COMMUNITY LIVING HOME PROVIDER PROVISIONS

A 1.1 PURPOSE: The South Dakota Department of Human Services ("State" or "DHS"), Division of Long Term Services and Supports (LTSS), provides home and community-based service options to individuals 60 and older and to individuals 18 years of age and older with disabilities. State services enable these South Dakotans to live independent, meaningful lives while maintaining close family and community ties. The State provides home and community-based services, as specified in the Individual Support Plan (ISP), to prevent or delay premature or inappropriate nursing facility placement

State consumers are given information on available home and community-based services and have the right to choose between receiving services in his/her home and community or receiving services in a nursing facility. When a consumer chooses a Community Living Home setting to receive services, a partnership between the State and the Community Living Home Provider is developed to ensure the health, safety, and welfare of the consumer.

A 1.2 PROVISION: In addition to the requirements outlined in the SD Medicaid Provider Agreement, the Provider agrees to comply with all the requirements in this document.

STANDARD PROGRAM DEFINITIONS

B 2.1 "Case Management" includes reassessing the consumer's needs and eligibility at least annually, facilitating the development of the ISP, convening annual and as-needed person-centered planning meetings to develop and approve changes to the ISP, authorizing additional services by the Provider and/or third parties, and resolving any consumer concerns and other consumer-related issues. The State will provide on-going case management for each consumer.

B 2.2 "**Community Living Home Service**" includes routine intermittent personal care, supervision, cueing, meals, homemaker services, chore services, medication management (to the extent permitted under State law), and other instrumental activities of daily living (e.g. transportation for necessary appointments and community activities, shopping, managing finances, and phone use) that is provided to a HOPE waiver consumer.

B 2.3 "Community Living Home" is a licensed setting in which the HOPE waiver participant receives the Community Living Home service. The Community Living Home is the entity responsible for managing the setting and/or staff employed at the Community Living Home.

The following waiver services cannot be billed separately: homemaker; personal care, respite care, emergency response service, meals, environmental accessibility adaptations, and chore services.

Adult companion services, adult day services, nursing, nutritional supplements, specialized medical equipment, and specialized medical supplies may be authorized by the LTSS Case Management Specialist, based on assessed need as identified in the LTSS ISP with a threshold equal to the average cost of nursing home care. When these additional services are authorized by the LTSS Case Management Specialist, the services/supplies must be provided by a third party that is enrolled as a HOPE Waiver Medicaid Provider. Any medical equipment purchased by the HOPE Waiver for a consumer is the property of the consumer.

B 2.4 "**Critical Service Need Consumer**" is a consumer who needs service(s) (i.e., oxygen, injection, medication, wound care, therapy) provided on each assigned day without which the consumer's health condition would decline. The LTSS Case Management Specialist will communicate with the Provider (through the ISP) when a consumer has been identified as a Critical Service Need Consumer. When a Critical Service Need Consumer is identified, the LTSS Case Management Specialist will work with the consumer and the Provider to develop a critical service back-up plan to ensure critical service needs are met during an emergency.

B 2.5 "**Eligible Consumer**" is any person in need of services who has been determined eligible by DHS.

B 2.6 "Individual Support Plan (ISP)" is an electronic document within each consumer's record in the Therap case management system. The ISP is developed by the LTSS Case Management Specialist with the consumer, as well as any individuals the consumer chooses. The ISP must be finalized with the agreement and informed consent of the consumer in writing and signed by all individuals and providers responsible for its implementation.

The ISP reflects the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the individual with regards to preferences for the delivery of such services and supports.

Any modification of the federal regulations for the HCBS Settings Final Rule, as described at CFR 42 § 441.710(a)(1)(vi), must be individualized and addressed in the LTSS ISP. If a provider is implementing any modification(s) to any of these federal

home and community-based settings requirements, the modification(s) must be discussed with the LTSS Case Management Specialist and documented in the LTSS ISP.

The Provider must notify the LTSS Case Management Specialist whenever a change in the consumer's condition occurs and/or a modification may be necessary. The Provider is expected to provide input and participate in the development of the initial and ongoing LTSS ISP.

B. 2.7 "Person-Centered Philosophy" encompasses values, concepts and tools that are used to promote a person's positive control over the life they have chosen for themselves. The core concept of what is important to (happy, content, satisfied) and important for (healthy, safe and seen as a valued member of their community) a person is the core concept and is foundational during care planning process.

B 2.8 "**Residential Respite"** is the short-term (less than 30 consecutive days) care and supervision for an individual who is unable to care for him or herself in the absence of or for the relief of the caregiver that is provided in a Community Living Home or nursing home. Residential Respite care is available to eligible individuals who reside with caregivers. When providing residential respite, the capacity cannot exceed the licensed available beds (maximum of 4).

B 2.9 "Significant Change" is a major decline or improvement in a consumer's status that results in an increase or decrease in aggression, cognition, activities of daily living, change in chronic diagnosis, or change in treatments received (for example, dialysis, chemotherapy, tracheotomy, IV medication) that is anticipated to last longer than 30 days.

B 2.10 "**Therap**" is the online case management documenting and billing software.

B 2.11 "Therap Service Auth" is the electronic document in Therap which details the services authorized for the consumer. The Therap Service Auth must be acknowledged by the Provider within seven (7) business days of receipt. Failure to acknowledge the Therap Service Auth within the designated time frame may negatively affect reimbursement for services provided.

If a Provider is concerned that there is an error on the Therap Service Auth, the Provider should not acknowledge the Therap Service Auth. The Provider should contact the LTSS Case Management Specialist assigned as the consumer's case manager to resolve any potential discrepancies.

STANDARD PROGRAM REQUIREMENTS

C 3.1 RULES AND REGULATIONS: The Provider shall comply with all South Dakota Codified Laws and Administrative Rules of South Dakota applicable to the services provided. The Provider also agrees to comply in full with all licensing requirements and other standards required by federal, state, county, city or tribal statute, regulation or ordinance in which the service and/or care is provided. Liability resulting from noncompliance with regulations, licensing and/or other standards required by federal, state, county, city or tribal statute, regulation, or ordinance or through the Provider's failure to ensure the safety of all consumers served is assumed entirely by the Provider. Medicaid rules and regulations supersede all Community Living Home policies and procedures.

C 3.2 VERIFICATION AND DOCUMENTATION: The Provider is required to maintain documentation and verification demonstrating compliance with all Provisions. This documentation must be readily available upon request.

C 3.3 REFERRALS AND GEOGRAPHIC AREA: Any LTSS consumer living within the Provider's identified geographic area may be referred to the Provider. The Provider is expected to consider all referrals but may turn down a referral due to safety concerns, unavailability of staff, or inability to serve consumer need. The consumer will be offered the choice of available Providers and select the Provider of his/her choice.

C 3.4 INTERPRETERS: If Interpreter services are necessary, the Providers must utilize DHS approved interpreters whenever authorized by the State. Interpreter services must be authorized by the LTSS Case Management Specialist prior to Interpreter services being utilized. LTSS Case Management Specialist and Provider will cooperatively arrange for interpreter services as necessary for service provision.

C 3.5 REIMBURSEMENT: The rate(s) for services are specified in the HOPE Waiver Fee Schedule. All services authorized and delivered by the Provider to eligible consumers will be reimbursed at stated rates. Community Living Home services are billed at a tiered daily rate. Rate tiers are determined by a standardized needs assessment tool that is completed by the LTSS Case Management Specialist at least annually with HOPE Waiver consumers.

The Provider must collect the Room and Board portion of the payment from the consumer. In situations where the consumer is unable to pay the Room and Board, he/she may be eligible to have the Room and Board subsidized by DHS. Eligibility is determined by the Department of Social Services Division of Economic Assistance. The Provider will be notified of the portion of the Room and Board that may be subsidized and what must be collected from the consumer by the Provider. Consumers residing in a Community Living Home are not eligible for the Supplemental Nutrition Assistance Program (SNAP) since their Room and Board is supplied.

The HOPE Waiver reimbursement rates are updated in July of each year. The Room and Board portion of the rate is adjusted in January of each year, based on the Cost-of-Living Adjustment (COLA). Notification of reimbursement rate adjustments is provided when these updates occur.

The State's reimbursement rate for services must not exceed the Provider's private pay rate(s). If the State's rate(s) of reimbursement exceeds the Provider's private pay rate(s), the State's reimbursement will be adjusted to match the private pay rate(s).

Approved claim forms, including all required information (e.g. Provider's National Provider Identification (NPI), consumer's primary diagnosis code, etc.) will be submitted by the Provider to the State for payment of services authorized and provided. The State will not reimburse or otherwise be liable for purchases or transactions made by the Provider on behalf of the consumer.

It is the responsibility of the Provider to review the Therap Service Auth to ensure the details (including the rate, units and frequency, and recipient ID) are correct prior to acknowledging the Therap Service Auth. If any of the Therap Service Auth information is incorrect, the Provider must contact the LTSS Case Management Specialist to mitigate potential claims error(s).

If the Provider is reimbursed at the incorrect rate resulting in an overpayment, necessary action to resolve this overpayment will be initiated by the State, including voiding of Medicaid claims. If the Provider is reimbursed at the incorrect rate resulting in an underpayment, the Provider will be required to initiate the necessary action(s) to correct the underpayment, including voiding of Medicaid claims. The Provider must resubmit the claims at the correct rate to receive appropriate reimbursement.

The Provider must only bill for services acknowledged in Therap and delivered by the Provider. The State will not reimburse or otherwise be made liable for purchases or transactions made by the Provider on behalf of the consumer, which are not previously authorized in Therap.

To be reimbursed at the established rate, the consumer must be physically present in the Community Living Home and must be receiving the Community Living Home service, except in the following situations:

> Hospital reserve bed days: A Community Living Home may bill SD Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to SD Medicaid per hospitalization; however, the recipient must return to the Community Living Home for a minimum of 24 hours before additional hospital reserve bed days will be paid. When a consumer is transferred from a Community Living Home to a hospital, it is expected that the Provider will accept the consumer back at the Community Living Home at the time of hospital discharge.

Therapeutic leave days: A Community Living Home may bill SD Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Community Living Home for non-medical reasons (e.g., visits to the homes of family or friends).

The State's reimbursement for services rendered shall be considered payment in full. Except for the cost-share for waiver services and Room and Board, the Provider may not bill the consumer for any additional fees. The Provider will be advised of the consumer's cost-share, if any, and will be responsible for collecting the cost-share and Room and Board from the consumer.

For assistance with claims denials and billing issues, Providers must notify the State within the 6-month time limits outlined in ARSD 67:16:35:04. For all claims inquiries, Providers must submit a Claims Resolution Template to ltsstherap@state.sd.us for further review and technical assistance. Providers are encouraged to resubmit all previously denied claims every 90 days for SD Medicaid and SD DHS/LTSS claims compliance. Claims inquires will be reviewed by appropriate LTSS staff in the order in which they are received.

LTSS will not address or review SD Medicaid or LTSS State-funded claims issues that are not in alignment with ARSD 67:16:35:04. LTSS staff will not review and research claims if there is not a claim submitted to Medicaid or LTSS within 6 months of the date of service and every 3 months thereafter per Medicaid billing requirements. It is ultimately the responsibility of the Provider to submit a request for reimbursement for services provided within established guidelines.

LTSS will assist Providers with claims resolution if there is a Claims Resolution Template submitted within 3 months of the date of service. This will ensure there is still time to resolve the issue prior to the timely filing deadline.

C 3.6 BACKGROUND CHECK: The Provider must, at a minimum, conduct a State fingerprint background check principal caregivers and employees hired to work in the homes of consumers to screen for disqualifying criminal convictions.

The Provider may request the State's approval for an alternative background check by completing and submitting the Provider Request for Approval of Alternative Background Check form, along with a description of the alternative background check (produced by the company that processes the background checks).

To receive approval, the alternative background check results for caregivers and for employees hired by the provider must be readily accessible to the State upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual by utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards);
- The alternative background check identifies the criminal history of the individual; and
- The alternative background check creates a report of the criminal history of the individual which is readily accessible to the provider.

An employee hired to provide direct services or supports to consumers residing in an Community Living Center must meet the following minimum standards:

1. Be 16 years of age or older;
2. Be employed by an enrolled Medicaid Provider; and
3. Pass a State fingerprint (or State approved) background check.
    a. The following are a list of disqualifying convictions that would automatically preclude an individual from being hired/contracted:
        i. Conviction of a crime of violence as defined by SDCL 22-1-2 or a similar statute from another state;
        ii. Conviction of a sex crime pursuant to SDCL 22-22 or SDCL 22-24A or SDCL 22-22A-3 or similar statutes from another state;
        iii. Class A and/or B felony convictions.
    b. The following are a list of fitness criteria that may preclude an individual from being hired/contracted at the discretion of the provider:
        i. Convictions of other felonies not described in 3.a.iii;
        ii. Misdemeanor convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
        iii. Any convictions, including any form of suspended sentence, which are determined to be detrimental to the best interests of SD Medicaid. This includes convictions related to a person's character such as perjury and fraud related charges as individuals determined to be dishonest with any party should not be assumed to be honest with SD Medicaid;
        iv. Any conviction related to obstruction of a criminal investigation.

C 3.7 OIG LEIE AND SAM EXCLUSION LIST(S): The Office of the Inspector General (OIG) has the authority to exclude individuals and entities from federally funded health care programs and maintains a list of all currently excluded individuals. The Provider must check the OIG List of Excluded Individuals and Entities (LEIE) a minimum of once every month to ensure that new hires and current employees are not on the excluded list. The OIG exclusions database can be searched online at https://exclusions.oig.hhs.gov/.

The System for Award Management (SAM) lists individuals and entities who are suspended or debarred from receive federal funding, contracts, subcontracts, financial

and non-financial assistance and benefits. The Provider must screen staff through the SAM system, a minimum of once every month, to ensure that new hires and current employees are not on the excluded list. The SAM exclusion database can be searched online at: https://sam.gov/content/exclusions.

Any payments made for services provided by an employee found on the OIG Exclusionary list or SAM list of individuals who are suspended or debarred must be reported to DHS staff. Participating providers receiving state and federal Medicaid or Medicare dollars have an obligation to report any payments received in error to DHS.

C 3.8 DRIVER'S LICENSE: The Provider is responsible for maintaining proof of a valid driver's license for any employees transporting consumers.

C 3.9 DHS COST REPORT: The Provider must submit a cost report in the format required by the State within four months following the end of the Provider's fiscal year. Failure to submit the report will result in the termination of the Provider's contract with the State. For further information regarding the DHS annual cost report, please visit DHS Budget and Finance webpage, link: https://dhs.sd.gov/budgetandfinance.aspx .

C 3.10 HCBS SETTINGS FINAL RULE: The Provider agrees to fully comply with the HCBS Settings Final Rule, 42 CFR §441.301(c)(4) and (5) specified here and in the HCBS Settings Guide to Expectations and Compliance. The Provider also agrees to cooperate with all action steps included in S South Dakota's HCBS Settings Final Rule Transition Plan.

PROGRAM POLICY REQUIREMENTS

D 4.1 POLICY AND PROCEDURE MANUAL: The Provider must have a policy and procedure manual. The policy and procedure manual must be easily accessible upon request. The policies required within the Provider Provisions must be included in the policy and procedure manual.

D 4.2 ADMISSION, TRANSFER, DISCHARGE: The Provider must have an Admission, Transfer and Discharge policy. When the Provider determines services to a consumer must be discontinued, the Provider must notify the consumer in writing at least 30 days before the transfer or discharge, unless a change in the consumer's health requires immediate transfer or discharge or if the consumer has not resided in the Community Living Center for 30 days. The written notice must specify the reason for and effective date of the transfer or discharge and the new location to which the consumer will be transferred or discharged to; the conditions under which the consumer may refuse transfer within Community Living; and a description of how the consumer may appeal a decision by Community Living to transfer or discharge the consumer as per ARSD 44:70:09:14.

Additionally, per ARSD 44:70:04:16, the Provider shall initiate planning with applicable agencies to meet identified needs of the consumer and the consumer shall be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care shall be made available to the community living setting and/or the individual to whom the consumer is discharged.

D 4.3 ASSESSMENT: The Provider must have an assessment policy that defines the Provider's process for assessing the consumer's needs (to include mental health and mobility) and the Provider's ability to meet the needs of the consumer, in compliance with HCBS Settings Final Rule prior to admission and ongoingly. It is the responsibility of the Provider to adapt the environment to ensure all accessibility features and environmental modifications have been installed to ensure the consumer is able to access all common areas throughout the entire duration of the consumer's residency at the Community Living Home.

D 4.4 DOCUMENTATION: The Provider must have a documentation policy. The documentation policy must include how Community Living Home staff document service provision, consumer progress and health/safety concerns with a consumer. Documentation must be kept for each consumer. Records must be retained for six (6) years after a claim has been paid or denied. Documentation must be easily accessible upon request.

D 4.5 HCBS REQUIREMENTS AND MODIFICATIONS: The Provider's facility standards and policies must address the federal Medicaid requirements for Home and Community-Based Settings (HCBS Settings Final Rule) as specified in 42 CFR §441.301(c)(4) and (5). Specific policies that must be addressed as part of facility standards include the following:

1. Access to the broader community;
2. Privacy, dignity, respect, autonomy, choice, control, freedom from coercion and restraints, and all consumer's rights as noted in ARSD 44:70 and the HCBS Settings Guide to Expectations and Compliance;
3. Consumer leases/tenant agreement requirements;
4. Roommate choice policy;
5. Visitor/Guest policy;
6. Policy to address ability to lock door to sleeping or living unit; and
7. Policy to address access to food.

The HCBS Settings Final Rule ensures that Medicaid eligible consumers residing in an HCBS setting have control over their location, living arrangements, privacy, dignity and respect, physical accessibility, autonomy, and community integration.

In rare instances, certain rights may need to be restricted to ensure a consumer's health and safety. If a consumer in the Provider's setting requires a modification, the Provider must complete and submit a HCBS Setting Modifications Request to the consumer's Case Management Specialist prior to implementing a restriction.

No modification or restriction may begin until the Case Management Specialist has met with the consumer and a signed copy of the Modification form is added to their Individual Support Plan.

D 4.6 OIG/LEIE AND SAM VERIFICATION: The Provider must have a policy that specifies both process(es) (OIG & SAM) for conducting staff exclusion search and the policy must have a mechanism for ensuring that the staff who perform the verifications are not listed on either exclusion list(s).

For review purposes, all employee files should contain evidence that the OIG list and SAM list was checked. A page can be printed from the OIG web page and SAM web page, or the file should contain documentation of the date the list was checked and the outcome of the check and who did the check. Background checks or screening information should also be contained in the personnel file and available to state program staff.

D 4.7 ABUSE NEGLECT AND EXPLOITATION: The Provider must have a policy for abuse neglect and exploitation. In accordance with South Dakota law, the Provider is mandated to immediately report any suspected abuse neglect or exploitation of a consumer. The policy for abuse neglect and exploitation reporting must conform to the mandatory reporting laws and address the requirement to provide training on mandatory reporting laws to staff on an annual basis. See South Dakota Codified Law (SDCL) 22-46 for South Dakota's mandatory reporting laws for elders and adults with disabilities. To make a referral to Adult Protective Services (APS), visit https://dhs.sd.gov/ltss/adultprotective.aspx.

D 4.8 INCIDENT REPORITNG: The Provider must have an incident reporting policy. The Provider must immediately notify State of any consumer-related concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care.

The Provider must follow the Department of Health's (DOH) policy for documenting the circumstances of any incident that involve falls with injury of a serious nature, restraint, seclusion, serious injury, missing person, or death from other than natural causes. For further information regarding the Department of Health reporting criteria, please visit DOH Health Facility Licensure webpage at: https://doh.sd.gov/providers/licensure/.

Upon being informed that a consumer has been hospitalized, or discharged from the hospital, the Provider will immediately communicate this information to the LTSS Case Management Specialist to assure the consumer's need for service provision continues to be met appropriately.

D 4.9 CONSUMER GRIEVANCE: The Provider must have a Grievance policy pursuant to ARSD 44:70:09:10. A consumer may voice grievances without discrimination or

reprisal. A grievance may be in writing or oral and may relate to treatment furnished, treatment that has not been furnished, the behavior of other consumers, and/or infringement of the consumer's rights. The Provider shall adopt a grievance process and make the process known to each consumer and to the consumer's immediate family. The grievance process shall include documentation of the facility's efforts to resolve the grievance and documentation of the grievance; the names of the persons involved; the disposition of the matter; and the date of disposition.

D 4.10 EMERGENCY RESPONSE: The Provider must have an emergency response policy. An "emergency" is defined as a situation that is sudden, generally unexpected, and demands immediate attention. The Provider must notify the State of the emergency upon resolution of the emergency or transfer of the consumer to emergency responders.

D 4.11 HEALTH AND SAFETY: The Provider must have a health and safety policy. The health and safety policy must detail the use of universal precautions. The provider must provide all supplies and equipment needed for staff members to practice infection control.

D 4.12 QUALITY ASSURANCE: The Provider must have a written Quality Assurance Plan detailing all activities conducted by the Provider to ensure quality service provision. The Provider must also have a Quality Assurance policy specifying how the Provider will discover, fix, and report problems. The Provider will cooperate with quality performance site visit activities conducted by State.

The Provider agrees to participate in any evaluation and/or consumer satisfaction program developed and/or conducted by the State which will be used to determine the effectiveness of service provision statewide.