ATTACHMENT 1

INTERPRETER SERVICES PROVIDER PROVISIONS

A 1.1. PURPOSE: The South Dakota Department of Human Services, Division of Long Term Services and Supports (State) provides translation/interpretation services to individuals age 60 and older, and age 18 and older who have physical disabilities to allow them to communicate effective.

A 1.2 RULES: The Provider shall comply with all federal laws, rules and regulations, Administrative Rules of South Dakota (ARSD), and South Dakota Codified Laws (SDCL) relative to 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:

Interpreter services are authorized by the Long Term Services and Supports (LTSS) Specialist. The consumer must choose a qualified in-home provider and the LTSS Specialist and in-home 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 in-home provider must contact the Interpreter Service Agency to cancel the visit within four (4) hours of the scheduled visit. If the in-home provider does not cancel the schedule visit, the in-home provider will be responsible for reimbursing the Interpreter Service Agency for the duration of the scheduled visit.

A 1.5 REIMBURSEMENT: All services authorized and delivered by the Provider to eligible consumers will be reimbursed as identified in the Fee Schedule located at http://dhs.sd.gov/ltss/ltssproviders.aspx.

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 review the Therap Service Authorization to ensure the rate is correct prior to acknowledging the Therap Service Authorization. If the rate is incorrect, the Provider must contact the 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 may only bill for services authorized and acknowledged in Therap and delivered by the Provider. Units authorized are a maximum. The Provider must contact the LTSS Specialist if the authorized services routinely take more or less time to complete if additional services or units 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 will not be reimbursed.

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 Pre-Authorization. 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. 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. The Provider may not bill the consumer for any additional fees.

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

STANDARD PROGRAM DEFINITIONS

B 2.1 "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 2.2 "Eligible Consumer" is any person in need of services who has been determined eligible by the State.

B 2.3 "Therap" is the online case management documenting and billing software.

B 2.4 "Therap Service Authorization" is the electronic document in Therap which details the services authorized for the consumer. The Therap Service Authorization must be acknowledged by the Provider within 7 business days of receipt. Failure to acknowledge the Therap Service Authorization within the designated time frame may negatively affect reimbursement for services provided. Any permanent change to the Therap Service Authorization must be reviewed and authorized by the State.

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

STANDARD PROGRAM REQUIREMENTS

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 must implement State fingerprint background checks to screen for convictions of abuse, neglect, or 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 (2) 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 must meet the following minimum standards:

1) Be at least 16 years of age or older;
2) Be employed by an enrolled Medicaid Provider; and
3) Pass a State fingerprint (or State approved) background check.
   a) The following are a list of fitness criteria that would automatically preclude a Translator/Interpreter from being hired/ contracted:
      i) Conviction of a crime of violence as defined by SDCL 22-1-2 or a similar statute from another state;
      ii) Conviction of a sex crime pursuant to SDCL chapters 22-22 or 22-24A or SDCL 22-22A or similar statues from another state; or
      iii) Class A and/or B felony convictions; and
   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; or
      iv) Conviction related to obstruction of a criminal investigation.

C 3.4 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 (6) months. The OIG exclusions database can be found online at https://exclusions.oig.hhs.gov/. The Provider must have a policy that specifies the processes for conducting this verification.

C 3.5 The Provider will assign and begin provision of authorized services within 7 business days of receipt of the Therap Service Authorization. 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 3.6 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 service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

C 3.7 The Provider must have a policy and procedure manual. The policy and procedure manual must be easily accessible upon request.

C 3.8 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 SDCL 22-46 for South Dakota's mandatory reporting laws for elders and adults with disabilities.

C 3.9 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 3.10 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.

The Provider must ensure that each employee receives a minimum of six (6) hours of training annually and must maintain a training record documenting the date, length, and topic of each training completed.

The Provider is responsible for the oversight of staff 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 3.11 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 3.12 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.

C 3.13 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 3.14 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 3.15 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 provisions. 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 provisions statewide.

C 3.16 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 3.17 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 3.18 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 3.19 A copy of all policies must be readily accessible upon request.