

ATTACHMENT 1

IN-HOME SERVICES 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 60 and older, and those 18 and over who are physically disabled. State services enable these South Dakotans to live independent, meaningful lives while maintaining close family and community ties. The State provides home and community-based services in sufficient type, scope, amount, duration, and frequency, as specified in the Care Plan/Service Plan, to prevent or delay premature or inappropriate institutionalization.

A 1.2 RULES: The Provider shall comply with all Administrative Rules of South Dakota ("ARSD") regarding the services provided.

A 1.3 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 1.4 INTERPRETERS The State will utilize DHS approved interpreters, at State expense, whenever necessary.

Interpreter services are authorized by the LTSS Specialist. The Consumer must choose a qualified provider and the LTSS Specialist and Provider will cooperatively arrange for interpreter services as necessary for service provision.

The State may not reimburse for interpreter services when the in-home aide or nurse is not available for a scheduled visit requiring interpreter services. If an in-home aide or nurse is not available for a scheduled visit requiring interpreter services, the Provider must contact the Interpreter Service Agency to cancel the visit within 4 hours of the scheduled visit. If the Provider does not cancel the scheduled visit, the Provider will be responsible for reimbursing the Interpreter Agency for the duration of the scheduled visit.

A 1.5 REIMBURSEMENT: The rate(s) for services are specified in the In-Home Services Schedule located at <http://dhs.sd.gov/ltss/ltssproviders.aspx>. All services authorized and delivered by the Provider to eligible consumers will be reimbursed at stated rates. Once the Provider's rate(s) are established, the State will not increase the rate(s) upon request by the Provider due to failure to advise the State of critical information significant to establishing Provider rate(s) for the duration of the contract.

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.

It is the responsibility of the Provider to review the Therap Service Auth to ensure the rate is correct prior to acknowledging the Therap Service Auth. If the rate is incorrect, the Provider must contact the Long Term Services and Supports (LTSS) Specialist to mitigate claims error(s).

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

The Provider must only bill for services authorized and acknowledged in Therap and delivered by the Provider. Total units authorized are a maximum for the entire duration of the Therap Service Auth. The scheduled frequency and duration of each service is included in the Therap Service Auth and must be followed. Reimbursement received for units above and beyond the total units, frequency, and/or duration specified in the Therap Service Auth will be recouped and the Provider will be responsible to continue to provide services at the scheduled frequency and/or duration as indicated on the Therap Service Auth.

The Provider must contact the LTSS 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.

If a situation arises in which unanticipated services must be provided in order to assure the well-being of the consumer, the Provider must notify the LTSS Specialist by the next business day in order to receive approval for the services. If the Provider does not notify the LTSS Specialist, the additional units will not be approved and may not be billed.

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. 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 Consumer 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 State for authorization.

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

If staffing shortages occur, the Provider must provide adequate coverage to serve the assigned consumers. "Clustering" visits to consumers 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 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.

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

STANDARD PROGRAM DEFINITIONS

B 2.1 "Adult Companion service" (waiver only) 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 consumer, as opposed to completing the tasks for the consumer. The adult companion service to be performed and the frequency will be specified in the "Therap Service Auth" and accompanying documents.

B 2.2 "Care Plan/Service Plan" is a written plan developed with each consumer and whomever he/she wishes to participate. The Care Plan/Service Plan summarizes the consumer's identified needs and the strategy for addressing unmet needs.

The 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 Care Plan/Service Plan, determining changes to the Care Plan/Service Plan, authorizing additional services by the Provider, and resolving any consumer concerns and other consumer-related issues.

B 2.3 "Chore service" (waiver only) are services needed to maintain the consumer's home in a healthy and safe environment. Chore services are lawn mowing, snow and ice removal from sidewalks and driveways, or other services which the homeowner is required to complete by city or county ordinance. Chore services to be performed and the frequency will be specified in the "Therap Service Auth" and accompanying documents.

B 2.4 "Critical Service Need Consumer", is a consumer who needs service(s) (i.e., oxygen, injection, medication, wound care, therapy) provided on each assigned day and/or without such service(s) the consumer's health condition would decline. The

LTSS Specialist will communicate with the Provider (through the Services Task List/Care Plan) when a consumer has been identified as a critical service need consumer. When a critical service need consumer is identified, the Provider will work with the LTSS Specialist to develop a critical service back-up plan to coordinate service provision when the usual caregiver(s) are not available to provide service(s)(i.e., personal care, nursing services to the consumer). The Provider must notify the State immediately of any change in scheduled visits and/or when a critical service need consumer cannot be provided needed services for any reason.

B 2.5 “Eligible Consumer”, is any person in need of services who has been determined eligible by DHS.

B 2.6 “Homemaker services” consist of the performance of general household tasks provided by an in-home aide, when the consumer is unable to manage the home and care for him or herself, or others in the home. The homemaker service to be performed and the frequency will be specified in the “Therap Service Auth” and accompanying documents.

B 2.7 “In-home aide” or “Nurse (RN or LPN)” is the individual who performs the homemaker, personal care, respite, adult companion, chore, or nursing services as identified on the “Therap Service Auth” and accompanying documents.

B 2.8 “Personal Care Service” is assistance provided to a consumer living at home, by an in-home aide, to perform his or her activities of daily living. The personal care services to be performed will be specified in the Therap Service Auth and accompanying documents.

B 2.9 “Respite service” is the performance, by an in-home aide of temporary substitute supports or living arrangements for care receivers to provide a period of relief or rest for the primary caregiver. The respite service to be performed and the frequency will be specified in the “Therap Service Auth” and accompanying documents.

B 2.10 “Therap” is the online case management documenting and billing software.

B 2.11 “Therap Service Auth” is the electronic document in Therap which details the services authorized for the consumer. The “Therap Service Auth” must be acknowledged by the Provider within 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.

STANDARD PROGRAM REQUIREMENTS

C 3.1 The Provider is bound to serve the geographical area specified in the In-Home Services Schedule located at <http://dhs.sd.gov/ltss/ltssproviders.aspx>. Any LTSS consumer living within the identified geographic area may be referred to the provider. 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 consumer need.

If staffing shortages occur, the provider must make every reasonable effort to actively recruit and hire in-home aide and nursing staff to serve the geographical area specified in the In-Home Services Schedule.

C 3.2 The Consumer will select the Provider of his/her choice. When a Provider makes a referral to the State, the LTSS Specialist will ensure the referring Provider is made known to the Consumer, but the Consumer will be offered the choice of Providers.

C 3.3 The Provider may hire a relative/legal guardian of a consumer to provide his/her services. The relative/guardian must meet all the Provider's qualifications and training requirements. If the relative/legal guardian hired to provide services resides in the same home as the consumer, a referral to structured family caregiving services is required.

C 3.4 The Provider must implement State fingerprint background checks to screen abuse, neglect, exploitation, for all employees hired to work in the homes of consumers. 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). In order 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 work in the homes of consumers 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 3.5 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 3.6 The Provider will assign and begin provision of authorized services within 7 business days of receipt of the "Therap Service Auth". If the Provider is unable to meet the 7-day deadline, the Provider must contact the consumer's LTSS Specialist to discuss the plan for ensuring services are provided.

C 3.7 The Provider must comply with federal Electronic Visit Verification (EVV) requirements. 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 time the service begins and ends.

C 3.8 The Provider must have a policy and procedure manual. The policy and procedure manual must be easily accessible upon request.

C 3.9 The Provider must have a policy for abuse neglect and exploitation reporting. In accordance with South Dakota law, the Provider is mandated to immediately report any suspected abuse or neglect of a consumer. The policy for abuse and neglect 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.

C 3.10 The Provider must have a staffing policy. The staffing policy must include job qualifications, the process for conducting background checks OIG exclusion, and the process for performance evaluations.

C 3.11 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 enters a consumer's home unsupervised.

The Provider must ensure that each in-home aide receives a minimum of 6 hours of training annually and must maintain a training record for each in-home aide, documenting the date, length, and topic of each training completed.

The Provider is responsible for the oversight of staff (including relatives/legal guardians) in the completion of their assigned tasks. The review process must include unannounced visits to the assigned work site of each employee. Documentation of the staff monitoring visits must be available for review.

C 3.12 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.

C 3.13 .The Provider must have a consumer discharge policy. When the Provider determines services to a consumer must be discontinued by their agency, the provider must notify the State at least 30 days before the consumer is discharged, unless the consumer's home constitutes an unsafe environment for Provider's staff and/or the consumer. The notice must be in writing and must specify the reason for discharge in accordance with the Provider's discharge policy.

Any changes to a consumer's Care Plan 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 consumer must be discontinued, the provider will be notified as soon as possible.

C 3.14 The Provider must have a consumer confidentiality policy. The confidentiality policy must include specifics on maintenance of consumer records, transmission of personal consumer information and confidentiality practices by staff.

C 3.15 The Provider must have a consumer rights and responsibilities policy. The consumer rights and responsibilities policy must include the consumer's right to remain free from restraints and seclusion and must provide staff training on the prohibition of restraints and seclusion on an annual basis

C 3.16 The Provider must have a documentation policy. The documentation policy must include how in-home aides and nurses document each interaction 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. Documentation must also meet the minimum EVV requirements which 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 time the service begins and ends. A pattern of missed visits must be reported to the LTSS Specialist.

C 3.17 The Provider must have an incident reporting policy. The Provider must immediately notify the State of any consumer-related concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care. The Provider must submit an incident report to the LTSS Specialist documenting the circumstances of any incident that involves serious injury, missing person, restraint, seclusion, or death.

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

C 3.18 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 consumer's home and an emergency occurs, the staff member must call 911 immediately. The Provider must notify the State of the emergency upon resolution of the emergency or transfer of the consumer to emergency responders.

C 3.19 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 performing home visits to practice infection control.

C 3.20 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 3.21 The Provider must have a consumer grievances policy. The Consumer grievance policy must include how the consumer is notified of the grievance policy, where grievances are reported and the process for addressing and resolving consumer grievances and feedback.

C 3.22 The Provider must have a gifting policy. The gifting policy must detail the Provider's expectations and prohibitions for staff accepting gifts from consumers.

C 3.23 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.

C 3.24 The Provider must submit a cost report in the format required by the State within four months following the end of the Provider's fiscal year. Failure to submit the report will result in the termination of the Provider's contract with the State.

C 3.25 The Provider is responsible for maintaining proof of a valid driver's license for any employees transporting consumers.

C 3.26 A copy of all policies must be readily accessible upon request.

NURSING SERVICES

D 4.1 Nursing services may be authorized when a consumer 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.

Nursing services must be performed by or under the direct supervision of an RN. 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 scope of practice and delegated services should be directed to the SD Board of Nursing. Services that are delegated to an unlicensed person will be authorized and reimbursed as personal care.

D 4.2 The Provider must verify, through the South Dakota Board of Nursing, licensure for each newly employed nursing staff who will be providing services to consumers.

The Provider must have a Staffing Policy that specifies the processes for conducting this verification.

D 4.3 The Nursing services to be performed will be specified in the Therap Service Auth and accompanying documents.

D 4.4 The State is not responsible for providing or obtaining the supplies and equipment needed to perform nursing tasks.

D 4.5 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. 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 Specialist will adjust the Care Plan if it is deemed necessary.

D 4.6 The nurse must also retain a copy of all physician's orders in the Consumer's record. It is the nurse's responsibility to maintain routine communication with the Consumer's physician and ensure nursing tasks are completed according to the current physician's order

D 4.7 If the Consumer exhibits any abnormal signs and symptoms during a visit, the Provider will notify the physician, the State, and any other appropriate individuals as necessary within 5 business days. Needs beyond the scope of traditional State nursing services may be provided by the nurse with the authorization of the State after all other resources have been exhausted. It is the responsibility of the nurse to obtain physician's orders for additional services requested by the physician.