coincide with the projected implementation of the waiver amendments.
- When the Policy Guide has been approved by DD Administration, an informal public comment period will be held to gather feedback at least 30 calendar days prior to implementation.

# Regulations

- Updates to Title 404 NAC has been drafted with input from providers.
- Changes include:
  - Removing information that conflicts with Title 403 (effective 7/2018) and the current CMS-approved Comprehensive Services and Adult Day Services Waivers;
  - Realigning the information in the chapters; and
  - Condensing from 11 to 6 chapters.
- Final drafts were submitted on 2/22/19 to the Governor's Policy Review Office for review, and were approved for public hearing on 6/25/19.
  The public hearing is scheduled for August 12, 2019 at 10:00am in the Gold's Building, Room 534.

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# Updated GER Guide

- An update to the current GER guide has been drafted to clarify when and how to report incidents
- The implementation of the draft guide has been extended to allow for additional feedback/input from providers.
- DHHS-DD is in the process of drafting a guide for completion of the investigations, required by 404 NAC.
  - There will be a similar review process to gather feedback and conduct training

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# Completing MARs

- Agency providers must maintain a MAR in Therap for all participants for whom the provider assists with any aspect of medication administration.
- In situations where the provider is not physically *giving* the medication/witnessing the medication being taken, they may still have a role in *administering* the medication, as medication administration includes activities beyond physically giving a dose of medication.
- Data can be recorded in a Therap MAR to accurately reflect the role the provider has in medication administration.
- A guidance document is being developed to give instruction on how medication administration can be documented when it does not involve provider staff directly giving medication or witnessing the participant take medication.
  - This guidance will include information on determining when a provider is involved in medication administration vs. self-administration.

# DHHS-DD & Vocational Rehabilitation

- DHHS-DD is working with Therap to customize Therap's employment module.
- Enclave and Prevocational:
  Enclave and Prevocational **cannot** be authorized unless participant has been determined **ineligible** for VR services.
- Referral to VR expectations have not changed.
  - Prior to starting DD services, a referral to VR should occur.
  - Anyone under age 25 cannot take part in sub-minimum wage work without a referral to VR and found ineligible for VR services.
  - Anyone in DD services that have expressed an interest in competitive integrated employment should be referred.

# Participant Rights and Restrictions

- All rights restrictions involving use of psychotropic medication must be reviewed by a provider's rights review committee at least semi-annually.
- Any other rights restrictions must be reviewed by a provider's rights review committee at least annually.
- Providers must communicate to a participant's service coordinator the date of rights review committee approvals for all rights restrictions, in order to have the information documented in the participant's ISP.
- A provider may choose to share documentation of the rights review committee approval with the service coordinator, but it is not required that the provider send this documentation to the service coordinator, unless it is specifically requested.
- DHHS-DD is planning participant rights training for service coordination and providers for late summer/fall to foster a better shared understanding of this topic.

# Shared Living – Maximus Enrollment

- Maximus is close to finalizing the changes necessary for Agency providers to begin enrolling Shared Living independent contractors as affiliates of the Agency.
- Each Shared Living contractor must be enrolled as an affiliate of the Agency.
- In order to enroll, each Shared Living contractor must have a Group Member Profile created for them by the agency.
  - Once the group member profile is created, Maximus will conduct the additional background checks required by Federal Medicaid regulation.
  - The Agency provider will continue to be responsible for the National Criminal History Checks, Sex Offender Registry Checks, and APS/CAN Central Registry Checks.

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# Shared Living – Maximus Enrollment

- Once the Group Member Profile (and background checks) have been completed, the Agency provider will be able to affiliate the Shared Living contractor with their Agency.
- An instructional guide will be released by Maximus on this process.
- Additional training will be provided this summer.
- The new Shared Living model will go into effect upon CMS-approval of the waiver amendments.

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# Notification Requirements

- Nebraska Administrative Code (NAC) 404, Chapter 4-002.09D outlines Notification Requirements: "The provider must notify the Department, in writing, of any the following situations:
  1. Change of ownership within 10 working days of the effective date;
  2. Change in director within 10 working days of the effective date;
  3. Any addition of a new service option at least 30 days prior to the effective date;
  4. Ending a service option currently being provided to individuals at least 60 days prior to the effective date; and
  5. Expanding services into another geographic area that was not included under the current provider certification at least 60 days prior to the effective date so that the Department can issue a provisional certification."

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# Medicaid Enrollment

- Section 6401 of the Affordable Care Act lists certain Medicaid provider screening and enrollment requirements states must follow. The requirements can be found in 42 CFR 455 Subpart E: https://www.govinfo.gov/app/details/CFR-2011-title42-vol4/CFR-2011-title42-vol4-part455-subpartE
- Because all Nebraska residents eligible for funding shall apply for and accept any federal Medicaid benefits for which they are eligible, all service providers of Home and Community Based Services must be enrolled as Medicaid Providers, see §83-1216: https://nebraskalegislature.gov/laws/statutes.php?statute=83-1216
- New site locations that include an office must have a separate Medicaid enrollment due to requirements in 42 CFR 455.450, which identifies new practice locations as requiring an application and risk level screening: https://www.govinfo.gov/app/details/CFR-2012-title42-vol4/CFR-2012-title42-vol4-part455
- DHHS-DD has worked with DHHS-MLTC to identify ‘new practice locations’ as an office, not as a ‘site’ as defined by the CMS Final Rule.

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# Medicaid Requirements

- When an agency representative signs the Provider Agreement in Maximus and becomes a Medicaid provider, the Provider assures to 15 bullet points including these two:
- Full compliance with the regulations and applicable policies and procedures of the Nebraska Department of Health and Human Services in the administration of program services;
- Full compliance with the requirement found at 42 CFR 455.432 that the provider agrees to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations;

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# Claims Processing

- Providers can only claim for services provided during the period shown on the Service Authorization.
- Claims are normally processed in 3-5 business days, however generally allow up to 10 business days for payment.
- The Nebraska Prompt Payment Act, Neb. Rev. Stat. §§81-2401–81-2408, allows the state 45 days to pay approved claims.

# New Provider Bulletins

- 3 New Provider Bulletins were released July 2:
  - PB 19-02: Guardians as Agency Employees
  - PB 19-03: Use of Appointments in the Therap Health Tracking Module
  - PB 19-04: Secure Communications

# Statewide Transition Plan - STP

- The Public Comment Period for the Statewide Transition Plan (STP) ended June 17th.
  - Comments will be evaluated and the anticipated submission date to CMS is July 2019.
- DHHS-DD completed all planned in-person assessments of Group Homes, CDDs, EFH, and Day Settings in 2018.
- All results letters for these site visits have been sent.
- New sites must be assessed before they open.
  - All new settings must be immediately compliant with the Final Rule.

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# Statewide Transition Plan – STP: Setting Trends

- 2018 Results:
  - Workshop:
    - 64% of settings required remediation
    - 52% of settings requiring remediation have completed their remediation plans*
  - Group Homes/CDDs:
    - 47% of settings required remediation
    - 81% of settings requiring remediation have completed their remediation plans*
  - EFH:
    - 17% of settings required remediation
    - 74% of settings requiring remediation have completed their remediation plans*

* *Numbers as of July 1, 2019.*

# Statewide Transition Plan – STP: Future Monitoring

- Part of the CMS requirements for the STP includes how the state will monitor its settings to assure continued compliance with the Final Rule.
- DHHS-DD has established a monitoring process specifically for DD settings. DHHS-DD's long term plan includes conducting monitoring reviews, until such time that the Final Rule language has been incorporated into quality and certification reviews.
- Additional informational letters will be distributed this summer outlining the exact processes.

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# State Transition Plan – STP: Integration Survey

- An integration survey was sent to all Agency providers on June 19.
  - Survey closes July 19.
- This survey is to collect data from providers about specific integration questions, as well as to ask for input into the future of DD day services.
- Survey data will be gathered and used to inform possible new day service definitions in future waiver amendments.
- Thank you for your participation!

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# Independent Provider Orientation

- A new orientation has been developed to assist Independent Providers in understanding what is required of them before and during enrollment, as well as before and during the provision of Medicaid HCBS DD Waiver Services.
- A similar orientation is required by prospective Agency Providers, prior to beginning the certification process.

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# NCI IPS Provider Recognition

- The Munroe-Meyer Institute (MMI) survey team has shared many positive comments regarding provider support with facilitating interviews during the 2017-18 survey cycle. The MMI survey team noted the following providers who went above and beyond:

| Agency Providers Recognition List | |
|---|---|
| • Better Living | • North Star |
| • Community Alternatives of Nebraska | • Ollie Webb Center Inc. |
| • ENCOR | • Prime Homes |
| • Hands of the Heartland | • Region I Services |
| • Integrated Life Choices | • Region II Services |
| • Mid-Nebraska Individual Services | • Region V Services |
| • MOSAIC | • VITAL |

**THANK YOU for your Support!**

* *Results for both the NCI In-Person Survey and Staff Stability Survey can be found at: http://www.nationalcoreindicators.org/Resources/Reports or on the DHHS public website, Developmental Disabilities Division Quality Assurance Page.*

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# HCBS Waivers: Reportable Incident Reviews

- **CMS Performance Measure:** Number and percent of reportable incidents completed and acted upon in accordance with DHHS policies and procedures.

- 50 agency providers submitted nearly 9,246 GER events (3,387 High; 5,859 Medium or Low) in Therap in the Dec. 2018 – Feb. 2019 quarter.
- CMS requires a minimum threshold of 86% compliance.
- The Division's Quality Management Team reviewed a random sample of 285 GERs from 32 providers for the quarter.
  - Of these, 84%, 240 of 285 GERs, were completed and acted upon in accordance with DHHS policies and procedures.

**The Quality Management Team reviews GERs to check:**

| | 1. Required GER Notifications Sent | 2. Timely GER Approval | 3.Timely GER Submittal | 4. Accurate GER Notification Level Assigned | 5. Immediate Action Taken Was Documented | 6. Corrective Actions Taken Were Documented |
|---|---|---|---|---|---|---|
| Done by: | 16 of 32 providers (254 of 285 GERs) in sample | 20 of 32 providers (265 of 285 GERs) in sample | 23 of 32 providers (271 of 285 GERs) in sample | 25 of 32 providers (271 of 285 GERs) in sample | 27 of 32 providers (278 of 285 GERs) in sample | 30 of 32 providers (281 of 285 GERs) in sample |

**Provider Summary for Dec. 2018 – Feb. 2019**

| # of providers that met all guidelines: | # of providers that did not meet all guidelines, but that identified action plans for remediation in their Quarterly Report or GER: | # of providers that did not meet all guidelines and did not identify action plans for remediation: |
|---|---|---|
| **16 of 32** | **10 of 32** | **6 of 32**<br>The Quality Management Team followed-up with these providers to discuss what action plans for remediation they would implement. |

# Post-Payment Claims Reviews

## Replacement/Resubmitted Claims

- Attendance must be updated when submitting a replacement claim(s) and re-submitting a rejected claim(s).
  - *Attendance is part of the supporting documentation for a billing claim.*
- Attendance must match the units in the billing claim.
  - *The nearest 15 minute increment should be used when updating attendance for replacement or resubmitted claims (to match quarter hour billing increments).*
- Reporting is based on attendance.
  - *Billing claims will continue to be included in post-payment review reports until the billing claim and associated attendance records have been corrected.*

# Post-Payment Claims Reviews

## ➢ Preventing Billing When There is Overlapping Attendance Records

- Therap will be implementing a mechanism to prevent a provider from billing if a participant has attendance records that overlap in that provider's Therap account.

- If a provider submits overlapping attendance records for a participant (in either the approval or the generate billing data phases), Therap will not allow the billing to go forward and will indicate which records are overlapping so the provider can make the needed correction(s).

- Estimated Implementation: August 2019

# Post-Payment Claims Reviews

- **Rate Adjustments**
  - Billing on two concurrent authorizations will not be possible once the check for overlapping attendance goes into effect.
  - With CMS approval of the waiver amendments, service authorizations will have fixed rates.
    - *Previously, rates were negotiable and were manually entered in the service authorization*
    - *Fixed rate service auths will decrease errors and the need for rate adjustment auths*
    - *Exception service authorizations are excluded from fixed rates*
  - It is important that service authorizations be reviewed for accuracy prior to acknowledgement.
  - Claims with errors in rate, rate type, service, and/or provider will need to be replaced through:
    - *Zeroing out units on the incorrect claim*
    - *Clearing attendance entered on the incorrect claim*
    - *Creating a correct authorization*
    - *Adding the new attendance records and the new claim on the new (corrected) authorization*
  - A step-by-step guide will be posted when the process is finalized.

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# ISP Quality Reviews

- Samples of ISP's are being randomly pulled and reviewed by our Quality Team for Waiver compliance.

- SC's may contact team members for additional information, which may require a team meeting.
  - Rights Restrictions and required elements in the ISP is our largest area of focus for improvement.
  - Sometimes the identification of something as a restriction is completely missing.

- An Operational Guideline for SC's has been approved to be shared with Providers.

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# ICAP Agency Liaisons

- How are ICAPs going?

- Discussion on importance of those being interviewed for the ICAP meeting the interviewee qualifications.
  - Must have known the participant for a minimum of 3 months and who sees him or her on a day-to-day basis.

- ICAP Provider Liaisons…..please remind those identified by the agency who will be interviewed for the ICAP to respond back timely to the Community Coordinator Specialists (CCS).

- Any changes to your agencies ICAP Liaison should be reported to Jan Wagner: jan.wagner@Nebraska.gov

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# ICAP Appeals

- Reminder that only the participant or guardian can sign and file an appeal.

- Families are reporting that agencies are encouraging appeals, which is absolutely a guardian's right.
  - Appeals are consuming a large number of hours and resources from both DHHS-DD and Hearing Officers
  - Appeals are being affirmed, as the data and subsequent scores in an ICAP are not contested

# Therap Referrals Discussion

- Thoughts on providers having a point of contact for Therap referrals?

- Discussion about referral response time. If providers could accept, deny, or add comments more quickly so that Service Coordination can take action
  - Often times, referrals are going without any response from Providers
  - Providers requesting additional information…..SC provides…..then SC doesn't hear anything further
  - DD Waivers only allow someone to go without services for 90-days, which causes us to terminate the Waiver and the person would have to re-apply for DD services and go onto the Waiting List.

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# Other

# Open Discussion

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