ATTACHMENT 1
COMMUNITY LIVING HOME PROVIDER PROVISIONS

A 1.1 PURPOSE: The South Dakota Department of Human Services, (DHS) Division of Long Term Services and Supports (State) provides home and community-based service options to individuals 65 years of age and older and 18 years of age and older with disabilities. State services enable these South Dakotans to live independent, meaningful lives while maintaining close family and community ties. State provides home and community-based services sufficient in type, scope, amount, duration, and frequency, as specified in the Long Term Services and Supports Care Plan/Service Plan (LTSS Care Plan; see Provision B 2.2), to prevent or delay premature or inappropriate institutionalization.

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

A 1.2 PROVISION: In addition to the requirements outlined in the SD Medicaid Provider Agreement, the Provider agrees to the following:

A 1.3 RULES AND REGULATIONS: The Provider shall comply with all Administrative Rules of South Dakota (ARSD) and South Dakota Codified Laws (SDCL) relative to the services provided. The Provider agrees to comply in full with all licensing requirements and other standards required by federal, state, county, city or tribal statute, regulation or ordinance in which the service and/or care is provided. Liability resulting from noncompliance with licensing and other standards required by federal, state, county, city or tribal statute, regulation or ordinance or through the Provider's failure to ensure the safety of all consumers served is assumed entirely by the Provider. Medicaid rules and regulations supersede all Community Living Home policies and procedures.

A 1.4 INTERPRETERS: The State will utilize DHS approved interpreters, at State expense, whenever necessary for communication between the LTSS Specialist and the consumer. Interpreter services are authorized by the LTSS Specialist. The consumer must choose an approved LTSS Interpreter Agency, and the LTSS Specialist and Provider will cooperatively arrange for interpreter services as necessary for service provision.

A 1.5 VERIFICATION AND DOCUMENTATION: The Provider is required to maintain documentation and verification demonstrating compliance with this Agreement. This documentation must be readily available upon request.

A 1.6 REIMBURSEMENT: The rate(s) for services are specified in the HOPE Waiver Fee Schedule located at http://dhs.sd.gov/ltss/ltssproviders.aspx. Community Living Home are billed at a tiered daily rate. Rate tiers are determined by a standardized needs assessment tool that is completed by the LTSS Specialist at least annually with all consumers of the HOPE waiver. The information collected during the assessment generates a RUG score based on an algorithm developed by InterRAI.

Community Living staff are expected to participate in the assessment process and doing so will ensure the most accurate tier is assigned. If a Provider is concerned that a consumer is not accurately classified into the appropriate tier based on his/her last assessment and/or there is an error on the 'Therap Service Auth', the Provider should not acknowledge the 'Therap Service Auth'. The Provider should contact the LTSS Specialist assigned as the consumer's case manager to resolve any potential discrepancies.

All services authorized and delivered by the Provider to eligible consumers will be reimbursed at stated rates. 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.

Approved claim forms, including all required information (e.g. Provider's National Provider Identifier, consumer's primary diagnosis code, etc.) will be submitted by the Provider to the State for payment of services authorized and provided.

The Provider must only bill for services acknowledged in Therap and delivered by the Provider.

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

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

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

be consecutive or non-consecutive. Therapeutic leave days are leave days from the Community Living Home for non-medical reasons (e.g., visits to the homes of family or friends).

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

STANDARD PROGRAM DEFINITIONS

B 2.1 "**Community Living Home Service**" includes routine intermittent personal care, supervision, cueing, meals, homemaker services, chore services, medication management (to the extent permitted under State law), and other instrumental activities of daily living (e.g. transportation for necessary appointments and community activities, shopping, managing finances, and phone use) that is provided to a HOPE waiver participant.

B 2.2 "Community Living Home" is a licensed setting in which the HOPE waiver participant receives the community living home service. The community living home is the entity responsible for managing the setting and/or staff employed at the community living home.

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

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

B 2.2 "**Critical Service Need Consumer**", is a consumer who needs service(s) (i.e., oxygen, injection, medication, wound care, therapy) provided on each assigned day without disruption, or without such service(s) the consumer's health condition would decline. The LTSS Specialist will communicate with the Provider (through the LTSS Care Plan) when a consumer has been identified as a Critical Service Need Consumer. When a Critical Service Need Consumer is identified, the LTSS Specialist is responsible to work with the consumer and the Provider to develop a back-up plan for service provision during an emergency. The LTSS Specialist assists the consumer to identify any services that will be needed during an emergency.

The Provider must notify LTSS Specialist whenever a change in the Consumer occurs and/or a modification may be necessary. The Provider is required to provide input and participate in the development of the initial and ongoing LTSS Care Plan.

B 2.3 "**Eligible Consumer**" is any person in need of services who has been determined eligible by DHS. State will provide on-going Case Management for each consumer. Case Management will include reassessing the consumer's needs and eligibility at least annually, facilitating the development of the LTSS Care Plan, convening annual and as-needed person-centered planning meetings to develop and approve changes to the LTSS Care Plan, authorizing additional services by the Provider and/or third parties, and resolving any consumer concerns and other consumer-related issues.

B 2.4 "LTSS Care Plan/Service Plan" is a written person-centered plan developed by the LTSS Specialist with a consumer, as well as any individuals the consumer chooses, and must be finalized and agreed to, with the informed consent of the consumer in writing, and signed by all individuals and providers responsible for its implementation. The LTSS Care Plan (Attachment 2) reflects the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the individual with regards to preferences for the delivery of such services and supports. If a consumer needs special supports or modifications based upon an assessed health and safety need, it must be identified within the LTSS Care Plan. Any modification of the federal regulations for the HCBS Settings Final Rule, as described at CFR 42 § 441.710(a)(1)(vi), must be individualized and addressed in the LTSS Care Plan. If a provider is implementing any modification(s) to any of these federal home and community-based settings requirements, the modification(s) must be discussed with the LTSS Specialist and documented in the LTSS Care Plan.

The Provider must notify the LTSS Specialist whenever a change in the consumer 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 Care Plan.

B. 2.5 "Person-Centered Philosophy" encompasses values, concepts and tools that are used to promote a person's positive control over the life they have chosen for themselves. The core concept of what is important to (happy, content, satisfied) and important for (healthy, safe and seen as a valued member of their community) a person is the core concept and is foundational during care planning process.

B 2.6 "**Therap**" is the online case management documenting and billing software.

B 2.7 "Therap Service Auth" is the electronic document in Therap which details the services authorized for the consumer. The "Therap Service Auth" must be acknowledged by the Provider within 7 business days of receipt. Failure to acknowledge the " Therap Service Auth" within the designated time frame may

negatively affect reimbursement for services provided. Any permanent change to the "Therap Service Auth" must be reviewed and authorized by the State.

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

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STANDARD PROGRAM REQUIREMENTS

C 3.1 The Provider must conduct fingerprint background checks to screen for abuse, neglect, and exploitation for all employees that provide direct services or supports. 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", along with a description of the alternative background check (produced by the company that process the 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
- 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 provide direct services or supports to consumers residing in an Community Living Center must meet the following minimum standards:

1. Be 16 years of age or older.
2. Be employed by an enrolled Medicaid Provider.
3. Pass a State fingerprint (or State approved) background check.
    a. The following are a list of fitness criteria that would automatically preclude an individual from being hired/contracted:

        i. A crime of violence as defined by SDCL 22-1-2 or a similar statute from another state;
        ii. A sex crime pursuant to SDCL chapters 22-22 or 22-24A or SDCL 22-22A-3 or similar statutes from another state;
        iii. Class A and/or B felony convictions.

    b. The following are a list of fitness criteria that may preclude an individual from being hired/contracted at the discretion of the provider:
        i. Other felonies not described in 3.a.iii.

ii. Misdemeanor convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
iii. Any convictions, including any form of suspended sentence, which are determined to be detrimental to the best interests of SD Medicaid. This includes convictions related to a person's character such as perjury and fraud related charges as individuals determined to be dishonest with any party should not be assumed to be honest with SD Medicaid;
iv. Conviction related to obstruction of a criminal investigation.

C 3.2 The Office of the Inspector General (OIG) has the authority to exclude individuals and entities from federally funded health care programs and maintains a list of all currently excluded individuals. The Provider must check the OIG List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list at a minimum of once every six months. Search the OIG exclusions database online at https://exclusions.oig.hhs.gov/. The Provider must have a policy that specifies the processes for conducting this verification.

C 3.3 The Provider must report bed occupancy in the format and frequency required by Long Term Services and Supports.

C 3.4 In accordance with South Dakota law, the Provider is mandated to immediately report any suspected abuse, neglect or exploitation of a consumer. The Provider must have a policy for abuse, neglect or exploitation reporting which conforms to the mandatory reporting laws and must provide training on mandatory reporting laws to staff on an annual basis. See South Dakota Codified Law (SDCL) 22.46 for South Dakota's laws regarding abuse, neglect or exploitation of elders or adults with disabilities.

C 3.5 The Provider agrees to fully comply with the HCBS Settings Final Rule, 42 CFR §441.301(c)(4) and (5) specified here and in the HCBS Settings Guide to Expectations and Compliance. The Provider also agrees to cooperate with all action steps included in South Dakota's HCBS Settings Final Rule Transition Plan. Both documents are available online at https://dss.sd.gov/medicaid/hcbs.aspx.

C 3.6 The Provider's facility standards and policies must address the federal Medicaid requirements for Home and Community-Based Settings (HCBS Settings Final Rule) as specified in 42 CFR §441.301(c)(4) and (5). Specific policies that must be addressed as part of facility standards include the following:

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

C 3.7 The Provider must have a written Quality Assurance and Improvement Plan detailing all activities conducted by the Provider to ensure quality service provision. The Provider must also have a Quality Assurance policy specifying how the Provider will discover, fix, and report problems. The Provider will cooperate with quality performance site visit activities conducted by State.

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

C 3.8 The Provider must have an Admission, Transfer and Discharge policy. When the Provider determines services to a consumer must be discontinued, the Provider must notify the consumer in writing at least 30 days before the transfer or discharge, unless a change in the consumer's health requires immediate transfer or discharge or if the consumer has not resided in the Community Living Center for 30 days. The written notice must specify the reason for and effective date of the transfer or discharge and the new location to which the consumer will be transferred or discharged to; the conditions under which the consumer may refuse transfer within Community Living; and a description of how the consumer may appeal a decision by Community Living to transfer or discharge the consumer as per ARSD 44:70:09:14 Admission, Transfer, and Discharge Policies. Additionally, per ARSD 44:70:04:16 Discharge Planning, the Community Living Home shall initiate planning with applicable agencies to meet identified needs of consumer and consumer shall be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care shall be made available to the community living setting and/or whomever the consumer is discharged to and to each referral agency as required by the discharge plan.

C 3.9 The Provider must have a Grievance policy pursuant to ARSD 44:70:09:10. A consumer may voice grievances without discrimination or reprisal. A grievance may be in writing or oral and may relate to treatment furnished, treatment that has not been furnished, the behavior of other consumers, and/or infringement of the consumer's rights. The Community Living Home shall adopt a grievance process and make the process known to each consumer and to the consumer's immediate family. The grievance process shall include the facility's efforts to resolve the grievance and documentation of the grievance; the names of the persons involved; the disposition of the matter; and the date of disposition.

C 3.10 The Provider must have an incident reporting policy. The Provider must immediately notify State of any consumer-related concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care. The Provider must follow the Department of Health's policy for documenting the circumstances of any incident that involves restraint, seclusion, serious injury, missing person, or death from other than natural causes.

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

C 3.11 The Provider must have an emergency response policy. An "emergency" is defined as a situation that is sudden, generally unexpected, and demands immediate attention. The Provider must notify the State of the emergency upon resolution of the emergency or transfer of the consumer to emergency responders.

C 3.12 The Provider must have a health and safety policy. The health and safety policy must detail the use of universal precautions. The provider must provide all supplies and equipment needed for staff members to practice infection control.

C 3.13 The Provider must have a documentation policy. The documentation policy must include how Community Living staff document service provision, consumer progress and health/safety concerns with a consumer. Documentation must be kept for each consumer. Records must be retained for 6 years after a claim has been paid or denied. Documentation must be easily accessible upon request.

C 3.14 The Provider must have a quality assurance policy. The Provider must have a written quality assurance and improvement 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 provider quality performance audits activities conducted by the State.

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

C 3.15 A copy of all policies must be readily accessible upon request.