Missouri Medicaid Audit and Compliance (MMAC)

Home and Community Based Setting Requirement

Annual Provider Self-Assessment

The Centers for Medicare & Medicaid Services (CMS) published a final rule to enhance the quality of Home and Community-Based Services (HCBS) and to provide protections for participants. **The rule, or "setting requirements" makes sure individuals receiving HCBS have full access to the benefits of community living and have the opportunity to receive services in the most integrated and still appropriate type of setting.**

Missouri, like other states, will assess the HCBS programs, and the rules and regulations that govern the programs, to ensure services are delivered in settings that meet the new requirements.

Missouri Medicaid Audit and Compliance (MMAC) requires all heightened scrutiny providers (adult day care and AIDS Waiver facilities) to complete a self- assessment (see below). The HCBS Settings Self-Assessment form, Assurance form and training will be required annually.

You may complete this self-assessment fill-in form in Adobe. You may also print and complete the assessment by hand. Once completed, please sign in the signature box at the top of the form. Scan the assessment form and send as an email attachment to mmac.hcbssettings@dss.mo.gov.

Providers that do not appear to have become compliant, or when there is a reason to believe they are not compliant are subject to review and will also be notified of future consequences. If a provider fails to become compliant, sanctions may be imposed according to 13 CSR 70-3.030.

The entire **Transition Plan** is available to view and increase familiarity with these requirements. Please submit any questions to mmac.hcbssettings@dss.mo.gov.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

HCBS Settings – Provider Self-Assessment

Provider Name:	**Date completed:**
Signature of person completing the form: electronic signatures not accepted	**Printed name of person completing form:**
Setting Address:	**NPI**:
Contact person email address:	**Average Daily Number of Participants:**
Setting Type (circle all that apply): Adult Day Care / AIDS Waiver	

Setting requirement	**Yes**	**No**	**Not Yet**	**N/A**	**If No or N/A, please describe why the requirement is not applicable or NO to your setting or location. If Not Yet, please describe the steps you are taking in order for it to be applicable AND the date they will be implemented.**
1. Do participants have the freedom to have snacks at their preferred time?					
2. Do participants have optional meal choices/menu choices?					
	Yes	**No**	**NY**	**N/A**	
3. Are there a variety of activities to fulfill various needs and goals?					
4. Are outside activities provided for the participants?					
5. Are there individual, small group, and large group activities?					
6. Are the activities matched to the participant's individual skills, abilities, and desires?					
7. Is information available to participants regarding activities in the community?					
8. Do participants know they do not have to adhere to a set schedule for eating, activities, etc.?					

	Yes	No	NY	N/A	
9. Does your setting develop individual plans for participants?					
10. Do the plans address physical, social, and psychological needs and goals?					
11. Does the setting provide an opportunity to restore optimal capability?					
12. Do personnel ask the participants about their needs and preferences?					
13. Are participants' schedules flexible so they can receive other types of HCBS services during the same day that they're at the ADC?					
14. Are the participants in charge of managing their own schedules?					
15. Do participants' schedules vary?					
	Yes	**No**	**NY**	**N/A**	
16. Do you encourage outside visitors/ people from the greater community?					
17. Is there evidence that visitors are present on a regular basis? (Written visitor policy and/or maintain a separate visitor log?)					
18. Are participants allowed visitors any time?					
19. Are Medicaid participants fully integrated with non-Medicaid participants?					
20. Do the Medicaid participants have access to all the same services and amenities as non-Medicaid participants?					

	Yes	No	NY	N/A	
21. Is your location near other residential buildings, private businesses, retail businesses, restaurants, doctor's offices, etc.?					
22. Do participants receive or have access to information about shopping, religious services, medical appointments, dining out, etc., outside of the ADC?					
23. Can participants access employment opportunity information about work opportunities in the community?					
24. Do the participants have access to public transportation and the phone numbers?					
	Yes	**No**	**NY**	**N/A**	
25. Are participants able to ask for help/assistance throughout the day?					
26. Are participants treated with dignity and respect?					
27. Do your personnel assist participants who need help with personal appearance, and is this done privately?					
28. Do you have practices in place to ensure that staff members refrain from discussing participants with other staff or individuals while the participant is present, treating them as if they were not there?					
29. Do participants/guardians have access to easily understandable information about filing a complaint?					
30. Can the participant/guardian complaints be anonymous?					
31. Do the participants/guardians know how to request a new provider?					

32. Are the procedures on how to make complaints or change providers posted anywhere in the facility?					
	Yes	**No**	**NY**	**N/A**	
33. Is there a secure location for participants to store personal belongings?					
34. Is health information kept private?					
35. Are medication schedules kept private?					
36. For participants who need help moving about, are there supports such as grab bars, seats in the bathroom, ramps for wheelchairs, viable exits for emergencies, etc.?					

Please double check to make sure that ALL questions have been answered. If you checked a box for "No", "Not Yet" or "N/A" be sure you have included the explanation as to why you checked that box. You are encouraged to supply additional pages if there is not enough room on the sheet.

At this time we do not have the capability for you to submit the assessment on-line. Please sign the completed assessment, scan, and email to MMAC at mmac.hcbssettings@dss.mo.gov or fax it to 573-634-3105. If you have further questions, please contact MMAC via email at mmac.hcbssettings@dss.mo.gov or by phone at 573-751-3399.