



ASSISTED LIVING PROVIDER PROVISIONS

A 1.1 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 participants served is assumed entirely by the Provider.

Medicaid rules and regulations supersede all Assisted Living policies and procedures.

A 1.2 VERIFICATION AND DOCUMENTATION: The Provider is required to maintain documentation and verification demonstrating compliance with these Provisions. This documentation must be readily available upon request.

STANDARD PROGRAM DEFINITIONS

B 2.1 "Assisted Living Services" include personal care (hands-on care and/or supervision and cueing required to complete activities of daily living) and supportive services that are furnished to eligible participant(s) by Assisted Living staff. Assisted Living settings must be homelike and non-institutional and include 24-hour on-site response capability to meet scheduled or unpredictable participant(s) needs and to provide supervision, safety, and security. Services shall support full access to the greater community of participants receiving Medicaid home and community-based services to the same degree of access as individuals not receiving Medicaid home and community-based services. The assisted living location promotes the health, treatment, comfort, safety, and well-being of participant(s), with easy accessibility for visitors and others. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the Assisted Living Provider and LTSS Case Management Specialist.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. State

reimbursement is not available for room and board (with the exception of subsidies approved by the Department of Social Services, Division of Economic Assistance) items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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 Individual Support Plan (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.

B 2.2 “Case Management” includes reassessing the participant’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 participant concerns and other participant-related issues. The State will provide on-going case management for each participant.

B 2.3 “Cost-share” is the portion of the cost of the HOPE waiver services that the participant is responsible for and paid directly to the Provider.

B 2.4 “Critical Service Need Participant” is a participant who needs service(s) (i.e., oxygen, injection, medication, wound care, therapy) provided on each assigned day without which the participant’s health condition would decline.

B 2.5 “Eligible Participant” 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 participant’s record in the Therap case management system. The ISP is developed by the LTSS Case Management Specialist with the participant, as well as any individuals the participant chooses.

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 participant regarding preferences for the delivery of such services and supports.

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 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 an assisted living 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.

B 2.9 “Significant Change” is a major decline or improvement in a resident’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 participant.

STANDARD PROGRAM REQUIREMENTS

C 3.1 REFERRALS AND GEOGRAPHIC AREA: Any LTSS participant 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 participant need. The participant will be offered the choice of available Providers and select the Provider of his/her choice.

C 3.2 INTERPRETER SERVICES: The Assisted Living Provider must meet the needs for residents. If interpreter services are necessary, LTSS will consider, on a limited basis, covering situations when a routine interpreter is not available and/or staff are unable to successfully communicate with the participant.

If it is identified that interpreter services may be necessary for service provision, this will be identified on the applicable Therap Service Auth. Providers must utilize the DHS-approved interpreter service providers, ISI or another SD registered interpreter for American Sign Language, and Volatia for all other interpreter services. Utilization of other agencies for these services will result in the Provider incurring the expense.

A Volatia interpreter services Access Code for the Provider must be in place prior to interpreter services being utilized. The LTSS Volatia interpreter services Provider

accounts must only be utilized for participants authorized by LTSS. Providers must include the First Name, Last Name and Date of Birth for all scheduled sessions through Volatia. Failure to do so may result in the Provider incurring the expense.

Volatia interpreter services are available on demand by audio/phone. Audio/phone interpretation is the preferred method. Video interpretation is available on demand, and may only be utilized when the audio/phone option does not meet the needs of the participant (i.e. hearing impairment) or other extenuating circumstance (i.e. cell service limitation). An in-person/onsite option is available upon request and approval by LTSS. This option may only be requested when audio/home or video options do not meet the needs of the participant, or an extenuating circumstance described in the request. To request approval for the in-person/onsite option, please complete the [LTSS Onsite Interpreter Services Request Form](#).

Providers must submit the in-person/onsite request 3 business days prior to scheduling in-person/onsite interpreter services. Any in-person/onsite visits that are scheduled without LTSS prior approval may be canceled, rescheduled, or denied. In-person/onsite visits that are not cancelled within 24 hours prior to the scheduled visit will result in a direct expense to the Provider.

C 3.3 REIMBURSEMENT: 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 Provider must collect the Room and Board portion of the payment from the participant. In situations where the participant 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 participant by the Provider. Participants residing in an Assisted Living are not eligible for the Supplemental Nutrition Assistance Program (SNAP) since their Room and Board is supplied.

Approved claim forms, including all required information (e.g. Provider's National Provider Identification (NPI), participant'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 participant.

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 participant, which are not previously authorized in Therap.

To be reimbursed at the established rate, the participant must be physically present in the Assisted Living Center and must be receiving the assisted living service, except in the following situations:

Hospital reserve bed days: An Assisted Living Center 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 Assisted Living Center for a minimum of 24 hours before additional hospital reserve bed days will be paid. When a participant is transferred from an Assisted Living Center to a hospital, it is expected that the Provider will accept the participant back at the Assisted Living Center at the time of hospital discharge.

Therapeutic leave days: An Assisted Living Center 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 Assisted Living Center for non-medical reasons (e.g., visits to the homes of family or friends).

The Provider must collect the cost-share and room and board for selected participants. 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 participant for any additional fees. The Provider will be advised of the participant's cost-share, if any, and will be responsible for collecting the cost-share and Room and Board from the participant.

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 3.4 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 participants 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 participants residing in an Assisted Living Center must meet the following minimum standards:

1. Be 16 years of age or older.
2. Be employed by an enrolled Medicaid Provider.
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 crime listed in [SDCL 22-24B-1](#), or any other crime under [SDCL Chapters 22-22](#), [22-22A](#) or [22-24A](#) 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 3.5 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 in the [OIG Exclusions Database](#). 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 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 in the [SAM Exclusions Database](#). 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.

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

C 3.7 PRIVATE PAY RATE: The Provider must attest to their established private pay rate (also known as the usual and customary charge) at the beginning of each state fiscal year. The private pay rate is the individual Provider's normal charge to the general public for a specific service. To verify and attest to your agency/agencies' private pay rate, complete the [LTSS Provider Pay Rate Verification form](#).

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). The State will only consider rate changes during the contract year in extraordinary circumstances.

C 3.8 DAKOTA AT HOME INCLUSION FORM: Prior to approval, the Provider must complete a [Dakota at Home Inclusion Form](#) if not already a participating provider in the [Resource Directory](#). The Provider must also review their record at least annually and make updates or confirm the record is accurate.

C 3.9 SERVICE AUTHORIZATIONS: 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 Services Auth, the Provider should not acknowledge the Therap Service Auth. The Provider should contact the LTSS Case Management Specialist assigned as the participant's case manager to resolve any potential discrepancies.

Assisted Living staff are expected to participate in the assessment process and doing so will ensure the most accurate reimbursement is assigned. If a Provider is concerned that a participant is not accurately classified based on his/her last assessment and/or 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 participant's case manager to resolve any potential discrepancies.

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).

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 [South Dakota's HCBS Settings Final Rule Transition Plan](#).

C 3.11 CRITICAL NEED PARTICIPANT: The LTSS Case Management Specialist will communicate with the Provider (through the ISP) when a participant has been identified as a Critical Service Need Participant. When a Critical Service Need Participant is identified, the LTSS Case Management Specialist will work with the participant and the Provider to develop a critical service back-up plan to ensure critical service needs are met during an emergency.

ASSISTED LIVING 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 per [ARSD 44:70:09:14](#) and [ARSD 44:70:04:16](#).

D 4.3 ASSESSMENT: The Provider must have an assessment policy that defines the Provider's process for assessing the participant's needs (including mental health and mobility) and the Provider's ability to meet the needs of the participant, in compliance with HCBS Settings Final Rule . 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 participant is able to access all common areas throughout the entire duration of the participant's residency at the Assisted Living Center.

D 4.4 DOCUMENTATION: The Provider must have a documentation policy. The documentation policy must include how assisted living staff document service provision, participant progress and health/safety concerns with a participant. Documentation must be kept for each participant. 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 participant's rights as noted in ARSD 44:70 and the [HCBS Settings Guide to Expectations and Compliance](#);
3. Participant lease/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 participants 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 participant's health and safety. If a participant in the Provider's setting requires a modification, the

Provider must complete and submit a [HCBS Setting Modifications Request](#) to the participant's Case Management Specialist prior to implementing a restriction.

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

Any modification of the federal regulations for the HCBS Settings Final Rule, as described CFR 42 § 441.710(a)(1)(vi)(F), 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 participant'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.

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 readily available upon request.

D 4.7 ABUSE NEGLECT AND EXPLOITATION: The Provider must have a policy against 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 participant. 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 [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), complete the [Adult Protective Services Referral Form](#).

D 4.8 INCIDENT REPORTING: The Provider must have an incident reporting policy. The Provider must immediately notify State of any participant-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, please visit the [Department of Health Assisted Living Centers page](#) and review reporting criteria.

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

D 4.9 PARTICIPANT GRIEVANCE: The Provider must have a grievance policy pursuant to and in compliance with [ARSD 44:70:09:10](#).

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 participant 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 quality assurance policy. 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 audit activities conducted by the State.

The Provider agrees to participate in any evaluation and/or participant and principal caregiver satisfaction program developed and conducted by the State to determine the effectiveness of service provision statewide.