

Agreement # _____

Service PO # _____

**STATE OF SOUTH DAKOTA
DEPARTMENT OF HUMAN SERVICES
DIVISION OF LONG TERM SERVICES AND SUPPORTS**

Purchase of Services Agreement
Between

State of South Dakota
Department of Human Services
Division of Long Term Services and Supports
Hillsview Plaza, East Highway 34
c/o 500 East Capitol
Pierre SD 57501-5070

Referred to as Provider

Referred to as State

1. This is a vendor-type contractual agreement for procurement of goods or services. While performing services hereunder, Provider is an independent contractor and not an officer, agent, or employee of the State of South Dakota.
2. DESCRIPTIONS, METHODS AND LOCATIONS OF SERVICES:
 - A. This agreement is made for the purpose of providing in-home services in the counties identified in the In-Home Services Schedule located at <http://dhs.sd.gov/ltss/ltssproviders.aspx>.

Refer to Attachment 1 – In-Home Provider Provisions for individual services being provided.
 - B. Does this Agreement involve Protected Health Information (PHI)? YES (X) NO ()
If PHI is involved, a Business Associate Agreement is attached and is fully incorporated herein as part of the Agreement (see Appendix A).

3. PERIOD OF PERFORMANCE:

This agreement shall be effective as of _____ and shall end on _____, unless sooner terminated pursuant to the terms hereof.

4. BASIS OF AGREEMENT AMOUNTS:

The rate and amount for in-home services are identified in the In-Home Services Schedule located at <http://dhs.sd.gov/ltss/ltssproviders.aspx>.

Provider agrees to submit the Homemaker Cost Report as outlined by the Department of Human Services within four (4) months following the provider's fiscal year end.

This Agreement has no TOTAL AGREEMENT AMOUNT.

5. METHOD AND SOURCE OF PROVIDER PAYMENT:

Provider agrees to submit a completed claim form within six months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist: 1) the claim is an adjustment or void of a previously paid claim and is received within three months after the previously paid claim; 2) the claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal; 3) the claim is received within three months after a previously denied claim; 4) the claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or 5) to correct an error made by the Department.

6. TECHNICAL ASSISTANCE:

The State agrees to provide technical assistance regarding Department of Human Services' rules, regulations and policies to the Provider and to assist in the correction of problem areas identified by the State's monitoring activities.

7. LICENSING AND STANDARD COMPLIANCE:

The Provider agrees to comply in full with all licensing and other standards required by Federal, State, County, City or Tribal statute, regulation or ordinance in which the service and/or care is provided for the duration of this agreement. 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 individuals served is assumed entirely by the Provider.

8. ASSURANCE REQUIREMENTS:

The Provider agrees to abide by all applicable provisions of the following assurances: Byrd Anti Lobbying Amendment (31 USC 1352), Debarment and Suspension (Executive Orders 12549 and 12689 and 2 C.F.R. 180) , Drug-Free Workplace, Executive Order 11246 Equal Employment Opportunity as amended by Executive Order 11375 and implementing

regulations at 41 C.F.R. part 60, Title VI of the Civil Rights Act of 1964, Title VII of the Civil Rights Act of 1968, Section 504 of the Rehabilitation Act of 1973 as amended, Title IX of the Education Amendments of 1972, Drug Abuse Office and Treatment Act of 1972, Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970, Age Discrimination Act of 1975, Americans with Disabilities Act of 1990, Pro-Children Act of 1994, Hatch Act, Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended, Clean Air Act, Federal Water Pollution Control Act, Charitable Choice Provisions and Regulations, Equal Treatment for Faith-Based Religions at Title 28 Code of Federal Regulations Part 38, the Violence Against Women Reauthorization Act of 2013, and American Recovery and Reinvestment Act of 2009, as applicable; and any other nondiscrimination provisions of any other nondiscrimination statute (s) which may apply to the award.

9. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION:

Provider certifies, by signing this agreement, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions by the federal government or any state or local government department or agency. Provider further agrees that it will immediately notify the State, if during the term of this Agreement, the Provider or its principals become subject to debarment, suspension, proposed for debarment, or declared ineligible from participating in transactions by the federal government, or by any state or local government department or agency.

10. OFFICE OF INSPECTOR GENERAL EXCLUSIONARY LIST REQUIREMENTS:

Providers, who utilize federal Medicaid or Medicare funds, agree to screen all employees and contractors, prior to hiring or contracting and on a regular basis, to determine whether any of them are listed on the Office of Inspector General (OIG) List of Excluded Individuals/Entities. Provider shall maintain documentation to support the screenings were performed and shall immediately report to DHS all cases in which employees are found on the exclusionary list. Provider understands that no payment shall be made for any goods or services furnished, ordered, or prescribed by an excluded individual or entity and any payment made for services provided by excluded parties will be recouped; and recoupment may include penalties.

11. RETENTION AND INSPECTION OF RECORDS:

The Provider agrees to maintain or supervise the maintenance of records necessary for the proper and efficient operation of the program, including records and documents regarding applications, determination of eligibility (when applicable), the provision of services, administrative costs, statistical, fiscal, other records, and information necessary for reporting and accountability required by the State. The Provider shall retain such records for six years following termination of the agreement. If such records are under pending audit, the Provider agrees to hold such records for a longer period upon notification from the State. The State, through any authorized representative, will have access to and the right to

examine and copy all records, books, papers or documents related to services rendered under this agreement.

All payments to the Provider by the State are subject to site review and audit as prescribed and carried out by the State. Any over payment of this agreement shall be returned to the State within thirty days after written notification to the Provider.

All reports, recommendations, documents, drawings, plans, specifications, technical data and information, copyrights, patents, licenses, or other products produced as a result of the services rendered under this agreement will become the sole property of the State. The State hereby grants the Provider the unrestricted right to retain copies of and use these materials and the information contained therein in the normal course of the Provider's business for any lawful purpose. Either the originals, or reproducible copies satisfactory to the State, of all technical data, evaluations, reports and other work product of the Provider shall be delivered to the State upon completion or termination of services under this agreement.

12. TERMINATION:

This agreement may be terminated by either party hereto upon thirty (30) days written notice, and may be terminated by the State for cause at any time, with or without notice. On termination of this agreement all accounts and payments shall be processed according to financial arrangements set forth herein for services rendered to date of termination.

13. FUNDING:

This agreement depends upon the continued availability of appropriated funds and expenditure authority from the Legislature for this purpose. If for any reason the Legislature fails to appropriate funds or grant expenditure authority, or funds become unavailable by operation of law or federal funds reduction, this agreement will be terminated by the State. Termination for any of these reasons is not a default by the State nor does it give rise to a claim against the State.

14. AMENDMENTS:

This agreement may not be assigned without the express prior written consent of the State. This agreement may not be amended except in writing, which writing shall be expressly identified as a part hereof, and be signed by an authorized representative of each of the parties hereto.

15. CONTROLLING LAW:

This agreement shall be governed by and construed in accordance with the laws of the State of South Dakota. Any lawsuit pertaining to or affecting this agreement shall be venued in Circuit Court, Sixth Judicial Circuit, Hughes County, South Dakota.

16. SUPERCESSION:

All other prior discussions, communications and representations concerning the subject matter of this agreement are superseded by the terms of this agreement, and except as specifically provided herein, this agreement constitutes the entire agreement with respect to the subject matter hereof.

17. SEVERABILITY:

In the event that any provision of this agreement shall be held unenforceable or invalid by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof.

18. NOTICE:

Any notice or other communication required under this agreement shall be in writing and sent to the address set forth above. Notices shall be given by and to the Division being contracted with on behalf of the State, and by the Provider, or such authorized designees as either party may from time to time designate in writing. Notices or communications to or between the parties shall be deemed to have been delivered when mailed by first class mail, provided that notice of default or termination shall be sent by registered or certified mail, or, if personally delivered, when received by such party.

19. SUBCONTRACTOR:

Provider may not use subcontractors to perform the services described herein without the express prior written consent of the State. Provider will include provisions in its subcontracts requiring its subcontractors to comply with the applicable provisions of this agreement, to indemnify the State, and to have insurance coverage in a manner consistent with this agreement. Provider will cause its subcontractors, agents, and employees to comply with applicable federal, state and local laws, regulations, ordinances, guidelines, permits and requirements and will adopt such review and inspection procedures as are necessary to assure such compliance.

20. HOLD HARMLESS:

The Provider agrees to hold harmless and indemnify the State of South Dakota, its officers, agents and employees, from and against any and all actions, suits, damages, liability or other proceedings which may arise as the result of performing services hereunder. This section does not require the Provider to be responsible for or defend against claims or damages arising solely from errors or omissions of the State, its officers, agents or employees.

21. INSURANCE:

Before beginning work under this agreement, Provider shall furnish the State with properly executed Certificates of Insurance which shall clearly evidence all insurance required in this

agreement and which provide that such insurance may not be canceled except on 30 days prior written notice to the State. Provider shall furnish copies of insurance policies if requested by the State.

a. Commercial General Liability Insurance:

Provider shall maintain occurrence-based commercial general liability insurance or an equivalent form with a limit of not less than \$ 1,000,000.00 for each occurrence. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two times the occurrence limit.

b. Business Automobile Liability Insurance:

Provider shall maintain business automobile liability insurance or an equivalent form with a limit of not less than \$ 500,000.00 for each accident. Such insurance shall include coverage for owned, hired, and non-owned vehicles.

c. Workers' Compensation Insurance:

Provider shall procure and maintain workers' compensation and employers' liability insurance as required by South Dakota law.

d. Professional Liability Insurance:

Provider agrees to procure and maintain professional liability insurance with a limit not less than \$ 1,000,000.00.

22. REPORTING:

Provider agrees to immediately report to the Department any event or incident encountered in the course of performance of this agreement which results in injury to any person or property, or which may otherwise subject Provider, or the State of South Dakota or its officers, agents or employees to liability. Provider shall report any such event to the State immediately upon discovery.

Provider's obligation under this section shall only be to report the occurrence of any event to the State and to make any other report provided for by their duties or applicable law.

Provider's obligation to report shall not require disclosure of any information subject to privilege or confidentiality under law. Reporting to the State under this section shall not excuse or satisfy any obligation of Provider to report any event to law enforcement or other entities under the requirements of any applicable law.

23. CONFLICT OF INTEREST:

Provider agrees to establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal organizational conflict of

interest, or personal gain as contemplated by SDCL 5-18A-17 through 5-18A-17.6. Any potential conflict of interest must be disclosed in writing. In the event of a conflict of interest, the Provider expressly agrees to be bound by the conflict resolution process set forth in SDCL 5-18A-17 through 5-18A-17.6.

24. RESTRICTION OF BOYCOTT OF ISRAEL:

Pursuant Executive Order 2020-01, for providers with five (5) or more employees who enter into an agreement with the State of South Dakota that involves the expenditure of one hundred thousand dollars (\$100,000) or more, by signing this Agreement the Provider certifies and agrees that it has not refused to transact business activities, have not terminated business activities, and has not taken other similar actions intended to limit its commercial relations, related to the subject matter of the agreement, with a person or entity that is either the State of Israel, or a company doing business in or with Israel or authorized by, licensed by, or organized under the laws of the State of Israel to do business, or doing business in the State of Israel, with the specific intent to accomplish a boycott or divestment of Israel in a discriminatory manner. It is understood and agreed that, if this certification is false, such false certification will constitute grounds for the State to terminate this agreement. The Provider further agrees to provide immediate written notice to the State if during the term of the agreement it no longer complies with this certification and agrees such noncompliance may be grounds for contract termination.

25. CONFIDENTIALITY OF INFORMATION:

For the purpose of the sub-paragraph, "State Proprietary Information" shall include all information disclosed to the Provider by the State. Provider acknowledges that it shall have a duty to not disclose any State Proprietary Information to any third person for any reason without the express written permission of a State officer or employee with authority to authorize the disclosure. Provider shall not: (i) disclose any State Proprietary information to any third person unless otherwise specifically allowed under this contract; (ii) make any use of State Proprietary Information except to exercise rights and perform obligations under this contract; (iii) make State Proprietary Information available to any of its employees, officers, agents or consultants except those who have agreed to obligations of confidentiality at least as strict as those set out in this contract and who have a need to know such information. Provider is held to the same standard of care in guarding State Proprietary Information as it applies to its own confidential or proprietary information and materials of a similar nature, and no less than holding State Proprietary Information in the strictest confidence. Provider shall protect confidentiality of the State's Information from the time of receipt to the time that such information is either returned to the State or destroyed to the extent that it cannot be recalled or reproduced. State Proprietary Information shall not include information that (i) was in the public domain at the time it was disclosed to Provider; (ii) was known to Provider without restriction at the time of disclosure from the State; (iii) that is disclosed with the prior written approval of the State's officers or employees having authority to disclose such information; (iv) was independently developed by Provider without the benefit of influence of the State's information; (v) becomes known to provider without restriction from a source not connected to the State of South Dakota. State's proprietary Information

shall include names, social security numbers, employer numbers, addresses and all other data about applicants, employers or other clients to whom the State provides services of any kind. Provider understands that this information is confidential and protected under applicable State law at SDCL 1-27-1.5, modified by 1-27-1.6, SDCL 1-36A-27, SDCL 27B-7-30, SDCL 27B-8-46, SDCL 27B-8-47, SDCL 27B-8-48, and SDCL 27B-8-49, as applicable, federal regulation and agrees to immediately notify the State of the information disclosure, either intentionally or inadvertently. The parties mutually agree that neither of them shall disclose the contents of the agreement except as required by applicable law or as necessary to carry out the terms of the agreement or to enforce that party's rights under this agreement. Provider acknowledges that the state and its agencies are public entities and thus bound by the South Dakota open meetings and open records laws. It is therefore not a breach of this contract for the State to take any action that the State reasonably believes is necessary to comply with the South Dakota open records or open meetings laws, including but not limited to posting this Agreement on the State's website. If work assignments performed in the course of this agreement require additional security requirements or clearance, the Provider will be required to undergo investigation.

Provider acknowledges that the State shares general information, including performance information, about Provider among and between other State agencies upon request of such agencies for the purpose of making determinations of the risk involved with potential, subsequent awards and for other purposes. Provider expressly consents and agrees to such uses by the State.

26. AUDIT REQUIREMENTS:

If the total of all Department of Human Service funding is greater than \$750,000 during the Provider's fiscal year, the Provider agrees to submit to the State a copy of an annual entity-wide, independent financial audit. The audit shall be completed and filed with the Department of Human Services by the end of the fourth month following the end of the fiscal year being audited or 30 days after receipt of the auditor's report, whichever is earlier. The audit should be sent to:

Department of Human Services
Provider Reimbursements and Grants
3800 East Highway 34
c/o 500 East Capitol
Pierre, SD 57501

If federal funds of \$750,000 or more have been received by the Provider the audit shall be conducted in accordance with OMB Uniform Guidance 2 CFR Chapter I, Chapter II, Part 200, et al Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards by an auditor approved by the Auditor General to perform the audit. On continuing audit engagements, the Auditor General's approval should be obtained annually. Audits shall be completed and filed with the Department of Legislative Audit by the end of the fourth month following the end of the fiscal year being audited or 30 days after receipt

of the Auditor's report, whichever is earlier. For a Uniform Guidance audit, approval must be obtained by forwarding a copy of the audit engagement letter to:

Department of Legislative Audit
427 South Chapelle
% 500 East Capitol
Pierre, SD 57501-5070

For either an entity-wide, independent financial audit or a Uniform Guidance audit, the Provider assures resolution of all interim audit findings. The Provider shall facilitate and aid any such reviews, examinations, agreed upon procedures etc., the Department or its' contractor(s)/subrecipient(s) may perform.

Failure to complete audit(s) as required will result in the disallowance of audit costs as direct or indirect charges to programs. Additionally, a percentage of awards may be withheld, overhead costs may be disallowed, and/or awards may be suspended, until the audit is completely satisfied.

27. AUTHORIZED SIGNATURES: In witness hereto, the parties signify their agreement by affixing their signatures hereto.

_____	_____
Provider Signature	Date
_____	_____
State - DHS Division Director	Date
_____	_____
State - DHS Office of Budget and Finance	Date
_____	_____
State - Office of the Secretary	Date

This template is approved as to form:

/s/Carole J. Boos 01/24/2020

Special Assistant Attorney General

Final agreement reviewed and recommendations made to Secretary.

Do sign recommendation: _____

Contract Description Code _____

State Agency Coding: _____

	Homemaker			
CFDA Number	03-003	_____	_____	_____
Company	1000	2003	3091	_____
Account	52060130	52060130	52060130	_____
Center Req	1920200	1920200	1920200	_____
Center User	08333	08302	83401	_____
Dollar Total	_____	_____	_____	_____
SVC PO Code	3111	3110	3112	_____
	PC 03-004			
Company	1000	2003	3091	_____
Account	52060130	52060130	52060130	_____
Center Req	1920200	1920200	1920200	_____
Center User	08333	08302	83401	_____
Dollar Total	_____	_____	_____	_____
SVC PO Code	3111	3110	3112	_____
	Nursing 08-093			
Company	1000	2003	_____	_____
Account	52060150	5260150	_____	_____
Center Req	1920200	1920200	_____	_____
Center User	08306	08301	_____	_____
Dollar Total	_____	_____	_____	_____
SVC PO Code	3215	3216	_____	_____

DHS Program Contact Person Misty Black Bear
 Phone (605) 773-4405

DHS Fiscal Contact Person Alan Fickbohm
 Phone (605) 773-5990

Provider Program Contact Person _____
 Phone _____

Provider Fiscal Contact Person _____
 Phone _____

Agreement# _____
 PO# _____
 Vendor # _____
 Group _____

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Appendix A HIPAA Business Associate Agreement

A. Definitions of Terms

1. Agreement means the agreement to which this Business Associate Agreement is attached to including this attachment entitled HIPAA Business Associate Agreement.

2. Business Associate shall have the meaning given to such term in 45 C.F.R. section 160.103 and 42 U.S.C. section 17938, and in reference to the party of this agreement, shall mean the Provider, Consultant, or other entity contracting with the State of South Dakota, Department of Human Services as set forth more fully in the Agreement this Business Associate Agreement is attached.

3. C.F.R. shall mean the Code of Federal Regulations.

4. Department shall mean South Dakota Department of Human Services

5. Designated Record Set shall have the meaning given to such term in 45 C.F.R. section 164.501.

6. Covered Entity shall have the meaning given to such term in 45 C.F.R. section 160.103, and in reference to the party to this agreement, shall mean South Dakota Department of Human Services.

7. Protected Health Information or PHI shall have the meaning given to such term in 45 C.F.R. section 164.103 and section 164.501, and is limited to the Protected Health Information received from, or received or created on behalf of Covered Entity by Business Associate pursuant to performance of the Services under the Agreement.

8. Regulations shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and 164, Subparts A and C, 45 CFR 164.314, and as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) §§ 13400-13424, 42 U.S.C. §§ 17921-17954 (2009) as it directly applies, as in effect on the date of this Business Associate Agreement.

B. Obligations of the Business Associate.

1. Security Safeguards. The Business Associate shall implement a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized use or

disclosure of PHI, and that reasonably protect the confidentiality, integrity, and availability of any electronic Protected Health Information that it creates, receives, maintains or transmits to or on behalf of Covered Entity as required by the Regulations. The Business Associate agrees to comply with the requirements of the Privacy and Security Rules directly applicable to Business Associates including the HITECH Act.

2. Affiliates, Agents, Subsidiaries and Sub-Contractors. The Business Associate shall require that any agents, employees, affiliates, subsidiaries or sub-contractors, to whom it provides PHI received from, or created or received by the Business Associate on behalf of the Department agree in writing to the same use and disclosure restrictions imposed on the Business Associate by this Agreement.

3. Reporting and Mitigating Unauthorized Uses and Disclosures of PHI. Immediately upon notice to the Business Associate, the Business Associate shall report to the Department any uses or disclosures of PHI not authorized by this Agreement. The Business Associate shall also notify the affected individual of the breach. If the breach affects more than 500 individuals, the Business Associate must contact the U.S. Health and Human Services Secretary and the media, under the American Recovery and Reinvestment Act of 2009. The Business Associate shall use its best efforts to mitigate the deleterious effects of any use or disclosure of PHI not authorized by this Agreement. Further, in the notice provided to the Department by the Business Associate regarding unauthorized uses and/or disclosures of PHI, the Business Associate shall describe the remedial or other actions undertaken or proposed to be undertaken regarding the unauthorized use or disclosure of PHI.

4. Permitted Uses and Disclosures. The Business Associate may not use or disclose PHI received or created pursuant to this Agreement except as follows:

(a) The Business Associate's Operations – Permitted Uses of PHI. The Business Associate may use the PHI it receives in its capacity for the proper management and administration of the Business Associate or to carry out the Business Associate's legal responsibilities.

(b) The Business Associate's Operations – Permitted Disclosures of PHI. The Business Associate may disclose the PHI it obtains in its capacity as a Business Associate if such disclosure is necessary for the Business Associate's proper management and administration or to carry out the Business Associate's legal responsibilities, and:

(i) The disclosure is required by law; or

(ii) The Business Associate obtains reasonable assurances from the person or entity to whom the PHI is disclosed that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person or entity notifies the Business Associate (and the

Business Associate in turn notifies the Department) of any instances of which it is aware in which the confidentiality of the PHI has been breached.

5. Disclosure Accounting. In the event that the Business Associate makes any disclosures of PHI related to the business associate function under this Agreement that are subject to the accounting requirements of 45 C.F.R. section 164.528, the Business Associate promptly shall maintain a record of each disclosure, including the date of the disclosure, the name and if available, the address of the recipient of the PHI, a brief description of the PHI disclosed and a brief description of the purpose of the disclosure. The Business Associate shall maintain this record for a period of six (6) years and make available to the Department upon request in an electronic format so that the Department may meet its disclosure accounting obligations under 45 C.F.R. section 164.528.

6. Access to PHI by Individuals. The Business Associate shall cooperate with the Department to fulfill all requests by individuals for access to the individual's PHI that are approved by the Department. The Business Associate shall cooperate with the Department in all respects necessary for the Department to comply with 45 C.F.R. section 164.524. If the Business Associate receives a request from an individual for access to PHI that affects funding eligibility, the Business Associate immediately shall forward such request to the Department within (10) business days. The Department shall be solely responsible for determining the scope of PHI and Designated Record Set to be released with respect to each request by an individual to access or obtain copies of the individual's PHI covered by this Agreement and in accordance with C.F.R. 164.524. The Business Associate shall make the PHI available in the format requested by the individual and approved by the Department, unless the PHI is not readily producible in such format, in which case the PHI shall be produced in hard copy format.

7. Access by the Department to the Business Associate's Books and Records. The Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of the Department available to the Department and the Secretary of the Department of Health and Human Services for purposes of determining the Department's compliance with the HIPAA laws and regulations. Upon reasonable notice to the Business Associate and during the Business Associate's normal business hours, the Business Associate shall make such internal practices, books and records available to the Department to inspect for purposes of determining compliance with this Agreement.

8. Amendment of PHI. As directed and in accordance with the time frames specified by the Department, the Business Associate shall incorporate all amendments to PHI received from the Department. The Business Associate shall provide written notice to the Department within ten (10) business days confirming that the Business Associate has made the amendments to PHI as directed by the Department. This confirmation shall also contain any other information that may be necessary for the Department to provide adequate notice to the individual in accordance with 45 C.F.R., section 164.526. The Department warrants that all time frames specified will be made in good faith and reasonable length so that the Business Associate can comply with the timeframe.

C. Obligations of the Department

1. The Department shall notify Business Associate of any limitation(s) in its notice of privacy practices of the Department in accordance with 45 CFR 164.520 to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

2. The Department shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI to the extent that such changes may affect Business Associates use or disclosure of PHI.

3. The Department shall notify Business Associate of any restriction to use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR 164.522 to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. Term and Termination.

1. Term. The term of this Agreement shall be effective as of and shall terminate on the dates set forth in the primary Agreement this Business Associate Agreement is attached to or on the date the primary Agreement terminates, whichever is sooner

2. Termination by Breach. The Department may immediately terminate the primary Agreement this Business Associate Agreement is attached to if the Business Associate has breached a material term of this Business Associate Agreement. Alternatively, the department may choose to

(i) provide Business Associate with five (5) days written notice of the existence of an alleged material breach; and

(ii) afford Business Associate an opportunity to cure said alleged material breach to the satisfaction of Department within five (5) days.

Business Associate's failure to cure shall be grounds for immediate termination of the primary Agreement to which the Business Associate Agreement is attached. Department's remedies under this Agreement are cumulative, and the exercise of any remedy shall not preclude the exercise of any other. However, in the event that the Department determines that termination of the Agreement is not feasible, the Department shall have the right to report the breach to the Secretary of the Department of Health and Human Services, notwithstanding any other provisions of this Agreement to the contrary.

3. Effects of Termination; Disposal of PHI. Upon termination of the primary Agreement to which this Business Associate Agreement is attached, the Business Associate shall recover all PHI that is in the possession of the Business Associate's agents, affiliates, subsidiaries or sub-contractors. The Business Associate shall return to the Department or destroy all PHI that the Business Associate obtained or maintained

pursuant to this Agreement on behalf of the Department. If the parties agree at that time that the return or destruction of PHI is not feasible, the Business Associate shall extend the protections provided under this Agreement to such PHI, and limit further use or disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible. If the parties agree at the time of termination of this Agreement that it is infeasible for the Business Associate to recover all PHI in the possession of the Business Associate's agents, affiliates, subsidiaries or sub-contractors, the Business Associate shall provide written notice to the Department regarding the nature of the unfeasibility and the Business Associate shall require that its agents, affiliates, subsidiaries and sub-contractors agree to the extension of all protections, limitations and restrictions required of the Business Associate hereunder.

E. Miscellaneous.

1. The Business Associate's Compliance with HIPAA. The Department makes no warranty or representation that compliance by the Business Associate with this Agreement, HIPAA or the HIPAA regulations will be adequate or satisfactory for the Business Associate's own purposes or that any information in the Business Associate's possession or control, or transmitted or received by the Business Associate, is or will be secure from unauthorized use or disclosure. The Business Associate is solely responsible for all decisions made by the Business Associate regarding the safeguarding of PHI.

2. Change in Law. In the event that there are subsequent changes or clarifications of statutes, regulations or rules relating to this Agreement, the Department shall notify the Business Associate of any actions it reasonably deems are necessary to comply with such changes, and the Business Associate promptly shall take such actions. In the event that there shall be a change in the federal or state laws, rules or regulations, or any interpretation or any such law, rule, regulation or general instructions which may render any of the material terms of this Agreement unlawful or unenforceable, or materially affects the financial arrangement contained in this Agreement, the Business Associate may, by providing advanced written notice, propose an amendment to this Agreement addressing such issues.

3. Assignment/Subcontracting. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. The Business Associate may not assign or subcontract the rights or obligations under this Agreement without the express written consent of the Department. The Department may assign its rights and obligations under this Agreement to any successor or affiliated entity.

4. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

5. Assistance in Litigation or Administrative Proceedings. The Business Associate shall make itself and any agents, affiliates, subsidiaries, sub-contractors or employees assisting the Business Associate in the fulfillment of its obligations under this Agreement, available to the Department, at no cost to the Department, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings resulting from the performance of this Agreement being commenced against the Department, its directors, officers, or employees, except where the Business Associate or its agents, affiliates, subsidiaries, sub-contractors or employees are a named adverse party.

The Department shall make itself and any agents, affiliates, subsidiaries, sub-contractors or employees assisting the Department in the fulfillment of its obligations under this Agreement, available to the Business Associate, at no cost to the Business Associate, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings resulting from the performance of this Agreement being commenced against the Business Associate, its directors, officers, or employees, except where the Department or its agents, affiliates, subsidiaries, sub-contractors or employees are a named adverse party.

6. Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA rules.

7. Conflicts. In the event of a conflict in between the terms of this Business Associate Agreement and the primary Agreement to which Business Associate Agreement is attached, the terms of this Business Associate Agreement shall prevail to the extent such an interpretation ensures compliance with the HIPAA Rules.

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.

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 Long Term Services and Supports (LTSS) Specialist if the authorized services routinely take more or less time to complete than indicated in the Therap Pre 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 Long Term Services and Supports Specialist (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 Pre 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 Pre 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 Pre 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 the State.

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 Pre 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 Pre 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 "Authorization for Services" Therap Pre 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 Pre Auth" and accompanying documents.

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

B 2.11 "Therap Pre Auth" is the electronic document in Therap which details the services authorized for the consumer. The Therap Pre Auth must be acknowledged by the Provider within 7 business days of receipt. Failure to acknowledge the "Therap Pre Auth" within the designated time frame may negatively affect reimbursement for services provided. Any permanent change to the "Therap Pre Auth" must be reviewed and authorized by the State.

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 18 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 either automatically preclude a Personal Care Attendant from being hired, or would be reviewed further to determine situational conditions and whether enrollment should be allowed:
 - 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. Within the preceding five years, a conviction for any other felony;
 - iv. Misdemeanor convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
 - v. 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.
 - vi. 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 Pre 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.

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 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**. 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

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 “Authorization for Services” Therap Pre 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 Following the initial nursing visit, the State may utilize the nurse’s professional assessment 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.