



LTSS PROVIDER POLICY MANUAL

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Department of Human Services

Division of Long Term Services and Supports (LTSS)

Provider Policy Manual

Overview

The Department of Human Services, Division of Long Term Services and Supports (LTSS) enhances and promotes the quality of life for older adults, adults with disabilities, and their caregivers, at home and in the community. LTSS provides home and community-based services to people age 60 and older and people with disabilities who are age 18 and older.

Eligible Providers and LTSS Enrollment

All eligible servicing and billing Providers' National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid to receive payment for LTSS authorized services. Please refer to the South Dakota Medicaid Provider Enrollment chart for additional details on South Dakota Medicaid enrollment eligibility and supporting documentation requirements.

HOPE Waiver Providers must meet both LTSS and South Dakota Medicaid Provider Enrollment requirements prior to LTSS initiating a Purchase of Services Agreement (contract) with the Provider. HOPE Waiver Providers must have a current contract with DHS/LTSS prior to receiving authorization to perform services to HOPE Waiver participants.

To enroll as an LTSS HOPE Waiver Provider, the Provider must complete and submit the LTSS HCBS Provider Enrollment Request. Once the LTSS HCBS Provider Enrollment request has been completed, an onsite review will be conducted by LTSS staff.

There are different enrollment criteria depending on the taxonomy code the Provider is enrolling in. LTSS Provider enrollment requirements vary for each service. Once the DHS/LTSS and South Dakota Medicaid Provider enrollment requirements have been met and a DHS/LTSS contract is in place, the Provider will receive an account in the LTSS's case management and billing system, Therap.

When a participant selects an eligible Provider for the provision of their services, LTSS will initiate a referral in Therap to the Provider's account. The Provider will receive an authorization for service(s). The Provider may only receive authorization for services they are enrolled to provide. Once the Provider's Therap account setup is complete, the Provider will receive Therap system training from a Therap representative. The Therap case management system provides access to all LTSS HCBS Providers to receive referrals for the Provider's contracted service(s). It is the

Provider’s responsibility to acknowledge and maintain Therap Service Auths and ensure the Provider Therap account contains accurate agency and staff information.

For more information on enrollment in the HOPE Waiver and other LTSS services, refer to the LTSS HCBS [Provider Enrollment Manual](#).

This table describes the enrollment requirements for SD Medicaid HOPE Waiver services.

| DHS LTSS Title XIX HOPE Waiver Services Enrollment Chart | | | | | |
|---|--|-------------------------------|---|---|----------------------------------|
| Services | LTSS Enrollment Review Required | LTSS Contract Required | HCBS Settings Final Rule Review Required | SD Medicaid Provider Enrollment Required | SD DOH Licensure Required |
| In-Home (Homemaker, Personal Care, Nursing, Adult Companion, Chore) | Yes | Yes | No | Yes | No |
| Respite/Residential Respite Care | Yes | Yes | No | Yes | No |
| Assisted Living | Yes | Yes | Yes | Yes | Yes |
| Structured Family Caregiving | Yes | Yes | No | Yes | No |
| Community Living Home | Yes | Yes | Yes | Yes | Yes |
| Adult Day | Yes | Yes | Yes | Yes | No |
| Community Transition Coordination | Yes | Yes | No | Yes | No |
| Community Transition Supports | Yes | Yes | No | Yes | No |
| Environmental Accessibility Adaptations Assessment | Yes | Yes | No | Yes | No |
| Environmental Accessibility Adaptations | Yes | Yes | No | Yes | No |
| Specialized Medical Equipment | No | No | No | Yes | No |
| Specialized Medical Supplies | No | No | No | Yes | No |
| Emergency Response Service | No | No | No | Yes | No |
| Nutritional Supplements | No | No | No | Yes | No |
| Meals | Yes | Yes | No | Yes | No |

Eligible Participants

LTSS authorizes home and community-based services to individuals 60 years of age and older and adults with disabilities. LTSS receives funding from the Administration for Community Living (ACL), the Centers for Medicare and Medicaid Services (CMS), and State funds, as well as other sources. Eligibility criteria vary by program and funding source. Please follow the links below for ARSD specific to each program.

KIND: <https://sdlegislature.gov/Rules/Administrative/67:40:19>

State Plan Personal Care: <https://sdlegislature.gov/Rules/Administrative/67:16:24:03>

HOPE Waiver <https://sdlegislature.gov/Rules/Administrative/67:44:03>

To maintain conflict-free services, Providers may not assess, determine, or influence participant eligibility and must not engage in activities that could compromise participant choice. Participants choose their Provider based on their preferences and needs. To support participant choice requirements, LTSS does not assign or direct participants to specific Providers. Please make a referral to Dakota at Home to initiate an eligibility determination. A referral can be made by completing an online referral form or by calling Dakota at Home. To learn more about Dakota at Home, please visit the [Dakota at Home webpage](#). If an individual is determined eligible, LTSS can authorize and reimburse some or all services in the Individual Support Plan.

LTSS Case Management Specialists maintain a list of approved Providers and share that list with participants so they can explore their options and make an informed choice. Providers may promote their services through community outreach, websites, brochures, local partnerships, and other advertising efforts, provided marketing materials are accurate and do not imply endorsement by the State or LTSS.

Standard Program Definitions

“Assessed Need” is determined by LTSS through a comprehensive evaluation of the participant’s circumstances. The assessed need considers multiple factors, including the participant’s functional and support needs, available programs and community resources, the presence of informal supports, and other adults residing in the household. Assessed need is a key element in determining service eligibility and authorization and is applied consistently to ensure services are appropriate, necessary, and aligned with LTSS requirements.

“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 ongoing case management for each participant.

“Caregiver Program” is a non-Medicaid program authorized under the Older Americans Act (OAA) and funded through Title III. The purpose of the Caregiver Program is to reduce caregiver burden and stress. Funds are utilized to provide comprehensive caregiver support services such as respite, counseling, training, and support groups.

“Case Management Specialist” is a Department of Human Services employee who provides case management to eligible participants.

“Cost-share” is the portion of the cost of the services that the participant is financially responsible for.

“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.

“Eligible Participant” is any person needing services who has been determined eligible by DHS.

“HOPE Waiver” The Home-and-Community-Based Options and Person-centered Excellence Waiver is a Medicaid Waiver operated by the Department of Human Services (DHS), Division of Long Term Services and Supports (LTSS). The HOPE waiver utilizes Medicaid funding to provide home and community-based services to individuals who are at risk for nursing facility placement. The purpose of the HOPE Waiver is to provide home and community-based services to South Dakotans age 65 and older, as well as individuals 18 years of age and older who have a qualifying disability, to allow them to remain at home or in the least restrictive environment available.

“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.

“KIND Program” The Keeping Independence and Nurturing Dignity Program is a non-Medicaid program that is utilized to provide home and community-based services to eligible participants in their own homes.

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

“Significant Change” is a major decline or improvement in a participant’s status that results in an increase or decrease in aggression, cognition, activities of daily living, a change in chronic

diagnosis, or a change in treatments received (for example, dialysis, chemotherapy, tracheotomy, IV medication) that is anticipated to last longer than 30 days.

“Therap” is the online case management, documenting, and billing software.

“Therap Service Auth” is the electronic document in Therap that details the services authorized for the participant.

Standard Program Requirements

Provider Operations and Business Administration

Agency Transitions

The Provider should contact LTSS to discuss agency transitions that would result in either updating or ending the agreement with the State to provide contracted services. SD DHS/LTSS requests at least 30 days' notice for any update to the current agreement, to include address/location change or business change of ownership. Careful coordination and appropriate licensures and certifications should be in place or in process before transitions ensue.

In addition, Providers must update their SD Medicaid Provider Enrollment record to reflect an updated address or new ownership update. To do so, Providers should visit [the SD Medicaid Provider Enrollment Portal](#) and update their records accordingly. Failure to do so will result in unenrollment from Medicaid services and termination of the LTSS agreement.

Documentation and Record Retention

The Provider is required to maintain documentation and verification demonstrating compliance with these Provider Provisions. This documentation must be readily available upon request. Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to SD DHS and South Dakota Medicaid. Documentation guidelines are outlined in the Documentation and Record Keeping Manual, housed on the DSS Provider Manuals webpage, here: <https://dss.sd.gov/medicaid/providers/billingmanuals/default.aspx>

Medical and financial records must be retained for at least six (6) years after the last claim is paid or denied. Records may not be destroyed when an audit or investigation is pending. Medical and financial records must be retained in their original form or in a legally reproduced form, which may be electronic. Providers must have a medical record system that ensures that the record can be accessed and retrieved promptly.

LTSS Quality Assurance Activities and Compliance

LTSS conducts routine quality assurance activities to ensure compliance with program standards. The Provider must participate in any evaluation and/or participant satisfaction program developed and conducted by the State to determine the effectiveness of service provision statewide. When a review is conducted, and the Long-Term Services and Supports (LTSS) program determines that additional information is required to assess compliance, or when the Provider is required to submit a Corrective Action Plan (CAP), all requested documentation and verifications must be received by LTSS within ten (10) business days of the request or by the specific date provided by LTSS. A maximum of two extensions may be granted at LTSS's discretion, and any request for an extension must be submitted by the provider before the original deadline.

The corrective action plan must detail what issues have been identified by the Provider and steps that will be put in place to meet compliance, with timelines and milestones identified. The corrective action plan should include ongoing monitoring and evaluation activities implemented as a result of the CAP and the protocol for documenting and reporting issues moving forward. Future validation or compliance reviews may verify continued adherence to the Corrective Action Plan and LTSS Provider standards.

Failure to fully participate in the review process, including timely submission of requested documentation or corrective actions, may result in contract termination. Additionally, Providers who demonstrate repeated non-compliance with LTSS requirements may be subject to contract termination.

LTSS Business Location Standards

The Provider must maintain a physical business location that supports day-to-day administrative and operational functions. The business location must be sufficient to ensure compliance with HIPAA and the protection of participant confidentiality. The Provider must display professionally produced, semi-permanent business signage that is affixed to the building or suite entrance, visible from outside the building, and clearly reflects the Provider agency's legal business name and/or DBA name. Posted office hours must be clearly displayed, and the Provider must maintain administrative coverage during those posted hours. The Provider must be able to receive mail at the business location and must maintain adequate space and staffing to support routine administrative operations, including staff supervision, meetings, and training activities.

Staff Training

The Provider must ensure all minimum training requirements are met for each service. Please refer to service-specific training requirements for details related to each service.

Driver's License and Auto Insurance

The Provider must retain proof of a valid driver's license for all employees transporting participants. The Provider must also maintain current and valid auto liability insurance. Auto liability insurance is required whether or not Provider transports participants, since employees are traveling from home to home for the provision of services.

Therap Account Maintenance

It is the Provider's responsibility to acknowledge and maintain Therap Service Auths and ensure the Provider Therap account maintains accurate agency and staff information.

Workforce Screening & Eligibility

Background Check

For services that require direct interaction between employees and participants, the Provider must, at a minimum, conduct a State fingerprint background check of all employees working directly with participants to screen for disqualifying criminal convictions.

The Provider may request the State's approval for an alternative background check by completing and submitting a [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 alternative background checks).

To receive approval, the alternative background check results 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 hired, 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 hired; and
- The alternative background check creates a report of the criminal history of the individual hired, which is readily accessible to the Provider.

An employee hired to work directly with participants in home and community-based settings must meet the following minimum standards:

- Be 16 years of age or older; or 18 years of age or older for Structured Family Caregiving services;
- Be employed by a DHS contracted Provider or a principal caregiver independently contracted with a Structured Family Caregiving Provider;
- Pass a State fingerprint (or State-approved) background check.

The following is a list of fitness criteria that would automatically preclude an individual from being hired/contracted:

- Conviction of a crime of violence as defined by [SDCL 22-1-2](#) or a similar statute from another state;
- Conviction of a sex 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;
- Class A and/or B felony convictions.

The following is a list of fitness criteria that may preclude an individual from being hired/contracted at the discretion of the Provider:

- Convictions of other felonies not described in 3.a.iii.
- Misdemeanor convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- 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.
- Any conviction related to obstruction of a criminal investigation.

OIG LEIE And SAM Exclusion Lists

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 receiving 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 the 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.

Intake, Access, and Transition of Services

Intake and Admissions

The Provider will assign and begin provision of authorized services within seven (7) business days of receipt of the Therap Service Auth. If the Provider is unable to meet the seven-day deadline, the Provider must contact the participant's LTSS Case Management Specialist to discuss the plan for ensuring services are provided.

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 meet the participant's needs. The participant will be offered the choice of available Providers and select the Provider of his/her choice. If a Provider has not accepted referrals and/or billed claims for 24 consecutive months, their contract may be terminated.

Interpreter Services

When interpreter services are required for service provision, Providers must use the DHS-approved interpreter service vendor to access services at no cost. ISI or another South Dakota-registered interpreter is DHS-approved for American Sign Language (ASL). Use of any other vendor will result in the Provider being responsible for the expense.

LTSS will provide each agency with an access code for interpreter services. Access codes for LTSS interpreter services must only be used for participants authorized by LTSS. Providers must include the First Name, Last Name, and Date of Birth for all scheduled interpreter sessions. Failure to provide this information may result in the Provider incurring the expense.

Interpreter services are available on demand by audio/phone, which is the preferred method. Video interpretation is also available on demand but should only be used when audio/phone does not meet the participant's needs (e.g., hearing impairment) or in other extenuating circumstances (e.g., poor cell service).

An in-person/onsite option is available upon request (and approval by LTSS) for American Sign Language (ASL) services. To request approval for the in-person/onsite option for ASL, please complete the [LTSS Onsite Interpreter Services Request Form](#). Providers must submit the in-person/onsite request 3 business days before scheduling in-person/onsite ASL services. Any in-person/onsite visits that are scheduled without LTSS prior approval may be canceled, rescheduled, or denied, resulting in a direct expense to the Provider. In-person/onsite visits that are not canceled within 24 hours prior to the scheduled visit will result in a direct expense to the Provider.

In licensed settings (AL and CLH), Providers are responsible for meeting the needs of the 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.

Dakota at Home Resource Directory and Enrollment

The Provider must complete an Enrollment Form located on the [Dakota At Home Resource Directory](#) before receiving a DHS contract if they are not already listed in the [Resource Directory](#). The Provider must also review their record at least annually and make updates or confirm that the record is accurate. The Provider must maintain their record, including contact information and county coverage. To update your agency's information, select the option to Update/Edit Listings in the [Resource Directory](#). Dakota At Home Intake Specialists and Case Management Specialists utilize the Resource Directory to make referrals to resources. Failure to keep the record accurate may result in reduced referrals.

Discontinuation of Participant Services

DHS LTSS may discontinue services for a participant in accordance with ARSD. When services are discontinued, the Provider will receive an updated Pre Auth in Therap notifying the Provider of the discontinuation of services. The Provider must acknowledge the end-dated authorization and discharge the participant from the Provider's Therap account.

When a Provider determines that services to a participant must be discontinued by their agency, they must provide written notice to the participant and LTSS with adequate notice specific to the service. Please refer to the Discharge requirements and Service Specific Requirements for details.

Billing, Payments, and Financial Responsibility

Reimbursement

To be eligible for reimbursement, services must be authorized by LTSS and delivered by the Provider. Billed services will be reimbursed at the rates listed on the current [LTSS Fee Schedule](#). Approved claim forms, including all required information (e.g., Provider's National Provider Identifier), participant's primary diagnosis code, etc., will be submitted by the Provider to the State for payment of services authorized and provided. The Provider is individually responsible and accountable for the completion, accuracy, and validity of all claims submitted, including claims submitted for the Provider by other parties.

If the Provider is reimbursed at the incorrect rate, resulting in an overpayment, the State will initiate necessary action to resolve the overpayment. This includes voiding Medicaid claims and

ACH recoupment for KIND Program/State-funded services. The Provider must initiate action(s) to correct underpayment, including voiding Medicaid claims and initiating an ACH return for KIND Program/State-funded services. If the Provider is reimbursed at the incorrect rate, resulting in an underpayment, the Provider must resubmit the claims at the correct rate to receive appropriate reimbursement.

Providers must submit a claim form for Medicaid services within 6 months following the month the service was provided in accordance with [ARSD 67:16:35:04](#). Providers are encouraged to resubmit all previously denied claims every 90 days for SD Medicaid. Additional information and guidance for HOPE Waiver and Medicaid State Plan services are available in the HOPE Waiver Billing Manual, and the Personal Care Agency Services Billing Manual is located on the [DSS Provider Billing Manuals webpage](#).

Providers must submit a claim for non-Medicaid services no later than six (6) months following the month of service. Claims submitted after this period may be denied unless both the original claim and a Long-Term Services and Supports (LTSS) Claims Resolution Request were submitted within six (6) months of the service date, and an LTSS Claims Resolution Request is approved by the State. The decision to grant an exception under a Resolution Request is within the sole discretion of the State. Reasons for granting an exception may include previously denied claims or Department errors.

The Provider must only bill for services authorized and acknowledged in Therap and delivered by the Provider. Total units authorized reflect the maximum units for the entire duration of the Therap Service Auth. Total units authorized must be distributed evenly throughout the duration of the Therap Service Auth and provided in accordance with the service amount and frequency described in the Therap Service Auth.

Additional units for mileage will not be authorized and must not be billed. Travel time is included in the non-billable time reported in the cost reports and is used to calculate the rate(s) for services.

The participant must be present when services are performed unless an exception is specified in the Therap Service Auth. If the Provider encounters a situation where an exception is needed, the Provider must contact the LTSS Case Management Specialist for authorization.

The State will not reimburse or otherwise be made liable for purchases or transactions made by the Provider on behalf of the participant.

The state's reimbursement for services rendered shall be considered payment in full; the Provider may not bill the participant for any additional fees with limited exceptions. Please refer to specific service sections and the Cost Share section below for exceptions

LTSS Claims Resolution Request

For all claims and billing inquiries, Providers must submit an [LTSS Claims Resolution Request](#) for further review and technical assistance. Claims inquiries will be reviewed by LTSS staff in the order in which they are received. LTSS requests that Providers submit an LTSS Claims Resolution Request within 3 months of the date of service to ensure sufficient time for resolution.

Prior to submitting an LTSS Claims Resolution Request, Providers are expected to conduct an internal review of the claim(s) to verify units billed, service dates, authorizations, rates, and prior payment activity. The LTSS Claims Resolution Requests must include sufficient detail to allow LTSS staff to identify and research the issue, including a description of the discrepancy, relevant claim identifiers, and the Provider's findings from their internal review. The LTSS Claims Resolution Requests that do not demonstrate evidence of Provider review, are incomplete, or consist solely of generalized statements (i.e., 'you owe me X units') may be returned without review or may be delayed until adequate information is provided.

Cost Shares

The cost shares for the HOPE Waiver are determined by the Department of Social Services (DSS), Division of Economic Assistance. The cost share amount is applied to the participant's billed HOPE Waiver services and deducted from the Provider's submitted HOPE Waiver claims. The Provider is responsible for collecting the cost share amount directly from the participant. Refer to the HOPE Waiver Billing Manual on the [DSS Provider Billing Manuals webpage](#) for further information.

The cost shares for the KIND Program are determined by the LTSS Case Management Specialist and communicated to the participant. Participants are notified of their Cost Share when they begin services and monthly thereafter. Providers are not involved in the collection of Cost Shares for the KIND Program. Participants must send them directly to the State. Failure to submit mandatory Cost Shares will result in termination of LTSS services.

Service Authorizations

The Provider must acknowledge the Therap Service Auth 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. It is the Provider's responsibility to review the Therap Service Auth to ensure the details (including the rate, units, and frequency, recipient ID, and referring Provider information) are correct before acknowledging the Therap Service Auth.

If the Provider finds a potential 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.

The State must review and authorize all permanent changes to the Therap Service Auth. All changes to the schedule (day, time, etc.) must be discussed with the participant.

Private Pay Rate

The Provider must attest to their 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 Provider's normal charge to the general public for a specific service. To verify and attest to your agency's 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 exceed 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.

Standard Policy Requirements

Governance & Administrative Oversight

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 mandatory policies outlined must be included in the Provider's policy and procedure manual.

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.

Confidentiality

The Provider must have a participant confidentiality policy. The confidentiality policy must include specifics on HIPAA and/or BAA compliance, maintenance of participant records, transmission of personal participant information, and confidentiality practices by staff.

Documentation

The Provider must have a documentation policy. The documentation policy must include how 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.

Intake and Admissions

The Provider must have an intake/admissions policy. The intake/admission policy must include the Provider's process for reviewing and accepting referrals, as well as the process to ensure services will begin in a timely manner.

Participant Rights & Protections

Participant Rights

The Provider must have a participant rights and responsibilities policy. The participant rights and responsibilities policy must include the rights and responsibilities of the participant. All participants have the right to remain free from restraint and seclusion. The participant rights policy must include how rights and responsibilities are conveyed to the participant, including the participant's right to remain free from restraints and seclusion.

Participant Grievances

The Provider must have a participant grievance policy. The participant grievance policy must include how the participant is notified of the grievance policy, where grievances are reported, and the process for addressing and resolving participant grievances and feedback.

Licensed Providers' grievance policy and procedure must be in compliance with [ARSD 44:70:09:10](#).

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 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 [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>.

Gifts

The Provider must have a gifting policy. The gifting policy must detail the Provider's expectations and prohibitions regarding staff acceptance of gifts from participants.

Workforce Standards

Staffing

The Provider must have a staffing policy. The staffing policy must include job qualifications, the process for conducting background checks, OIG exclusion, SAM exclusions, the process for conducting applicable license verification, and the process for performance evaluations. The Provider must deactivate any staff member account in their Therap Provider account upon employee termination.

Staff Training

The Provider must have a staff training policy. The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The Provider must provide a new employee orientation to each new employee before the employee provides services unsupervised.

OIG/LEIE and SAM Verification

The Provider must have a policy that specifies both processes (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 the SAM list were checked. documentation of the date the list was checked, the outcome of the check, and who did the check. Acceptable documentation may include a printed page from the OIG and SAM websites, or written records indicating the date the lists were reviewed, the results of the review, and the staff member who performed the check. Background checks or screening information should also be contained in the personnel file and readily available upon request.

Health, Safety & Incident Response

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 to practice infection control.

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. When a staff member

is in a participant's home, and an emergency occurs, the staff member must call 911 immediately.

Incident Reporting

The Provider must have an incident reporting policy. The Provider must immediately notify the State of any participant-related concerns, incidents, and occurrences, including possible exploitation, that are not consistent with routine care.

Licensed Providers must follow the Department of Health's (DOH) policy for documenting the circumstances of any incident that involves falls with injury of a serious nature, restraint, seclusion, serious injury, missing person, or death from other than natural causes.

Non-licensed Providers submit a [LTSS Critical Incident Report](#) to the LTSS Case Management Specialist documenting the circumstances of any incident that involves serious injury, a missing person, restraint, seclusion, abuse, neglect, exploitation, or death. The Provider must also notify the LTSS Specialist of any incidents, participant-related concerns, incidents or occurrences not consistent with routine care.

Examples of a serious injury include fracture, concussion, laceration requiring sutures, severe burn, dislocation of a major limb, internal injury, etc. Examples of a participant-related concern, incident, or occurrence include falls without serious injury, stroke, heart attack, malnutrition, dehydration, or any reports of hospitalizations or emergency room visits due to illness, etc. An incident report does not relieve a Provider of any mandatory reporting requirements under South Dakota law.

Upon being informed that an LTSS participant has been hospitalized or discharged from the hospital, the Provider must communicate this information to the LTSS Case Management Specialist to ensure the participant's need for service provision continues to be met appropriately. The LTSS Critical Incident Report can be found on the [DHS/LTSS Provider Portal](#).

Medication Administration

The Provider must have a medication administration policy. The medication administration policy must include recording and tracking of medication errors and ensuring appropriate physician notification and follow up was conducted. The recording and tracking of all medication errors, as well as documentation of physician notification and follow-up, must be readily available upon request.

Service Specific Definitions and Requirements

In Home Services

In-Home Service Definitions

“Adult Companion service” is the performance, by an in-home aide, of non-medical care, assistance, and socialization. Companions perform tasks that are incidental to the care and supervision of the participant, as opposed to completing the tasks for the participant.

“Chore services” are services needed to maintain the participant’s home in a healthy and safe environment. Chore services are lawn mowing, snow and ice removal from sidewalks and driveways, or other services that the homeowner is required to complete by city or county ordinance.

“Electronic Visit Verification (EVV)” is a required tracking system that provides electronic verification of when a person receives services. The electronic verification must include the type of service performed, the participant receiving the service, the date of service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

“In-home aide” is an individual who performs homemaker, personal care, respite, adult companion, and chore services as identified on the Therap Service Auth and accompanying documents.

“Nurse (RN or LPN)” is an individual licensed by the SD Board of Nursing who provides nursing services as identified on the Therap Service Auth, which fall within the scope of practice of a licensed nurse.

“Personal Care Service” is assistance provided to a participant living at home by an in-home aide to perform his or her activities of daily living.

“Respite Service” is the performance, by an in-home aide or temporary substitute, of temporary support or living arrangements for participants to provide a period of relief or rest for the primary caregiver.

In-Home Service Requirements

Critical Service Need Participants and Service Back-Up Plan

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 needs participant is identified, the LTSS Case Management Specialist will work with the

participant and the Provider to develop a critical service backup plan to coordinate service provision during an emergency and when the usual caregiver(s) are not available to provide service(s), i.e., personal care, nursing services to the participant. The Provider must notify the LTSS Case Management Specialist immediately of any change in scheduled visits and/or when a critical service need participant cannot be provided the necessary services for any reason.

Discharge

The Provider must have a participant discharge policy. When the Provider determines that services to a participant must be discontinued by their agency, the Provider must provide a written discharge notice at least 10 days before the participant is discharged. If the participant is a critical service needs participant, the Provider must provide a written discharge notice at least 30 days before the participant is discharged.

If the participant's home constitutes an unsafe environment for the Provider's staff and/or the participant is demonstrating unsafe behaviors toward agency staff, resulting in intent to discharge, the Provider must provide a written discharge notice upon the determination to discharge. The discharge notice must be in writing, identify the last day services will be rendered by the Provider, and specify the reason for discharge in accordance with the Provider's discharge policy. The Provider must provide a copy of the discharge notice to both the participant and the State.

Any changes to a participant's Individual Support Plan (ISP) will be communicated to the Provider as soon as the State is made aware of the change, including discontinuation of services. When the State determines that services to a participant must be discontinued, the Provider will be notified as soon as possible.

Documentation

Documentation must meet the minimum EVV requirements, which include the type of service performed, the participant receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Additionally, the Provider must retain documentation of all tasks completed during each visit with a participant. A pattern of missed visits must be reported to the LTSS Case Management Specialist. Documentation must be easily accessible upon request.

EVV Requirements

The Provider must comply with federal Electronic Visit Verification (EVV) requirements for no less than 75% of all services that require EVV. Manually entered EVV, or EVV that has an exception, is not considered compliant EVV due to the manual edits.

The State has purchased an EVV system for Providers to utilize at no cost to the Provider. If the Provider determines utilization of the State-purchased EVV system is not feasible, the Provider

may complete the [Provider Request for Approval for Alternative IT System for Electronic Visit Verification \(EVV\) form](#).

If an alternative IT system is approved, the Provider must ensure the minimum EVV requirements are met. EVV requirements include the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the times the service began and ended. If more than one service is authorized and provided in the same visit, Provider staff must check in and out of each service as it occurs.

Initial Nursing Visit

During an initial visit for nursing, the Provider may only bill for time spent completing nursing tasks indicated on the Therap Service Auth. Time spent completing the Provider's Initial Admit Assessment may not be billed; however, the State may utilize the nurse's professional assessment findings to authorize additional services in accordance with LTSS Program guidelines.

Licensure Verification

The Provider must verify, through the [South Dakota Board of Nursing](#), licensure for each newly employed nursing staff member who will be providing services to participants.

Nursing Notification

If the participant exhibits any abnormal signs and symptoms that do not rise to the level of an emergency during a visit, the Provider will notify the physician, the State, and any other appropriate individuals as necessary within five (5) business days. It is the responsibility of the nurse to obtain the physician's orders for additional services requested by the physician.

Nursing Services

Nursing services may be authorized when a participant has a medical condition that requires medical observation, needs services that fall within the scope of practice of a licensed nurse, or has other needs that require the supervision of a nurse. The Nursing services to be performed will be specified in the Therap Service Auth and accompanying documents.

Nursing services must be performed by or under the direct supervision of an RN or LPN. Services delegated by professional medical staff to non-medical staff within their scope of practice will be monitored by the Provider and the professional medical staff. Certain nursing services may not be delegated according to [ARSD 20:48:04.01:07](#). The Provider is required to ensure that only qualified individuals complete authorized tasks. Questions regarding the scope of practice and delegated services should be directed to the [South Dakota Board of Nursing](#). Nursing tasks that are delegated to an unlicensed person will be authorized and reimbursed as personal care.

Physician's Order

If additional services require a physician's order, the nurse will obtain a copy of the physician's order and provide a copy to the State. The LTSS Case Management Specialist will adjust the Individual Support Plan (ISP) if it is deemed necessary and within the service limits. The nurse must retain a copy of all the physician's orders in the participant's record. It is the nurse's responsibility to maintain routine communication with the participant's physician and ensure nursing tasks are completed according to the current physician's order.

Referrals And Geographic Area

In order to ensure the Provider receives referrals for their county coverage area, Providers must complete the LTSS Provider County Coverage Survey at initial enrollment and any time in the event the service coverage area changes (add or remove counties). The results of the LTSS Provider Coverage Survey are distributed to LTSS staff ongoingly. Any LTSS participant living within the identified county area may be referred to the Provider. Agency coverage areas updates are implemented on the following month. Providers must ensure that accurate service coverage area is reported on the LTSS Provider County Coverage survey, to reduce risk of privacy concerns with sharing referral information to agencies that do not have adequate staffing coverage in that area to serve.

The Provider is expected to consider all referrals; however, may turn down a referral due to safety concerns, unavailability of staff, or inability to serve a participant's needs. The participant will be offered the choice of available Providers and select the Provider of his/her choice.

Note, if additional services are added to your agency's service menu, LTSS will request the Provider also complete the LTSS Private Pay Rate Verification survey to intake the Provider's private pay rate for the new service addition. An example of this would be if a non-medical in-home agency has added Nursing as a new service or if an in-home agency has enrolled in SD Medicaid to provide Respite service.

Reimbursement

The Provider must only bill for services authorized and acknowledged in Therap and delivered by the Provider. The total units authorized reflect the maximum units for the entire duration of the Therap Service Auth. Total units authorized must be distributed evenly throughout the duration of the Therap Service Auth and provided in accordance with the service amount and frequency described in the Therap Service Auth.

If a situation arises requiring more time than authorized to ensure the health and safety of the participant, and the participant has underutilized services in the last 60 days (for example has missed visits due to hospitalization, visit cancellations, or a visit(s) took fewer units than authorized) the Provider does not need to request additional units or seek approval from the Case Management Specialist. If the participant has not underutilized service units, the Provider

should attempt to utilize careful planning and adjustment of future visits to offset the overage. If the Provider is unable to adjust future visit(s) to offset the overage, the Provider must request approval from the LTSS Case Management Specialist within one week following the occurrence.

Additional units may only be provided when necessary to ensure the health and safety of the participant and not at the participant's request. In general, nursing and personal care tasks are more likely to be considered to contribute to the health and safety of the participants than homemaker tasks. If additional units are necessary, the Provider may be asked to submit care logs to verify the services rendered during the affected timeframe. If the Provider does not request approval from the LTSS Case Management Specialist and/or the additional units are determined unnecessary to ensure the health and safety of the participant, the additional units will not be approved and may not be billed.

The Provider must contact the LTSS Case Management Specialist if the authorized services routinely take more or less time to complete than indicated in the Therap Service Auth, or if additional services are being requested for the remaining duration of the Therap Service Auth. Due to federal requirements associated with the [21st Century CURES Act and Electronic Visit Verification \(EVV\)](#), the Provider may only bill for time spent completing authorized services. The Provider may not bill for units not delivered. As such, the Provider may not update EVV data to reflect agency-established minimums, and the Provider may not bill for "not home" visits.

Additional units for mileage will not be authorized and must not be billed. Travel time is included in the non-billable time reported in the cost reports and is used to calculate the rate(s) for services.

The participant must be present when services are being performed unless an exception is specified in the Therap Service Auth. If the Provider encounters a situation where an exception is needed, the Provider must contact the LTSS Case Management Specialist for authorization. If staffing shortages occur, the Provider must provide adequate coverage to serve the assigned participants. "Clustering" visits to participants should be employed to more efficiently manage personnel resources during staffing shortages. No additional units will be authorized to cover the Provider's staffing shortages.

The State's reimbursement for services rendered shall be considered payment in full. Except for the cost-share for HOPE Waiver services, 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 from the participant.

The State will not reimburse or otherwise be made liable for purchases or transactions made by the Provider on behalf of the participant.

The State will not reimburse or otherwise be made liable for pet care performed by the Provider.

Relatives And Legal Guardians

The Provider may hire a relative/legal guardian of a participant to provide his/her services. The relative/guardian must meet all the Provider's qualifications and training requirements. When an individual being considered to provide services to a participant is the participant's spouse or resides in the same home as the participant, the Provider must contact the Case Management Specialist to discuss service options. When this situation occurs, a referral to structured family caregiving services may be required. Individuals who do not comply with the structured family caregiving referral requirement may be limited to the services available.

Staff Training

The Provider must ensure that each in-home aide completes a minimum of six (6) hours of training annually and must maintain a training record for each in-home aide. Training records must document, at a minimum, the staff member's name, training topic or title, the date the training was completed, and the length of the training. Training documentation should also include the staff member's signature or electronically generated verification, such as a training certificate or learning management system record. Training records must be specific to the individual staff member and the training completed. Summary statements or general attestations without supporting detail do not demonstrate compliance.

The six (6) hours of annual training must include content addressing mandatory reporting laws for abuse, neglect, and exploitation, the prohibition of restraints and seclusion, and how to report Medicaid fraud, waste, and abuse.

Providers must ensure each staff member has the training necessary to perform the tasks authorized. Providers are encouraged to conduct supervised visits before any newly hired staff complete visits unsupervised in participants' homes. New employees must complete six (6) hours of required training within the first thirty (30) days of hire. The Provider is responsible for the oversight of all staff, including relatives and legal guardians, in the completion of their assigned tasks.

Supplies and Equipment

The State is not responsible for providing or obtaining the supplies and equipment needed to perform nursing tasks.

Unannounced Visits

Providers are required to conduct unannounced visits to the assigned work site of each employee. At a minimum, one unannounced visit must occur for every staff member on an annual basis. Documentation of these staff monitoring visits must be maintained and made available for review upon request.

Structured Family Caregiving (SFC)

Structured Family Caregiving Service Definitions

“Medicaid-Enrolled Structured Family Caregiving Provider Agency” (also referenced as “Provider” throughout this document) is the entity responsible for the oversight of the Structured Family Caregiving service. The Medicaid-enrolled Structured Family Caregiving Provider Agency provides coaching and support to the principal caregiver and passes through a portion of the Medicaid reimbursement to the principal caregiver.

“Principal Caregiver” is the primary caregiver for the eligible participant. The principal caregiver provides 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) to the eligible participant. The principal caregiver receives a stipend from the Medicaid-enrolled Structured Family Caregiving Provider Agency. A principal caregiver is not an employee of the Medicaid-enrolled Structured Family Caregiving Provider Agency and is not subject to employee regulations such as wage/hour laws, workers' compensation, and unemployment.

“Staff” are individuals employed by the Medicaid-enrolled Structured Family Caregiving Provider Agency to complete the tasks necessary to oversee the provision of the Structured Family Caregiving service.

“Structured Family Caregiving” is personal care and support services provided to a participant in the participant’s private home or the private home of the principal caregiver that exceed informal support and are not part of shared household responsibilities. Structured Family Caregiving services rendered by the principal caregiver include frequent and substantive 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, community activities, shopping, managing finances, and phone use) and other appropriate activities as described in the participant’s person-centered service plan are included activities in structured family caregiving.

Structured Family Caregiving Service Requirements

Reimbursement

The stipend paid to the structured family caregiver must be 50% or more of the HOPE Waiver participant’s identified rate.

Hospital reserve bed days: The Provider may bill SD Medicaid for a maximum of five consecutive days when a participant is admitted to an inpatient hospital stay. Up to five consecutive days

may be billed to SD Medicaid per hospitalization; however, the participant must return home for a minimum of 24 hours before additional hospital reserve bed days will be paid.

The daily reimbursement for Structured Family Caregiving services is permissible when a participant travels out of state and is accompanied by his/her principal caregiver. Travel-related expenses will not be reimbursed by the State. If out-of-state travel exceeds 30 days, the Provider must notify the LTSS Case Management Specialist.

Consistent with a participant's assessed needs and as reflected in the person-centered Individual Support Plan (ISP), separate payment for other waiver services provided by a third-party Medicaid Provider may be authorized by the State including community transition supports, community transition coordination, adult companion services, adult day services, respite care, emergency response systems, in-home nursing services, specialized medical equipment, specialized medical supplies, environmental accessibility adaptations, and nutritional supplements.

Consistent with a participant's assessed needs and as reflected in the person-centered Individual Support Plan (ISP), extraordinary personal care needs that exceed routine intermittent daily assistance may also be authorized for separate payment, for example, when the participant requires more than one person's assistance to complete activities of daily living.

Separate payment for meals, homemaker services, and/or chore services will not be provided on behalf of participants receiving Structured Family Caregiving services, as these activities are integral to and inherent in the provision of Structured Family Caregiving. Payments made for Structured Family Caregiving are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, or improvement.

Provider Staffing

The Provider must have sufficient staff and resources to perform care conferences with the participant and principal caregiver on a regular basis. Staff will perform in-home assessments of the principal caregiver and home, collaborate with the LTSS Case Management Specialist in the development and ongoing review of the Care Plan/Service Plan, review and follow-up on caregiver notes, and provide caregiver education resources and ongoing support to principal caregivers.

Provider staff must have experience in working with elders and/or adults with disabilities and/or be trained by the Provider agency in conducting assessments of the principal caregiver and home, and trained in providing coaching to lay caregivers.

Qualifications of Caregivers and Homes

The Provider must administer caregiver and home qualification policies and procedures to ensure each principal caregiver who participates in Structured Family Caregiving can meet the assessed needs of the eligible participant to whom the principal caregiver will be providing care and other supports, and that the home is safe and accessible to the eligible participant. The policies and procedures must address all of the following requirements.

The principal caregiver must:

- Live in the same qualified home as the participant
- Be the primary person responsible for providing daily care and support to the participant based on the participant's assessed needs
- Pass a background check as detailed in Section D 4.2
- Be a responsible adult who is 18 years of age or older and be assessed by the Provider Agency as capable of providing the support the participant needs
- Be qualified as a Structured Family Caregiving caregiver before the principal caregiver receives a Structured Family Caregiving caregiver stipend
- Does not support more than two participants in Structured Family Caregiving.
- The home must:
 - Not be owned by the Provider, but rather owned or rented by the participant or principal caregiver or a member of the participant's family.
 - Be safe, accessible, and allow for the comfort and privacy of the participant receiving care.

The Provider must collaborate with the State to support the principal caregiver to remedy any issues that may come up with the safety of the home (e.g., the need for safety and accessibility accommodations, the need to address concerns such as pests, obstructions, or other hazards) throughout the time that the participant and principal caregiver participate in Structured Family Caregiving.

Structured Family Caregiving Support Plan

The Provider must establish a family-centered Structured Family Caregiving support plan for the coaching and support of the principal caregiver. The family-centered Structured Family Caregiving Support Plan must identify the resources, coaching, and support the Medicaid-enrolled Structured Family Caregiving Provider Agency will provide to the principal caregiver.

Staff Training

The Provider will ensure that each Structured Family Caregiving staff member receives a minimum of six (6) hours of training annually. The Provider must maintain a training record for each Structured Family Caregiving staff member and document the date, length, and topic of each training completed.

Training records must document, at a minimum, the staff member's name, training topic or title, the date the training was completed, and the length of the training. Training documentation should also include the staff member's signature or electronically generated verification, such as a training certificate or learning management system record. Training records must be specific to the individual staff member and the training completed. Summary statements or general attestations without supporting detail do not demonstrate compliance.

Statewide Coverage

The Provider is bound to serve statewide. The Provider must have a policy and procedure manual that includes a policy for statewide coverage. The statewide coverage policy must detail the Provider's process for ensuring statewide coverage for Structured Family Caregiving.

Caregiver Coaching and Support

The Provider must provide education, resources, and coaching to caregivers that are appropriate for lay caregivers and that includes but are not limited to: managing chronic conditions, understanding the progression of behavioral health conditions (if applicable), medication reconciliation, and handling urgent and emergency situations.

Additionally, the Medicaid-enrolled Provider agency must be accessible during normal business hours to coach a principal caregiver to manage urgent and emergency situations in the home and, in conjunction with the principal caregiver and the waiver case manager, establish an emergency back-up plan for instances when the principal caregiver is unable to provide care. The Provider must begin providing ongoing caregiver education (as described below), coaching, and support to the principal caregiver after the start of services. The Provider must review the principal caregiver's coaching needs as part of a monthly care conference and document and address any changes necessitated by changes in the participant's condition or by other circumstances in the home.

The Provider must provide each principal caregiver with an orientation to the general requirements of Structured Family Caregiving within 30 days of the start of Structured Family Caregiving services. The orientation must include:

- The requirements of Structured Family Caregiving and the principal caregiver's obligations to complete the personal care and related activities noted in the participant's ISP; the required collaboration with the Structured Family Caregiving Provider agency to oversee activities in the home; the required reporting on the participant's health status and general well-being and critical incidents; and the requirement to provide notes in accordance with the Provider's documentation requirements.
- The roles and responsibilities of Structured Family Caregiving Provider staff and principal caregivers.
- Respecting the participant's privacy and protecting the confidentiality of the participant's private health care information and the relevant provisions of the Health Insurance Portability and Accountability Act of 1996 and any other applicable act or regulation; and

- Prevention of, and reporting of, abuse, neglect, mistreatment, and misappropriation/financial exploitation.

The Provider must provide each principal caregiver with other general foundational knowledge within 90 days of the start of Structured Family Caregiving services, including:

- Basic first aid, cardiopulmonary resuscitation (CPR), and the Heimlich maneuver;
- Universal precautions and infection control practices;
- Techniques for safely providing personal care, including good body mechanics;
- Recognizing the physical, social, emotional, and behavioral support needs of the participant.
- Training records must document, at a minimum, the principal caregiver's name, training topic or title, the date the training was completed, and the length of the training. Training documentation should also include the principal caregiver's signature or electronically generated verification, such as a training certificate or learning management system record. Training records must be specific to the individual principal caregiver and the training completed. Summary statements or general attestations without supporting detail do not demonstrate compliance.
- The Provider must identify any additional training and coaching needs of the principal caregiver that are specific to the needs of the participant and deliver that training and coaching as needed. The training may be delivered by whatever methods are most appropriate to the learning style of the caregiver.

The Provider must engage and communicate with principal caregivers on a regular basis to review information or changes in the participant's status, to report incidents or accidents as they occur, and to participate in monthly case conferences and home visits (on-site or virtual). At least one care conference must be conducted as an on-site, face-to-face visit on an annual basis with the participant and principal caregiver.

The Provider must issue stipends to principal caregivers in a timely manner in accordance with the independent contractor agreement between the Provider and the principal caregiver.

Provider Collaboration With LTSS and Service Back-Up Plan

The Provider must provide LTSS Case Management Specialists with an update on each eligible participant through participation in the participant's ISP meeting(s) and/or through providing case notes and other documentation. Updates should be given upon a significant change in the participant's health status or circumstances in the home and whenever requested by the State. The Provider must collaborate with the State and the Structured Family Caregiving caregiver to establish an emergency backup plan for instances when the principal caregiver is unable to provide care.

Assisted Living and Community Living Home

Assisted Living and Community Living Home Services Definitions

“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.

“Community Living Home Services” include 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 participant. A 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.

“Residential Respite” is the short-term (less than 30 consecutive days) care and supervision for an individual who is unable to care for himself 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.

Assisted Living and Community Living Home Requirements

Admission, Transfer, Discharge

The Provider must have an Admission, Transfer, and Discharge policy. When the Provider determines that services to a participant must be discontinued, the Provider must notify the participant in writing at least 30 days before the transfer or discharge, unless a change in the participant’s health requires immediate transfer or discharge, or if the participant has not resided in the Community Living Center for 30 days.

The written notice must specify the reason for an effective date of the transfer or discharge and the new location to which the participant will be transferred or discharged; the conditions under

which the participant may refuse transfer within Community Living; and a description of how the participant may appeal a decision by Community Living to transfer or discharge the participant as per [ARSD 44:70:09:14](#).

Additionally, per [ARSD 44:70:04:16](#), the Provider shall initiate planning with applicable agencies to meet the identified needs of the participant, and the participant 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 participant is discharged.

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 the 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.

HCBS Settings Final Rule

The Provider must 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](#).

HCBS Settings Final Rule Staff Training

The Provider must have a policy that addresses Provider agency staff and volunteer training about the HCBS Settings Final Rule. Staff training on the HCBS Settings Final Rule must be conducted on an annual basis. Verification of the training must be readily available upon request.

HCBS Requirements and Modifications

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.

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:

- Access to the broader community;
- Privacy, dignity, respect, autonomy, choice, control, freedom from coercion and restraints, and all participants' rights as noted in ARSD 44:70 and the [HCBS Settings Guide to Expectations and Compliance](#);

- Participant lease/tenant agreement requirements;
- Roommate choice policy;
- Visitor/Guest policy;
- Policy to address the ability to lock the door to the sleeping and/or living unit; and
- 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.

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 deems it necessary to implement any modification(s) to any of the federal home and community-based settings requirements, the modification(s) must be discussed with the Participant and the LTSS Case Management Specialist and documented in the LTSS Individual Support Plan (ISP). Each modification request must be submitted to the Department of Human Services and approved prior to the implementation of the restriction.

No modification or restriction may begin until the Case Management Specialist has met with the participant and has signed their Individual Support Plan.
Provider

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.

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. Rates are also posted on the LTSS Provider Portal, online at <https://dhs.sd.gov/en/Provider-portal/long-term-services-and-supports-Provider-portal>.

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 or Community Living Home are not eligible for the Supplemental Nutrition Assistance Program (SNAP) since their Room and Board is supplied.

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.

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 participant is the property of the participant.

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.

Environmental Accessibility Adaptations

Environmental Accessibility Adaptations Definitions

“Environmental Accessibility Adaptations (EAA)” are those physical adaptations to the private residence of the participant, or the participant's family, required by the participant's ISP, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are excluded. Adaptations or improvements that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (i.e. in order to improve entrance/egress to a residence or to widen a bathroom to accommodate a wheelchair). This service does not include general repair or maintenance to the residence, which are standard housing obligations of the owner or tenant.

Environmental Accessibility Adaptations Requirements

EAA Referrals

The LTSS Case Management Specialist will make a referral to the chosen EAA Provider when the need for an EAA is identified. The Provider must accept or deny the referral. If the Provider accepts the referral, a “Therap Service Auth” will be sent to the Provider by the LTSS Case Management Specialist authorizing the Initial Assessment.

Scope of Work

The Provider must coordinate and supervise the project to completion. The Provider must complete an Initial Assessment, which includes the following:

- Visit the site to determine the scope of work involved;
- Locate and obtain EAA bids from a minimum of two contractors to complete the project; and
- Submit two EAA bids to the LTSS Case Management Specialist and acknowledge the “Therap Service Auth” prior to starting the project.
- The Provider must monitor completion of the EAA project. Monitoring tasks include:
 - Writing a contract with the contractor;
 - Monitoring the progress of the contractor with telephone calls or onsite visits;

- Monitoring the contractor to ensure work is being completed as authorized; and
- Contacting the LTSS Case Management Specialist if the cost of the project is expected to exceed the initial authorized amount. The Provider must receive an Therap Service Auth from the LTSS Case Management Specialist to ensure reimbursement for the full cost of the project.

The Provider must conduct a Final Assessment of the completed EAA project. A Final Assessment requires:

- Going onsite to confirm completion of the project; and
- Submitting a copy of the Final Assessment Report to the LTSS Case Management Specialist (including the amount of face-to-face staff time spent on the project and the final cost of the EAA project)
- The Provider must bill Medicaid for the EAA project, which requires:
- Obtaining written (e.g. fax, e-mail) confirmation from the LTSS Case Management Specialist for approval to bill for services once the Final Assessment Report is accepted.

Request For Reimbursement

Initial Assessment (Service Code T1028):

- Providers' in-home initial face-to-face staff time to obtain project specifics in order to obtain bids and secure a contract, and
- must be submitted and shall be paid regardless of whether the EAA was completed or not.

Monitoring of the Project (Services Code S5165):

- Units spent securing a contract and writing a contract, units spent monitoring the progress of the project to ensure successful completion

Cost of the Project (Service Code S5165):

- Materials necessary to complete the project.
- Labor required for completion of the project.
- Provider must complete Final Assessment and receive approval from the LTSS Case Management Specialist before billing for the Cost of the Project.

Final Assessment (Service Code T1028):

- Providers' in-home face-to-face staff time to assess completion of the project for compliance and safety and ensure the project meets the needs of the participant.
- Provider must submit a Final Assessment Report to the LTSS Case Management Specialist (including the amount of face-to-face staff time spent on the project) to receive approval to bill for the EAA project.
- The LTSS Case Management Specialist will review the report and will authorize the Final Assessment. Following approval, the Provider may bill both the Cost of the Project (S5165) and the Final Assessment (T1028)

Discontinuation Of Authorization

The Department of Human Services' Division of Long Term Services and Supports may discontinue services if DHS exhausts its resources for providing the services, the participant can no longer benefit from the services provided, or the participant's or the Provider's health or safety would be jeopardized if the services were continued.

Adult Day

Adult Day Services Definitions

“Adult Day Services (ADS)” provide regular care, supervision, and structured activities in a non-institutional, community-based setting, including health and social services that are necessary to ensure the optimal functioning of a participant, for a period of less than twenty-four hours per day;

“Personal Care Services” refers to assistance provided to a participant living at home by an in-home aide to perform their activities of daily living.

“Unit of Service” is a 15-minute increment of time that can be billed for specific services, such as adult day services and personal care services. Each unit represents one-quarter of an hour of direct service provided to an eligible individual, and billing must accurately reflect the actual time spent delivering the service.

Adult Day Services Requirements

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.

HCBS Settings Final Rule

The Provider must 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](#).

HCBS Settings Final Rule Staff Training

The Provider must have a policy that addresses Provider agency staff and volunteer training about the HCBS Settings Final Rule. Staff training on the HCBS Settings Final Rule must be conducted on an annual basis.

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:

- Participant Care Plan;
- Grievance Procedures;
- HCBS Settings Final Rule Staff Training;
- Modifications;
- Services;
- And Visitation

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 deems it necessary to implement any modification(s) to any of the federal home and community-based settings requirements, the modification(s) must be discussed with the Participant and the LTSS Case Management Specialist and documented in the LTSS Individual Support Plan (ISP). Each modification request must be submitted to the Department of Human Services and approved prior to the implementation of the restriction.

No modification or restriction may begin until the Case Management Specialist has met with the participant and has signed their Individual Support Plan.

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.
Provider

Activities

The activity plan is an integral part of the total plan of care for the individual based on the interests, needs, and abilities of the participant. A balance of purposeful activities should be provided to meet the participants' interrelated needs and interests, including social, intellectual, cultural, economic, emotional, physical, and spiritual needs.

Assistance with Activities of Daily Living (ADLs)

Staff with adequate training, as outlined below in the Staff Training and Evaluation section, may provide moderate assistance with ADLs. Moderate assistance is defined as assistance with 1-3 ADLs and includes standby or hands-on assistance throughout the completion of the ADL. Staff must aid with and provide supervision of ADLs in a safe and hygienic manner with recognition of an individual's dignity and right to privacy.

Participants should be encouraged to take part in activities, but may choose not to do so, or may choose another activity. Reasons for non-participation should be evaluated to determine whether it reflects personal preference or indicate a need for a change in activity.

A monthly calendar of activities should be prepared and posted in a visible place. This may be distributed to participants, family/caregivers, and others as the Provider deems appropriate.

Education

Provider's staff should establish relationships with other community agencies and Providers to coordinate services and form service networks. Education must be provided to the families/caregivers and participants to improve the well-being and functional level of the participants and/or caregiver upon admittance into the program and annually. Education includes, but is not limited to, health, nutrition, and other services available.

Health-related Services

Health-Related Services must be offered according to participant needs, as identified in the health assessment, plan of care, and physicians' orders. The Provider must train staff and supervise the use of standard protocols for communicable diseases and infection control. The Provider must initiate emergency first aid and emergency response procedures by a person trained in Emergency First Aid and CPR when necessary.

Providers must collect, maintain, and update – within the scope of practice of the staff involved – medical and functional information and assessments. For those areas outside of the scope of practice of the staff involved, the Provider maintains a file and notifies others when assessments and other medical and functional reports are due. The Provider must manage medications in accordance with Administrative Rules of South Dakota (ARSD) 20:48:04.01 and any other applicable law, rule, or regulation.

Nutrition Services

Providers operating through the lunch hour must ensure that participants have access to at least one meal per day. Snacks, nutritious meals, and fluids shall be offered as needed to meet the participants' needs. The Provider will respect dietary restrictions related to religion or cultural needs and offer ethnically appropriate foods whenever feasible. Food provided shall be

nutritious and ensure dietary guidelines are being met, as defined by the American Dietetic Association.

Social Services

Social services should be provided to participants and their families. Staff should assess the families' needs and assist them in gaining access to additional services as needed.

Staff-to-participant Ratio

Staff must be adequate in number and skills to provide essential administrative and service functions. Staff must be sufficient to serve the number and functional levels of the participants and meet program objectives.

Staff Training

The Provider must ensure that each employee receives a minimum of 6 hours of training annually and maintain a training record for each aide, documenting the date, length, and topic of each training completed. Training records must document, at a minimum, the staff member's name, training topic or title, the date the training was completed, and the length of the training. Training documentation should also include the staff member's signature or electronically generated verification, such as a training certificate or learning management system record. Training records must be specific to the individual staff member and the training completed. Summary statements or general attestations without supporting detail do not demonstrate compliance.

Staff Positions

Providers must have written job descriptions for all staff positions as follows:

For programs with participants requiring nursing services, the nurse must be a Registered Nurse (RN) with a valid state credential or a Licensed Practical Nurse (LPN) with a valid state credential.

Transportation

All programs provided and contractual transportation systems must meet local, state, and federal regulations. If feasible to provide transportation to and from the adult day setting and to and from doctor's appointments, a transportation policy must be included and posted in all vehicles.

Adult Nutrition

Adult Nutrition Services Definitions

“Catered Meal Site” A subcontractor that has been licensed by the Department of Health (DOH) to prepare food and has subcontracted with an approved Nutrition Provider to provide congregate and/or home-delivered meals to eligible participants.

“Congregate Meal” A nutritious meal served in accordance with the [Dietary Guidelines for Americans](#), with the Provider’s scheduled mealtime provided to an eligible participant at an Adult Nutrition Program meal site.

“Congregate Nutrition Services” are nutritious meals provided to eligible participants in a group setting, including adult day settings, multigenerational community centers, senior centers, senior housing, and restaurants.

“Home-Delivered Meals” Nutritious meals in accordance with the [Dietary Guidelines for Americans](#) are delivered to older adults who are authorized for home-delivered meals.

“Reimbursable meals” Any meals provided to an eligible participant for the HOPE Waiver and LTSS.

Adult Nutrition Services Requirements

Access to Meals

Providers must ensure that all congregate meal sites are accessible in accordance with the [Americans with Disabilities Act](#) (ADA). Providers must also review and update meal sites’ emergency plan annually to describe how meals will be provided to LTSS participants during an emergency.

The State’s reimbursement for services rendered shall be considered payment in full. The Provider may not bill the participant for any additional fees.

Facility, Safety, and Sanitation

Providers must ensure that all meal sites meet safety and sanitation requirements, which are outlined in the State of South Dakota’s Food Service Code found in [Administrative Rules of South Dakota \(ARSD\) 44:02:07](#).

Additionally, meal sites must adhere to the [Building and Fire Safety Code](#) located within the Administrative Rules of South Dakota.

Meal Requirements

Provide meal options that meet the dietary needs of older adults who may have different health, religious, ethnic, or cultural requirements. Ensure a diabetic-friendly meal option is available.