The transition period for HCBS compliance is for currently operating settings only. New settings are required to be fully HCBS compliant prior to providing Medicaid HCBS. **New settings are NOT eligible for a transition period to demonstrate compliance.**

HCBS Provider Self-Assessment Overview

Part 1:
Gather general provider information and demographics including:

- Provider Business Name and Business Address
- Provider Number
- Contact name, title, email and phone number

New HCBS setting being assessed:

A series of questions designed to determine organizational and systemic approach to compliance with HCBS settings requirements.

- Submission of written evidence to support narrative responses to questions is required. Evidence for Part 1 should be copied/scanned and saved as a PDF document and submitted with the self-assessment narrative responses.

Part 2:
Provide general provider information about the setting:

- Setting Address
- Service provided and number served
- Contact name, title, email and phone number

A series of questions designed to demonstrate the approach and practices that will be implemented to integrate HCBS requirements into daily operations and individualized services.

- Submission of written evidence (i.e.: policies, photos, etc.) to support narrative responses to questions is required.
- Evidence for Part 2 should be copied/scanned and saved as a PDF document and submitted with the self-assessment narrative responses.

HCBS Provider Self-Assessment for ADHC Services

INSTRUCTIONS:

Providers of Medicaid HCBS must assess their level of compliance with the Centers for Medicare & Medicaid Services (CMS) HCBS settings requirements.

Providers must respond to each question. Responses must include a narrative response and, as appropriate, written evidence to validate compliance. The types of documentation that will be deemed

acceptable evidence to demonstrate compliance include, but are not limited to, the following:

- Provider Policies and Procedures
- Participant Handbook
- Staff Training Curriculum
- Training Schedules
- Activity Schedules
- Menus
- Person Centered Service Plan
- Pictures
- Google Map of service location
- Individual and Family Survey Results
- Documentation Records
- Forms
- Meeting Agendas/Minutes

Settings not in full compliance with the CMS HCBS settings requirements will need to remediate areas of non-compliance prior to providing Medicaid ADHC services.

NOTE: Please review the self-assessment companion guide. The companion guide is intended to be a side by side tool that providers use when completing the self-assessment.

HCBS Self-Assessment Part 1

* Provider Information:

Organization Name:
Address:
Address 2:
City/Town:
State/Province:
ZIP/Postal Code:

All NPI/API numbers associated with HCBS services being billed:

* Contact Person/Responsible for completing assessment:

Name:
Title:
Email:
Phone Number:

Part 1: Response to the questions, and evidence submitted, should reflect your organization's approach for ensuring compliance with HCBS settings requirements.

Questions:

1. Is the new setting in which HCBS will be provided located in a building that is also a publically or privately operated facility that provides inpatient institutional treatment (e.g. NF, IMD, ICF/IID, hospital)?

☐Yes ☐No

If you replied, "Yes" provide a description of the setting:

2. Is the new settings in which HCBS will be provided located in a building on the grounds of, or immediately adjacent to a public institution? Refer to Self-Assessment Companion Document for additional information.

☐Yes ☐No

If you replied, "Yes" provide a description of the setting:

3. Is the new settings in which HCBS will be provided in a gated/secure "community" solely for people with disabilities?

☐Yes ☐No

If you replied, "Yes" provide a description of the setting:

4. Is the new setting in which HCBS will be provided co-located and/or clustered on a street or property?

☐Yes ☐No

If you replied, "Yes" provide a description of the setting:

5. Is the new setting in which HCBS will be provided located in a farmstead community for people with disabilities? Refer to Self-Assessment Companion Document for additional information.

☐Yes ☐No

If you replied, "Yes" provide a description of the setting:

6. Do you have policies outlining the HCBS specific rights of individuals receiving services?

☐Yes ☐No

If you replied, "Yes" list the policies that are being provided as evidence.

Provide Evidence:

7. Do paid staff and volunteers receive training and education on the rights of individuals receiving HCBS and member experience as outlined in HCBS rules?

☐Yes ☐No

(Describe your process for staff training and education on individual's rights and experience as outlined in HCBS rules):

Provide Evidence:

8. As a provider of Medicaid HCBS, how will you ensure freedom from coercion and restraint?

(Provide a brief overview of your process and/or policy and identify your evidence of compliance):

Provide Evidence:

9. Does the person centered service planning process ensure individuals' choices and preferences are honored and respected?

☐Yes ☐No

(Describe how your organization ensures individuals' choices and preferences are honored and respected):

Provide Evidence:

HCBS Self-Assessment Part 2

10. Will individuals have the opportunity to regularly access the community as part of their service? If yes, please provide a brief overview, including the frequency of the opportunities to access/integrate within the community, and identify your evidence of compliance.

☐Yes or ☐No

(Describe how individuals become aware of activities outside of the setting and regularly access the community as part of their service):

Provide Evidence:

11. Are policies outlining the HCBS rights for the individuals receiving the services and also available to staff and volunteers?

☐Yes or ☐ No

(Please provide a brief overview of how those policies are made available):

Provide Evidence:

12. How are relationships with community members/people <u>not</u> receiving Medicaid HCBS fostered?

☐Yes or ☐ No

(Please describe how and provide specific examples):

Provide Evidence:

13. Will individuals receiving services, or a person of their choosing, have an active role in the development and update of their person-centered plan of care? In other words, will Medicaid and non-Medicaid members be able to participate in the same activities together?

☐Yes or ☐ No

(Please provide a brief overview, and evidence that the individual has an active role in development of the plan of care, and identify your evidence of compliance):

Provide Evidence:

14. Does/will the ADHC setting have partnerships with other community organizations and volunteers?

☐ Yes or ☐ No

(Please provide specific examples):

Provide Evidence:

15. Will individuals have access to materials and/or resources to become aware of activities occurring outside the setting? How will individuals access information for community outings and events? Examples include: brochures, calendar of events, information board, internet access, sign-up sheets for community activities, etc.

☐ Yes or ☐ No

(Please describe how and provide specific examples):

Provide Evidence:

16. Will the individuals have the ability to choose their activities and menu options? Examples: provide a copy of the monthly activity calendar, and copy of a monthly lunch/snack menu with alternative options listed for both the activity calendar and the menu.

Provide Evidence: