

TN Non-Residential Provider Self-Assessment

In January 2014, the Centers for Medicare and Medicaid Services (CMS) announced a requirement for states to review and evaluate current Home and Community-Based Services (HCBS) Settings, including residential and non-residential settings, and to demonstrate compliance with the new federal HCBS Setting rules that went into effect March 17, 2014. These rules were developed to ensure that individuals receiving long-term services and supports through HCBS programs under Medicaid waiver authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. The following self-assessment is designed to measure HCBS providers' current level of compliance with these HCBS Setting rules and provide a framework for assisting those providers with the necessary steps to compliance.

Instructions:

1. Providers must complete a self-assessment for EACH setting which they own, co-own, and/or operate.
2. Providers must demonstrate compliance with HCBS setting rules by providing evidence that policies and procedures are in place and regularly assessed for effectiveness AND made available to individuals receiving services. The following self-assessment contains a set of questions designed to measure each provider's level of compliance with HCBS rules. The following sections include a series of Yes/No questions and requests for documentation, or evidence, to (1) demonstrate current level of compliance or (2) submit a plan and timeline for reaching compliance.
3. Documentation that will be deemed acceptable evidence to demonstrate compliance includes, but is not limited to:
 - Advisory Council/ Committee Assessment
 - Provider Policies/ Procedures
 - Recipient Handbook
 - Staff training curriculum
 - Training Schedules
4. For every YES response you must provide evidence to support compliance. For every NO response you must address in your transition plan and include timeline for meeting compliance.
5. The Provider Self-Assessment Cross Walk (template provided separately) must be attached and must reference evidence for every YES response.

Remember: As you assess your agency's compliance with the HCBS Setting Rule, think not only about the setting itself, but whether or not compliance with the rule is applied to each individual served.

Before beginning your self-assessment process, please indicate if you intend to meet all HCBS Setting Rule compliance requirements:

Select a Choice YES/NO

If YES, please continue beginning with Section A below.

If NO, please enter the total number of individuals served through Medicaid HCBS that will need to be transitioned to another provider:

Note: Questions in this document followed by an asterisk (*) indicate that there are instructions that accompany these sections to provide guidance for completing the self-assessment. Please see Attachment A, which immediately follows the Section B questions, to view the instructions. The same instructions appear in the Wufoo portal when you hover over a question with your mouse pointer.

Section A - Provider Information
Please select HCBS Provider type*
Number of people served*
Name and 'Role' of Stakeholder Group*
Methodology for Completing Self-Assessment*

Section B		
<i>Demonstrate that the setting has access to integrated community living in which individuals' abilities to interact with the broader community are not limited</i>		
Physical Location	YES/NO	Required Evidence of Compliance with HCBS rules
1. The service setting is NOT located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment (a NF, IMD, ICF/IID, hospital)?*		
2. The service setting is NOT located in a building on the grounds of, or immediately adjacent to, a public institution?*		

3. The provider does NOT own or operate multiple locations on the same street?*		
4. The service setting is NOT in a gated/secured 'community' for people with disabilities?*		
5. The service setting is NOT located in a farmstead or disability-specific community?*		
6. The setting is NOT located in the same building as an educational program or school?		
7. The service setting is NOT designed specifically for people with disabilities?*		
8. Individuals who participate in services are NOT primarily or exclusively people with disabilities?*		
9. Does the provider provide options for community integration and utilization of community services in lieu of onsite services (including medical, behavioral, therapeutic or recreational services that may be offered on site)?		

Community Integration	YES/NO	Required Evidence of Compliance with HCBS rules
10. Do individuals shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as they choose?		
11. Does the individual regularly access the community and is he or she able to describe how he or she accesses the community, who assists in facilitating the activity and where he or she goes?		

12. Are individuals aware of or do they have access to materials to become aware of activities occurring outside of the setting?		
13. Are individuals able to come and go at any time?		
14. Do individuals talk about activities occurring outside of the setting?		

Policy Enforcement	YES/NO	Required Evidence of Compliance with HCBS rules
15. Do paid and unpaid staff receive new hire training and continuing education related to the rights of individuals receiving services and member experience as outlined in HCBS rules?		
16. Are provider policies outlining rights of individuals receiving services and member experience made available to individuals receiving services?		
17. Are provider policies on member experience and HCBS rules regularly reassessed for compliance and effectiveness and amended, as necessary?		

ATTACHMENT A

Instructions

The following sections contain instructions to provide guidance for completing the self-assessment. Each instruction is preceded by a short description of the corresponding question from Section A or B above.

Section A	
Section A Question	Instruction
Please select HCBS Provider type	Select ONLY ONE provider type per assessment.
Number of people served	Enter the total number of people served in the setting that is included in this self-assessment. Include only those for whom you receive Medicaid HCBS reimbursement.
Name and Role of Stakeholder Group	<p>For purposes of this self-assessment, 'Role' is defined as consumer, family member, agency staff (including executive and DSP staff), ISC/Care Coordinator/Case Manager and community advocate. Each provider is required to conduct self-assessment activities with a stakeholder group that includes consumers, family members, agency staff, a service coordinator and an advocate from an advocacy organization not directly affiliated with the provider agency.</p> <p>In this section, enter the first and last names, and role (consumer, family member, DSP, etc) of each stakeholder involved in your self-assessment process.</p>
Methodology for Completing Self-Assessment	In this section, please describe your agency's approach to completing the self-assessment process. For example, how did you determine the persons selected to represent the required roles of the stakeholder group? Did you convene meetings or conference calls? Was each member of the stakeholder group provided with a copy of the self-assessment tool? Who was responsible for which aspects of the self-assessment? How did you get to unanimous agreement on results of the self-assessment before submission?

Section B	
Section B Question	Instruction
Question 1	A YES response indicates agreement with the statement.
Question 2	A YES response indicates agreement with the statement.
Question 3	A YES response indicates this statement is true of the service setting(s) you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were the settings grouped together at request of individuals served, were individuals able to choose to participate in services at this setting from other options made available to them, does participation in services at this setting prohibit individuals from being integrated in their community?
Question 4	A YES response indicates this statement is true of the service setting(s) you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them, does participation in services at this setting prohibit individuals from being integrated in their community?
Question 5	A YES response indicates this statement is true of the service setting(s) you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them, does participation in services at this setting prohibit individuals from being integrated in their community?

Question 7	A YES response indicates this statement is true of the service setting(s) you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them, does participation in services at this setting prohibit individuals from being integrated in their community?
Question 8	A YES response indicates this statement is true of the service setting(s) you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them, does participation in services at this setting prohibit individuals from being integrated in their community?