Changes made to the Nevada Transition Plan in response to e-mail from CMS dated November 7, 2016.

The Centers for Medicare and Medicaid Services (CMS) requested additional detail be included in the State Transition Plan amendment regarding Public Comment component, Settings, Systemic Assessment and the Systemic Remediation. The State of Nevada reviewed each area of concern and question and has updated the State Transition Plan accordingly. The following adjustments have been included in the April 13, 2017 State Transition Plan revision:

**Public Comment:**
- Clarification was provided that the State Transition Plan in its entirety was open for Public Comment.
- The State has ensured that all Public Comment to date has been included in the revised State Transition Plan.

**Settings:**
- The settings have been reviewed and amended as appropriate.
- Duplication of Assisted Living Facilities, and Social Adult Day Care has been removed and assured that it is incorporated into the different sections of the State Transition Plan for consistency. This information was called out separately within the State Transition Plan and was found to not be necessary as a separate section.
- Incorporated Home Based Habilitation Providers
- The STP has been amended to include the term Community Care Facility as part of the definition of Assisted Living Services as referenced in the HCBS Waiver for Persons with Physical Disabilities. In addition, the term Assisted Living has been included under Augmented Personal Care as part of the definition under the HCBS Waiver for the Frail Elderly.

**Regulatory Assessments:**
- The State has combined the areas that are based on a Nursing Facility Level of Care and the areas that are based on an Intermediate Care Facility for Individuals with Intellectual Disabilities Level of Care based on an example provided from the State of Ohio.
- The State has amended the crosswalk to include clarifying language from the NRS, NAC and Waiver Application and Medicaid Services Manual to provide additional support of the various regulations.
Introduction and Summary

The Centers for Medicare and Medicaid Services (CMS) issued new regulations in early 2014 that define the home and community based settings that will be allowable under HCBS. The purpose of these regulations is to ensure that individuals receiving HCBS are fully integrated into the community in which they live. These individuals must be offered opportunities to seek employment and engage in community activities in the same manner as individuals who do not receive HCBS.

CMS defines this regulation as, “a setting which is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.”

This rule was published in January 2014 and became effective March 17, 2014. States have until March 17, 2015 to provide a transition plan which includes an assessment of the state’s current settings, proposed changes to settings, and public comment.

Initial Meetings, Public Workshops, Dissemination of Information, and Settings Assessment

Nevada began by holding internal meetings across multiple state agencies in order for State staff to understand the regulation in its entirety and how the regulation may or may not affect current HCBS within home and community based waiver programs as well as 1915 (i) State Plan Services. During the same time period, the State has held four public workshops in which all members of the public were invited to learn about the new regulations and to provide written and recorded comments and public testimony regarding Nevada’s proposal. In addition, State Staff across multiple DHHS agencies presented information regarding the new rules at various stakeholder meetings, advisory meetings, and advocacy groups. The State also presented this information to Nevada’s Tribes. All public notices and Plan drafts can be found on the DHCFP webpage http://dhcfp.nv.gov/Home/WhatsNew/HCBS/.

A Steering Committee was created shortly after the first Public Workshop along with two sub-committees: HCBS Regulatory Sub-Committee; and HCBS Lease Agreement Sub-Committee. These two Sub-Committees were combined into the Regulatory Sub-Committee after the first few meetings.

Program Areas Affected

- **1915(c) Waivers:**
  - **HCBW for Individuals with Intellectual Disabilities and Related Conditions:** This waiver provides an array of services for individuals with intellectual disabilities or related conditions to provide opportunities to receive community based services as an alternative to institutional placement.
  - **HCBW for the Frail Elderly:** This waiver provides services and supports for recipients who are 65 years of age and older to remain in their homes or communities, in lieu of an institutional setting.
  - **HCBW for Persons with Physical Disabilities and Related Conditions:** This waiver provides services and supports for recipients who are physically disabled to remain in their own homes or communities who would otherwise require care in an institutional setting.
• 1915(i) State Plan Services:
  
  o **Adult Day Health Care:** These settings are not residential, but are services provided during the day for individuals who are elderly, intellectually or developmentally disabled, or physically disabled. The State believes that the current Adult Day Health Care facilities are community based and allow for access to the greater community.
  
  o **Home Based Habilitation Services:** This service is provided to individuals with a traumatic brain injury or an acquired brain injury in both inpatient and outpatient settings.
  
  o **Partial Hospitalization:** This service is primarily for individuals who require intensive substance abuse services as an outpatient. These individuals live in their own homes, and attend services either full day or half day.

I: HCBS Waiver for Individuals with Intellectual Disabilities and Related Conditions:

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Consultation Training and</td>
<td>This non-residential service provides behaviorally-based assessment and intervention for participants and/or positive behavior support plans, necessary to improve an individual's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. This service may be provided in the recipient's home, school, workplace, and in the community.</td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>Career Planning</td>
<td>This non-residential service engages waiver recipients in indentifying a career direction and developing a plan for achieving integrated employment at or above minimum wage and include planning for sufficient time and experiential learning opportunities to allow for appropriate exploration, assessment and discovery processes for learning about career options. This service may be provided in the recipient's home, school, workplace, and in the community.</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>Services that are provided when nursing services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State plan. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes, as well as a day program or in other community settings as described in the recipient’s Service Plan.</td>
</tr>
<tr>
<td>Counseling Services</td>
<td>This non-residential service provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes. This service may be provided in the recipient’s home, school, workplace, and in the community.</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>This non-residential service is offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan in addition to medical transportation provided under the State Plan. This service may be provided in the recipient’s home, school, workplace, and in the community.</td>
</tr>
<tr>
<td>Nutrition Counseling</td>
<td>This non-residential service includes assessment of the individual’s nutritional needs, development and/or revision of recipient’s nutritional plan, counseling and nutritional intervention, observation and technical assistance related to successful implementation of the nutritional plan. This service may be provided in the recipient’s home, school, workplace, and in the community.</td>
</tr>
<tr>
<td>Residential Support Management</td>
<td>This service is designed to ensure the health and welfare of individuals receiving residential support services from agencies in order to assure those services and supports are planned, scheduled, implemented and monitored as the individual prefers, and needed, depending on the frequency and duration of approved services ISP. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.</td>
</tr>
<tr>
<td>Residential Support Services</td>
<td>This service is to ensure the health and welfare of the individual through protective oversight and supervision activities and supports to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for an individual to successfully, safely, and responsibly reside in their community. Those services are provided at the recipient’s residence including assisted living, group homes and their individual homes. When these services are provided in a 24 hour setting, they are limited to four recipients unless otherwise authorized by the Developmental Services Regional Center Director. Host Home Supported Living Arrangement’s are limited to two service recipients residing in one home, unless otherwise authorized by the Developmental Services Regional Center Director.</td>
</tr>
</tbody>
</table>

These services are those that are thought to fully comply with changes to current policy and regulation. The State will provide a list of needed changes and a timeline for compliance.

| Day Habilitation | Day habilitation services are non-residential services and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. These services are provided in a non-residential setting. This service may be provided in the recipient’s home, school, workplace, and in the community. |
| Supported Employment | This non-residential service consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. This service may be provided in the recipient’s home, school, workplace, and in the community. |
| Prevocational Services | Non-Residential services that prepare a participant for paid or unpaid employment that include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. This service may be provided in the recipient’s home, school, workplace, and in the community. |

II: HCBS Waiver for the Frail Elderly

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>These services are thought to fully comply with the HCBS rule requirements because they are provided in the recipient’s private home in which individuals are allowed full access to the community and choice of all services and supports. Most of the individuals on this waiver do not wish to seek employment.</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>This non-residential service includes a variety of activities to include care planning, assessment of needs, ongoing monitoring, and services that promote the quality and goals of the recipient. This service is provided on an ongoing basis and includes assistance with HCBS intake referral, facilitating Medicaid eligibility, coordination of care, documentation for case records, case closures and changes, outreach activities and constant communication with the recipient and his/her service providers. This service is not setting specific, it is recipient oriented.</td>
</tr>
<tr>
<td>Respite Services</td>
<td>Short-term relief for full time non-paid caregivers. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.</td>
</tr>
<tr>
<td>Homemaker Services</td>
<td>This service provides additional time for IADL’s, over and above what is offered under the Medicaid State Plan. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.</td>
</tr>
</tbody>
</table>
### Personal Emergency Response Systems (PERS)

This allows for a recipient to call for help in an emergency by pushing a button. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes, but also include a non-residential component as the recipient may elect to wear a portable PERS device.

### Adult Companion

This service provides socialization to a recipient and may assist with chores and shopping.

### Chore Services

This service is intermittent and provides for heavy cleaning activities and may include the packing and unpacking of boxes, and the movement of furniture. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.

*These services are those that are thought to fully comply with changes to current policy and regulation. The state will provide a list of needed changes and a timeline for compliance.*

### Augmented Personal Care (Assisted Living)

This 24 hour in-home service provides activities of daily living and instrumental activities of daily living in a group care setting which is located within the community.

This service includes 24 hour in home supervision to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence. This service has 3 different levels of care: Level One - supervision and cueing; Level Two - minimal physical assistance; and Level Three - moderate physical assist.

Recipients are encouraged to participate by cooperating with the providers of residential facility for groups in the delivery of services, and by reporting any problems with the service to the group administrator and/or ADSD case manager.

### Social Adult Day Care

These settings are non-residential, and provided as an outpatient setting. These settings are services provided during the day for individuals who are elderly, intellectually or developmentally disabled, or physically disabled. These services are provided in a non-institutional community-based setting on a regularly scheduled basis. The state believes that the current Adult Day Care facilities are in community based settings and allow for access to the greater community as they are not associated with, or located on, a campus like setting, a nursing facility, or an impatient setting which make them acceptable.

### III. HCBS Waiver for Persons with Physical Disabilities

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Management</strong></td>
<td>This non-residential service includes a variety of activities to include care planning, assessment of needs, ongoing monitoring, and services that promote the quality and goals of the recipient. This service is provided on an ongoing basis and includes assistance with HCBS intake referral, facilitating Medicaid eligibility, coordination of care, documentation for case records, case closures and changes, outreach activities and constant communication with the recipient and his/her service providers. This service is not setting specific, it is recipient oriented.</td>
</tr>
<tr>
<td><strong>Respite Services</strong></td>
<td>Short-term relief for full time non-paid caregivers. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.</td>
</tr>
<tr>
<td><strong>Homemaker Services</strong></td>
<td>This service provides additional time for IADL’s, over and above what is offered under the Medicaid State Plan. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
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<td>--------------</td>
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</tr>
<tr>
<td>Personal Emergency Response Systems (PERS)</td>
<td>This allows for a recipient to call for help in an emergency by pushing a button. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes, but also include a non-residential component as the recipient may elect to wear a portable PERS device.</td>
</tr>
<tr>
<td>Attendant Care</td>
<td>This service is provided in the recipient’s residence and may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. The service may include hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual.</td>
</tr>
<tr>
<td>Chore Services</td>
<td>This service is intermittent and provides for heavy cleaning activities and may include the packing and unpacking of boxes, and the movement of furniture. These services are provided at the recipient’s residence including assisted living, group homes and their individual homes.</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person’s home. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.</td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td>Equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform ADLs. These services may be provided in the recipient’s residence, or be intended to stay with the person to assist with mobility and transferring whether this be in the residence or the community.</td>
</tr>
<tr>
<td>Environmental Modifications</td>
<td>This service is provided in the recipient’s residence and may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient.</td>
</tr>
<tr>
<td>Assisted Living Service (Augmented Personal Care)</td>
<td>Assisted living services are all-inclusive services furnished by an assisted living services provider. Assisted living services are intended to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. If a recipient chooses assisted living services, no other waiver services may be provided, except case management services. This waiver utilizes disability specific apartments.</td>
</tr>
</tbody>
</table>

**IV. Adult Day Health Care Services**

*Services that are thought to fully comply with changes to current policy and regulation. The State will provide a list of needed changes and a timeline for compliance.*
Adult Day Health Care Services

These settings are not residential, but are services provided during the day for individuals who are elderly, intellectually or developmentally disabled, or physically disabled. The State believes that the current Adult Day Health Care facilities are community based and allow for access to the greater community as they are not associated with, or located on, a campus like setting, a nursing facility, or an impatient setting.

V. Home Based Habilitation Services

| Home Based Habilitation Services | With the exception of two providers, these services are outpatient, and individuals live in their own homes, and attend services either full day or half day. Some of these providers are located on campus like settings that include other medical providers, who provide an array of outpatient services. One concern is that some campuses do have acute care hospitals or rehabilitation clinics, which are inpatient. This needs to be addressed further. There are two residential homes for individuals with traumatic brain injury under Home Based Habilitation Services. These individuals have been through rehabilitation and are ready to live in the community, but the need a greater level of service, which includes 24 supervision, cuing, and medication management, in order to be successful in a community setting. |

VI. Partial Hospitalization

| Partial Hospitalization | The State has not evaluated this program. This service will be removed from 1915 (i) upon response from CMS. As of this date, the DHCFP is pending a decision from CMS which is expected to be received in 3-6 months. |

Definition of Institutional Setting:

Institutional settings are those settings that that provide skilled care and related services, in addition to a room, meals, and assistance with activities of daily living, which keep individuals from living on their own. Institutional settings or facilities are more commonly known as hospitals, rehabilitation facilities, nursing facilities, facilities for mental disease, and intermediate care facilities for individuals with intellectual disabilities.

The home and community based rules changes will not allow for Medicaid reimbursement of any type of provider who is located on the same property or campus, or within the same building as any of the settings indentified above.

The final rule also indentifies areas that have institutional like qualities, such as publicly or privately owned facilities that provide inpatient services (identified above) because these settings have the effect of isolating people from the greater community.

American Association on Health and Disability: Over the past years, four settings have been “automatically deemed” institutional. These are nursing facilities (NFs), institutions for mental diseases (IMDs), intermediate care facilities for persons with intellectual disabilities and other developmental disabilities (ICFs/ID), and long term care units of hospitals.
Definition of a Home and Community Based Waiver Program:

HCBS programs offer choices to some people who qualify for Medicaid. Individuals may receive services in their home and community so they can remain independent and close to family and friends. HCBS programs help the elderly and disabled, intellectually or developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services to specific target populations in lieu of an institutional setting.

The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Definition of Community:

The Olmstead Act emphasizes community as something that is defined by the individual, specifically, what is the definition of community to one person? Definitions will vary from person to person, but it is about individual choice.

*American Heritage Dictionary Definition of Community:* A group of people living in the same locality or under the same government, or a group viewed as forming a distinct segment of society.

Assessment Process

The first major phase of the process was the provider self assessment questionnaire which was sent to residential providers under the Frail Elderly Waiver and the Waiver for Individuals with Intellectual Disabilities. The major objectives of the self-assessment were to:

- Verify service viability
- Identify potentially isolating locations and congregate member living
- Identify whether the setting maximizes opportunity for HCBS program participants to have access to the benefits of community living and receive services in the most integrated settings.

The second phase of the process was the provider on-site assessments. These were completed in the months of April and May 2016. The State of Nevada elected to conduct 100% residential site reviews including assisted living settings, and also included 100% site reviews for adult day health care providers. In regards to our Jobs and Day Training providers, and day habilitation service providers, including supported employment and prevocational services, provider self assessments were accepted.
**Provider Assessment Results**

**Assisted Living Settings:**

**First phase - Provider Self-Assessment Survey #1:**

The State sent out 295 self assessment surveys to providers under the State’s HCB Waivers for Individuals with Intellectual Disabilities and Related Conditions, the Frail Elderly, and Persons with Physical Disabilities. Of the 295 survey sent, 147 were returned, or 49%.

The Provider Self Assessment Survey (Appendix A1) includes 44 questions. The results indicated that there was 100% compliance in all but six areas. Those areas are addressed below.

a. Fifty percent of respondents stated that the individuals were not employed in the larger community.

b. Seventy-one percent of respondents stated that choice of roommate was not-applicable.

c. Fifty-three percent of respondents stated that individuals do not have control over their own money or resources. Fifty-three percent of respondents stated that individuals are not able to come and go as they please.

d. Thirty-two percent of respondents stated that bedroom doors cannot be locked.

e. Thirty-two percent of respondents stated that they do not have adequate staff to accommodate specific and spontaneous requests from individuals.

**Analysis of Assessment Results (Appendix A2):**

f. Employment is an issue that is addressed with the individual during the ISP or POC process. If the individual would like to work, then the team facilitates and assists with helping the individual gain employment.

g. Some individuals in supported living arrangements have their own rooms.

h. Money management may be something that individuals need assistance with. Some individuals have financial guardians and some individuals can manage their own money. This is addressed in the ISP or POC.

i. The main reason individuals cannot come and go as they please is due to safety concerns; these are documented in the plan of care.

j. Typically, doors are not locked for safety reasons; meaning individuals could not exit their rooms in a safe manner. However, doors do have locking mechanisms.

k. The staffing ratios are typically one staff to four or six residents.

The Steering Committee met on September 29, 2014 and discussed the reasons providers were hesitant to fill out the survey. Feedback from Providers indicated a lack of understanding of the context of the questions. The Steering Committee decided to resend the survey to the same providers, with an explanation for each question (Appendix A3 and A4). Provider advocates were encouraged to inform the provider community to complete the 2nd survey. The state faced a short-fall with the response of provider self-assessments, at which time it was decided that 100% of the assisted living and adult day health care settings would receive an in person on-site assessment.

ADSD Developmental Services elected to work with the non residential providers and complete a non residential assessment form via telephone or in person during a recipient contact (Appendix D3). The results from this assessment (Appendix D4) demonstrated that there are areas that need to be addressed for each setting to meet 100% compliance with the new settings rule. Nevada Developmental Services recognizes the need to address the areas that were less than 100% compliant in a systemic manner. The following items are current projects for which Nevada Developmental Services has initiated, or are soon to being to initiate, to address the issues identified during this review:

- Continued interagency collaboration with state agencies, community leaders, non-profit
organizations and businesses to enhance and strengthen supported employment systems.

- Developing Memorandum of Understanding between school systems, Vocational Rehabilitation and Regional Centers, transportation and providers to outline roles, responsibilities and agreements.
- Work with all partners on the implementation of the Nevada Strategic Plan on Integrated Employment. Taskforce members were appointment by Governor Brian Sandoval.
- Begin Career Development/Planning as a discreet waiver service to begin to prepare individuals for competitive jobs.
- Continue membership in the State Employment Leadership Network (monthly membership meeting, annual meeting, resources, webinars, and on-site visits. Nevada Developmental Services is currently working on Funding Strategies Study Recommendations for Nevada (See attachment 2). Membership with the National Employment First community of Practice to support the alignment of policy, practice, and funding streams toward prioritizing competitive non-residential providers.
- Develop state a workgroup which will consist of representative from the State Developmental Services and community non-residential providers to support continue systems change with respect to the provision of day habilitation services that focus on community based activities, versus facility based activities.
- Continue to support community non-residential support providers in accessing training from the Direct Course – College of Employment Services.
- Continue to provide access to training and webinars for State Service Coordinators keeping the focus on community integration and competitive employment outcomes.
- Set and measure progress toward employment goals.
- Generate a list of who is in day training and who could be successful in integrated employment.
- Prepare budgets to support the ability to set a percent of people to move people out of day training services and into integrated employment over the next three years.
- Continue funding community provider pilot programs that expand integrated employment outcomes.

State Developmental Services to revise and expand Supported Employment definition, requirement of providers and develop outcome data.

Second phase – On-site Assessments:

The State attempted to conduct 151 on-site assessments to Assisted Living settings under the State’s HCBS Waivers for the Frail Elderly, and Persons with Physical Disabilities. Of the 151 survey attempted, 147 were completed. The 4 that were not completed were due to changes of ownership and Medicaid disenrollment.

The On-site assessment (Appendix B1) covered 22 areas that included the relevant questions CMS requested be presented. The results indicated that there were questionable results, or noncompliance in all but one area as stated below:

1. Needs/Preference is considered when settings options offered?

Analysis of Assessment Results:

m. Less than a 10% non-compliance result – 14 areas
n. 10%-20% non-compliance result – 3 areas
o. More than 20% - 3 areas

The three areas that resulted in the highest noncompliance with the new settings requirements are as follows:

- Are sleeping or living unit doors lockable by recipient?
- Is availability of sleeping or living unit key limited to appropriate staff?
- Provides opportunities and support for employment in competitive, integrated settings?
On May 9, 2016 the DHCFP sent correspondence to each setting that had an on-site assessment completed. These letters were provided with the intent to outline the areas that were reviewed; the areas the settings met the requirements; as well as the areas that required remediation (Appendix C1). Remediation responses were requested to be returned no later than June 10, 2016. The DHCFP is still in receipt of remediation plans as many settings have asked for extensions to the June 10, 2016 deadline. The State is in the process of contacting the settings that have not responded to find out their status and progress with the remediation response. The State is also in the process of reviewing the remediation responses received for compliance. The State will contact the settings if further information is needed. The expected timeframe for this step is October 31, 2016.

### Provider Assessment Results for 1915 (i) State Plan Services

#### Adult Day Health Care Services

**First phase - Provider Self-Assessment Survey #1:**

A provider self assessment form was sent to 14 Adult Day Health Care providers, which is a non-residential setting, and 10 were returned, for a percentage of 73%.

The results indicate that that all areas are in compliance with exception of the following:
- 73% of recipients have access to public transportation;
- 55% can come and go as they please;
- 73% chose what to eat and with whom they eat.

**Analysis of Assessment Results:**

- Almost all providers provide their own transportation; however, recipients may use public transportation where available, or friends and family. It should be noted that most of Nevada is considered rural or “frontier” area and public transportation is not available.
- All providers have dining rooms in which individuals can sit where they choose.
- All providers post daily menus which offer at least two choices. (One provider had menus posted in four languages).
- All providers accept individuals with dementia and Alzheimer’s, so doors are monitored in order to prevent elopement.
- Providers are all located within the community and allow for access into the greater community. Potential providers, who are located on a campus, or within the same building as an institutional like environment, will not be reimbursed for this service.

#### Second phase – On-site Assessments:

The State conducted 17 Adult Day Health Care on-site reviews. The same questionnaire (Appendix A1) was used for these reviews, although, it is understood some of the questions do not necessarily pertain to these settings as they are not residential. One Adult Day Health Care had an answer to the assessment that resulted in a noncompliance area pertaining to roommates; however, after contact was made with the Adult Day Health Care, it was explained that this question was answered incorrectly and the result was reversed. The Adult Day Health Care settings were found to meet 100% compliance for each setting. No remediation actions were requested. The State did provide the results via mail (Appendix F) to each setting to ensure they understood they did not require remediation.
## Provider Assessment Results for 1915 (i) State Plan Services

### Home Based Habilitation Services

There are three providers of this service.

One provider is located on a campus setting with other State agencies and buildings. This provider operates day services from 9:00 – 3:00 pm, and is considered non-residential. Recipients who attend this provider use public transportation, or friends and family. The day program is located on a campus that is associated with the University system and includes providers who provide various outpatient medical services. This campus is considered to meet setting requirements as there are no in-patient services provided.

The other two providers are 24-hour residential settings. One provider has the main office located on a campus like setting similar to provider number one. This same provider has several supported living arrangements located throughout the community. Many of these arrangements are for up to 4 individuals. These settings are fully integrated within the community.

**Analysis of Assessment Results:**
- One provider is located on a campus, and is a non-residential setting.
- One provider has group homes located within the community and those homes are fully integrated into the community.
- All providers have access to transportation in the form of public transportation, family, or friends.
- Meal times can be together or separate based on individual schedules. Some recipients choose to make their own meals, while others choose to eat the prepared meal.
- All residential settings provide 24 hour supervision. Level of supervision required is indicated in the person centered care plan.

**Identified problem area:**
- Residential Setting: this program is geared to a target population: individuals with traumatic brain injury or acquired brain injury.

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## Provider Assessment Results for 1915 (i) State Plan Services

### Partial Hospitalization

There were no assessments completed for partial hospitalization as the premise of this program is to provide outpatient treatment up to seven days per week. The individuals who utilize this service reside in their own homes.

**Analysis of Assessment Results:**
- Provider facilities are located on campus settings, which are not home and community based; however, recipients receive services during the day only and do not reside on that campus.

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### General Analysis of Provider Surveys for all Programs

- Recipients are afforded choice in the majority of our home and community based settings which include choice of providers, choice of roommates, and choice of activities. Additionally, it has been found that recipients do have a choice in the staff employed by the provider. If the recipient requests different staff, all efforts will be made by the provider to change staff schedules.
- Nevada is a large, mostly rural, State. Recipients who choose to live in rural areas have limited access to public transportation, but those who live in urban areas have access to public transportation. Some providers own vans, and others make every effort possible to allow residents participation in the community.
Employment is a choice. Those who wish to work are offered that choice, but many, especially among the frail elderly population, do not choose to work. This question was addressed as part of the on-site assessment and resulted in 52% non-compliance; however, after speaking with many providers, this question was misunderstood. This is being addressed with the remediation responses.

- Some waiver recipients need little to no supervision, while others need constant attendance due to cognitive issues. Supervision is addressed on a case by case basis in the person centered plan.
- Some individuals have the capability to control their own finances, and others do not. Often a guardian or authorized representative takes care of the recipients’ finances. This is addressed in the person centered plan.

Areas that need to be addressed with the transition:

- Many providers do not have locks on living and sleeping quarters due to recipients requiring supervision. However, some providers have indicated they will install locks to become compliant. The appropriate staff will have access to the keys and will use only when necessary.

### Recipient Assessment Results

**Recipient survey’s were sent to over 5100 recipients who receive services under a 1915 (c) or (i) program.**

- 1080 surveys were returned completed
- 500 surveys returned to sender

**Analysis of Assessment Results:**

- Recipients indicated they are given a choice of where to live and with whom they can eat with. They are free from coercion, can have visitors, and are comfortable in their environment.
- About half of the recipients responded either positively or negatively at the choice of roommates, with about 40% stating they were not given a choice of roommates.
- Public transportation is an ongoing problem in Rural Nevada which is reflected in these results.
- Most recipients indicated that staff use keys when appropriate, but some indicated that they did not.
- Some recipients indicated that there are no rental agreements in place in their residence.
- Surveys returned as undeliverable are being reviewed for . . .

**Comments from Recipients:**

- Many recipients responded that the survey does not apply to them because they live in their own home either alone, with parents, or with children.
- Many recipients stated they were happy with their situation, while others stated they have remained independent with the assistance of family and Medicaid services.
- Some recipients complained about the purpose of the survey and didn’t understand how the questions pertained to them.
- Family members and guardians comments on behalf of the recipient that the recipient was unable to answer, so they answered for them.
**Summary of Public Comments**

Notices of Public Workshops were posted on the DHCFP website in the section for Public Notices: [http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/](http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/) as well as on the page devoted to the HCBS New Rule: [http://dhcfp.nv.gov/Home/WhatsNew/HCBS/](http://dhcfp.nv.gov/Home/WhatsNew/HCBS/)

The notices were also posted physically at the DCHFP Central Office in Carson City and the Las Vegas District Office as well as the Nevada State Library and in the public libraries throughout the State. Copies of these public notices are available as Appendix F1-F3.

Following is a summary of the comments made during each of the Public Workshops held by the DHCFP and copies of written notices received are available as Appendices Q, R and S.

### Public Workshop – June 6, 2014

- For those facilities not considered Home and Community Based Settings (HCBS), could we ask the Centers for Medicare and Medicaid Services (CMS) to grandfather them in?
- Consumer Bill of Rights
- Concerned about: Alzheimer’s recipients and Fire Regulations
- Alzheimer’s recipients and choice of roommates, menus, when and where to eat
- How is the Program for All Inclusive Care for the Elderly (PACE) program affected?
- Recommend that a steering committee be created
- Concerned lack of choices in rural regions would be interpreted as silos of service
- Recommends working with Commission on Aging and Disability and Alzheimer’s Task Force
- Suggested consideration of external vendor for project management
- Private Room: some providers cannot afford to provide private rooms
- Waiting for Waiver
- Appreciate flexibility in interpretation regarding institutions on campuses, etc.
- Concerned about electronic Level of Care (LOC) and concerned that recipients and families do not understand the choices available to them between HCBS and Institutional Care
- Concerned about the “Unintended Consequences of our Best Efforts”
- Do not create more silos of care
- Already hard to access care
- Co-location of services
- Concerned that individuals who truly need Nursing Facility placement will be placed in community settings
- Concerns: Scheduled Times for Visits, Category 1 and Category 2 differences and Staffing
- What happens to someone who has such low income we cannot take them?
- Will CMS identify “wiggle room” areas for interpretation or is everything steadfast?

### Public Workshop August 19, 2014

- Several States have already submitted Transition Plans to CMS, but none have been accepted. Additionally, the feedback indicates that a ‘Plan to Make a Plan’ is not going to be accepted. Details of what will be done and how it will be accomplished will be required.
- Who will pay for it? How will it be staffed?
- Disability Dominant Settings, Accessible Space for example, appear not to meet the New Rule requirements by definition since the residences are primarily for individuals with disabilities.
- What about those group homes with residents who have Alzheimer’s? These individuals are unable to make choices.
- Given that the CMS Regulations are the Regulations, it is my understanding that the State has the ability to interpret the New Rule for Disability Dominant settings and programs. Person Centered Planning changes how we think about providing services.
### Public Workshop August 19, 2014 (continued)

- As a rural provider, community means different things in different locations. It is also more expensive to provide services in rural areas.
- Can there be more access to these meetings for rural providers? I am here today because I had other commitments in the Reno/Sparks area, but I would normally not be able to afford to come to Carson City. Is it possible to videoconference to a site in Winnemucca or Elko?
- To participate in the Person Centered Planning, we sent staff to 104 quarterly meetings. That is staff time that is not paid for. Looking at reimbursement for that time is important.
- One aspect of the New Rule we have not discussed today is the requirement for Recipients to have Lease Agreements that afford them the same rights and responsibilities any other individual would have in the State of Nevada.
- Training with family and guardians about Recipient’s Rights
- Training for Providers and State staff
- Regulations and Licensing
- Rates
- This is a 5 Year Transition Plan. If we start working now, we can determine if a setting does not meet the New Rule and why. How can it be changed? Whether by regulation changes or the business plan of the facility.
- Regarding residential care facilities, the language used may not be consistent across types of recipients and/or settings. Is the State looking for demonstration projects?
- Regarding Alzheimer’s patients, we want to work on creating processes and programs that prevent people from being placed out of State, and even to facilitate bringing them back to Nevada.
- Regulations have become so over-protective and rigid that it has affected the Provider mindset.
- How is the State going to help group homes and individuals finance this?
- But, if one resident does not want to eat at the set dinner time, the Provider has to pay the cook to stay around and be available.

### Public Workshop November 10, 2014

- Person Centered Planning should be emphasized
- Cognitive Functioning needs to be taken into consideration
- Medical Regulations matrix supported, although concern expressed that some changes to NRS would be necessary
- If ADHC setting is integrated into larger community, but participants are not diverse mix, does that create a problem?
- It seems that the New Rule requirements that community services not be offered in combination with a medical facility contradicts the sections of the Affordable Care Act (ACA) that encourage co-location. This is especially true in rural Nevada where many services are only available in shared locations.
- Survey recipients and families
- It would be useful to have more public meetings with community partners to help explain changes
- Barry Gold of AARP provided written comments, Appendix G1
- Mark Olson of LTO Ventures provided written comments, Appendix G2
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<th>Summary of Public Comments (continued)</th>
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<td><strong>Public Workshop January 16, 2015</strong></td>
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<td>- Focus groups should be incorporated since the recipient survey didn’t capture resources that people can’t access.</td>
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<td>- Various community stakeholders have offered to host focus groups.</td>
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<td>- The surveys should be translated into Spanish.</td>
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<td>- Establish a formal complaint process.</td>
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<td>- State staff is in the process of doing provider site reviews to verify survey results, or to do a survey, if the provider did not do one.</td>
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<td>- Jobs and Day Training – belief that CMS has clarified that people can receive JDT services with other people with disabilities IF they have been given a choice.</td>
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<td>- Request to indicate State resources needed for full compliance with the transition plan.</td>
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<td>- Question regarding timeline and if it the work can be completed prior to 2019.</td>
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<td>- The State will hold another public workshop once feedback from CMS is received.</td>
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<td>- Public comment in writing has been added, Appendix G3 and G4.</td>
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State of Nevada’s Summary of Responses to Public Comment

The State appreciated the thoughtfulness and genuineness of the comments provided at the four public workshops and various submissions directly to the DHCFP.

The State compiled the results from the four workshops and other public comment submissions into seven (7) areas: HCBS, Recipient, CMS, Transition Plan, Heightened Scrutiny and Other.

HCBS:
The State found that there were six (6) main areas of focus surrounding these responses. The first focused on the facilities themselves in regards to the New Rule regulations. One comment requested that CMS “Grandfather” the facilities in that do not meet the HCBS New Rule Regulations. In response to this comment, the State understands that all settings must meet the requirements as provided by CMS and will ensure that during the transition, the State continues to work with the facilities that remain questionable. In regards to the same type of concern, two questions were focused on how long a facility has to come into compliance with the New Rule as this is a 5 year Transition. Throughout this State Transition Plan document, the State has acknowledged its intent and assistance to ensure facilities that are able to be brought into compliance are. One comment mentioned that they “appreciate flexibility in interpretation regarding institutions on campuses, etc.” The State will continue to address this concern during the on-site reviews. Rural areas were brought up with a couple comments. One comment focused on the lack of choice in rural areas as well as the definition of community in rural settings. The State will continue to work with these providers throughout the transition process to ensure they are also brought into compliance if questionable, all concerns are addressed, and the definition of community is addressed when the on-site visit(s) are completed. It was mentioned that it is hard to access care and we do not want to create silos. The State fully understands these concerns. The purpose of this transition is to promote integrated community settings, not limit individuals to one setting that is secluded from the community and to encourage person-centered planning. The individuals should be afforded the choice in providers. Unfortunately, the State understands that in the rural settings, it may be difficult to ensure there are multiple providers to chose from, this is a barrier all rural States face. Many comments were focused around the cost of providing this care. There were concerns regarding the cost of private rooms, staffing for scheduled visit times, rates, financing for the care of individuals and meal times. This Transition plan is focused around recipient choice, if the recipient chooses to have a snack in the middle of the evening, the State and CMS understand that there will not be a chef on call, but a snack should be available. If a recipient requests that their family visits them during “off” hours, this needs to be accommodated. The State will continue to work with the providers addressing each of these concerns throughout the Transition process. One comment addressed provider and staff training. The recipients of HCBS Waivers have case managers that assist with the recipient’s needs and concerns. The providers are encouraged to contact these case managers regarding specific areas of concern. In regards to formal training, CMS has not mentioned any requirements for additional training above what the State offers through our Fiscal Agent Hewlett Packard Enterprise (HP).

Recipients:
The State found four (4) areas of concern. The first area focused around the Recipient rights to have a lease agreement that afford them the same rights and responsibilities any other individual in the community would have. The State agrees and has included this into our on-site reviews and this is being addressed during these visits. One question asked what happens when a recipient has such low income that the provider cannot take them. The Department of Welfare and Supportive Services has different Medicaid models that may be reviewed for each recipient. The question regarding income of an individual would only make a difference in regard to their eligibility, and since Medicaid would pay the provider, this should not be a concern. Five comments focused on the recipients that have an Alzheimer’s diagnosis, or a cognitive impairment. Concerns focused around the current Fire Regulations are shared by the DHCFP. The DHCFP is in the process of working with the Department of Public and Behavioral Health to help better define this concern. One comment addressed Alzheimer’s recipients and their choice of roommates, menus, where to eat and when etc.
The State shares the concern regarding the community setting aspect of an individual that may not be “safe” to have the same access as other individuals that would be in the same setting. This is currently being addressed with CMS and will be shared as soon as the State has more information. One comment mentioned preventing individuals with the Alzheimer’s diagnosis from being placed out of State. The purpose of HCBS is to keep individuals in their community and out of placement. The State shares this concern as well and will review this with any facility that is reviewed as an out of State placement. Two comments focused on concern for the individuals with an Alzheimer’s diagnosis, or families of individuals of HCBS not understanding the choice of providers they would have. Each HCBS individual is assigned a case manager that thoroughly understands the individual’s needs and limitations and will work with the individual, responsible person, or family to provide choice of services received. One comment focused on concern that individuals that need Nursing Home placement will be placed in the community. The Transition plan is for individuals receiving HCBS, not those currently in Nursing Facilities. Individuals in Nursing Facility placement will not be affected by this transition. Person Centered Planning was mentioned in two comments with requests for training and an emphasis on the planning itself. The DHCFP is in the process of working with the ADSD to develop a training for the HCBS case managers in regards to the New Rule which includes the Person Centered Planning.

CMS:
The State identified four (4) comments. The first asked if CMS would identify any “wiggle room” areas for interpretation or is everything steadfast. Two comments pertained to the guidelines and conditions set by CMS. The State has been actively involved with CMS to identify any concerns regarding interpretation of the New Rule. CMS has provided information on their website, as well as through their webinars. The last comment reads “the New Rule requires that community services not be offered in combination with a medical facility which contradicts the sections of the Affordable Care Act (ACA) that encourage co-location. This is especially true in rural Nevada where many services are only available in shared locations.” The State has researched the ACA and is only able to find one excerpt related to co-location. Section 5604 b States “The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care.” The State’s understanding is that this reference is in regards to services rendered rather than the recipient’s residence. The State is in the process of conducting on-site assessments of all group homes and assisted living facilities regardless of their location. After the reviews are completed and the final information is reported to CMS, the State will have a better understanding of what constitutes a co-location or shared location and the impact the New Rule may have on these settings.

Transition Plan:
The State identified two (2) areas. Two comments focused around the Public Comment process. Public Comment was opened on June 24, 2016 for the Heightened Scrutiny submission to CMS. The State did not allow the public 30 days to provide adequate feedback prior to the submission. Public Comment was opened on July 12, 2016 for the June 24, 2016 submission of the Transition Plan to CMS. This did not allow the public 30 days to provide adequate feedback prior to the submission. The State has reviewed these comments and has taken into consideration the inadequate time the public comment period was opened prior to and after submission of the Transition Plan and the Heightened Scrutiny proposals. The State has pulled back both submissions from CMS and will open it up for Public Comment prior to resubmission. The State will also make certain to notify all stakeholders and request public engagement prior to submission to the best of our ability. The second area was in regards to the Provider Assessment that was completed by the ADSD and the DHCFP. Additional areas to review were proposed for a future assessment which focus around the individual within the residential setting and their abilities and inabilities. Suggested areas to ask about include:

- Ask what the average age of residents are;
- What is the average ADL level of residents;
- Do they wear briefs;
- The number that use a walker or other adaptive device, or don’t walk at all;
• Do any residents have chronic mental, cognitive or other physical illness that limits their practicality ever living alone or getting a job;
• Would getting a job or living on their own without 24-hour supervision put the safety of that resident at risk;
• List some diagnoses that the population has that limits their ability to work or live alone;
• How many residents have already received therapy for their illness and still can’t live alone or seek employment;
• Would licking the door to the room put the residents at risk in case of a fire or in case their mood changed quickly and needed assistance;
• Would taking your resident out in the community potentially agitate them and stress them cognitively or physically;
• Would leaving your resident aloe in a room or at home without some level of monitoring put them at risk of bad events;
• Is there any scenario you can envision medically where your residents will with treatment medical or behavioral be able to live alone, work or live without protective supervision;
• On average, would you describe your residents as independent living/transitional living or tending more toward Long term care residents who are closer to needing a nursing home than living on their own even with assistance, training and improvement in their health condition;
• What they of irreversible illness do your residents typically have;
• Given the age and expected progression of needs for your residents, is it likely any will improve enough to where they can be independent with community supportive services;
• Would you agree that your residents might not get the needed supervision, protective supervision, and care that they need if they get care in an independent living/transitional living setting where they have less than 24 hour care and a place that can give PRN medications when needed;
• Does your care setting offer coordination of medications;
• Does your staff ensure the residents take their medications;
• If the doctor called in a medication change does the resident process that including drop the prescription off and pick it up form the pharmacy and record it;
  • If not, do you have staff to do this for the resident.

Based on the information gathered during the Provider Assessments, the State does not feel an additional assessment is necessary at this time. The State feels that that the residents were considered during the assessment and many of these areas that are being asked to be addressed during a follow-up assessment go against the Final Rule regulation released by CMS. In addition, the assessments did not reveal an abundance of inadequacy for our residential providers. Many of the questions that were asked are being resolved via the remediation plans and/or during contact with the DHCFP office directly. If it is found that a new assessment needs to be completed by the State, the DHCFP will reach out to our stakeholders and the public to assist with the development of a follow-up assessment form.

Heightened Scrutiny:
The State identified two (2) areas. The first area had one comment was in response to the 56 proposed Heightened Scrutiny reviews submitted to CMS for review. None of the 56 settings included in the proposed submission to the CMS received the notice of public comment directly via email, fax or US mail. None of the residents and/or their families or legal guardians received the notice. The STP Advisory Council did not receive a notice nor did the A-Team, the largest organization of adults with intellectual developmental disabilities, nor did the State of Nevada Association of Providers (SNAP). The second area expressed concern over the Provider on Site review/Heightened Scrutiny Questionnaire table used to make its assessments and containing the findings of the on-site settings reviews. Concerns included the following:
• The tool itself was not made available for public comment prior to its use
• The first criterion “more than 10 beds” has no relation to the Final Rule
• DHCFP offers no explanation about how it determined that “more than 10 beds” would not be a major criterion of the tool, nor does it present any evidence supporting its relevance to the Final Rule or STP.
• No other place in the STP dates 6/26/16 is there a mention of “more than 10 beds”.

The State understands the concern surrounding the Proposed Heightened Scrutiny submissions to CMS. The DHCFP utilized the guidance provided from CMS to develop the Heightened Scrutiny tool which was used to address the residential setting specifically. The tool that is referenced is not the tool that was used to determine the Heightened Scrutiny submission, this tool was intended to be used for the public to identify the provider review results to see any areas that were identified as requiring remediation. The State also understands that there is no reference in the Final Rule related to “10 or more beds” for Heightened Scrutiny reviews. The State had initially elected to submit residential settings that have 10 or more beds as they may appear to be institutional in nature. After further guidance from CMS and public comment consideration, the State will re-evaluate the Heightened Scrutiny proposed submissions with feedback and suggestions taken from our stakeholders and throughout future public workshops and public comment.

Other:
The State identified six (6) areas. Five comments were focused around the request for stakeholders to be involved including focus groups, and to create a steering committee. The State created a Steering Committee comprised of providers, advocates and recipients as well as State employees to work on the creation of the Transition Plan. The first Steering Committee meeting was held on June 24, 2014 – only 18 days after the first Public Workshop. As the State progresses with the Transition Plan and more areas are identified, the State will post in invitation for additional public workshops that include seeking stakeholder input. Access to these meetings was questioned as far as rural providers and the request to have the surveys sent out to be translated into Spanish. The State will look into making the public workshops that are to be scheduled in the upcoming months accessible via the web or telephone for the rural communities. The State is available and willing to translate the surveys into Spanish if specifically requested as we are trying to ensure we provide the same level of access to all individuals and providers throughout the State. Reimbursement of staff time was an requested for staff to attend trainings for the Person Centered Planning. The State has provider qualifications for each provider type that include trainings for the staff and management to relay to the staff. This is part of the provider enrollment process and re-certification process. With that being said, if these trainings are a requirement for the provider to remain certified with the DHCFP, the DHCFP would expect this to be completed as part of the ongoing process. It was requested to indicate the resources needed for full compliance with the Transition Plan. The State is currently in the process of utilizing staff to complete on-site reviews as part of the ongoing transition. It was acknowledged that some changes to the NRS may be needed, as well as support for a Medical Regulation Matrix support. The State is in constant review of the NRS to ensure full compliance with the current regulations, and if any require amendment, submitting this as such. It has been requested to establish a formal complaint process. The State has sectioned part of the DHCFP.nv.gov website for the New Rule which includes a place for public comment. The State asks that all comments be submitted through this realm. For complaints directed to CMS, the comments would need to be forwarded to them directly.

Some advocates requested the DHCFP to survey recipients about their current services and their level of satisfaction with their current providers (Appendix W). That survey was sent to 5,100 recipients. The DCHFP received responses from approximately 20% of the recipients surveyed (Appendix X). The response was overwhelmingly positive.

The final version of the Nevada Transition Plan that was submitted to CMS on February 23, 2015 contained responses to many of the public comments received throughout the prior ten month period. In particular, a more detailed plan to visit providers who had not responded to the self-assessment. Initially, the DHCFP planned to have 50% of these onsite assessments completed by June 2015. That goal has been achieved and the deadline to complete 100% of the onsite assessments was accomplished by May 2016.

In addition, the State has created more detailed remedial milestones found in the section titled “Transition Plan for Compliance” that begins on page 34 and continues through page 43.
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<td>March 17, 2014</td>
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<td>February 9, 2015</td>
<td>Committee on Senior Citizens, Veterans and Adults with Special Needs</td>
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<tr>
<td>February 10, 2015</td>
<td>Home for Individual Residential Care Advisory Council</td>
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<tr>
<td>February 12, 2015</td>
<td>Adult Day Health Care Advisory Council</td>
</tr>
<tr>
<td>February 19, 2015</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
</tr>
<tr>
<td>March 18, 2015</td>
<td>Transition Plan to CMS</td>
</tr>
<tr>
<td>March 19, 2015</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
</tr>
<tr>
<td>March 24, 2015</td>
<td>Commission on Aging Senior Strategic Plan Accountability Subcommittee</td>
</tr>
<tr>
<td>April 21, 2015</td>
<td>Medical Care Advisory Committee</td>
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<tr>
<td>April 21, 2015</td>
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<tr>
<td>May 28, 2015</td>
<td>Adult Day Health Care Advisory Council</td>
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<tr>
<td>June 16, 2015</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
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<tr>
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<tr>
<td>August 27, 2015</td>
<td>Adult Day Health Care Advisory Council</td>
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<tr>
<td>September 15, 2015</td>
<td>Commission on Aging Senior Strategic Plan Accountability Subcommittee</td>
</tr>
<tr>
<td>September 15, 2015</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
</tr>
<tr>
<td>October 7, 2015</td>
<td>Annual NV Medicaid Conference</td>
</tr>
<tr>
<td>October 20, 2015</td>
<td>Assisted Living Advisory Council</td>
</tr>
<tr>
<td>October 22, 2015</td>
<td>Annual NV Medicaid Conference</td>
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<td>October 27, 2015</td>
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<td>November 10, 2015</td>
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<tr>
<td>February 25, 2016</td>
<td>Adult Day Health Care Advisory Council</td>
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<tr>
<td>March 2-3, 2016</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
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<tr>
<td>March 15, 2016</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
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<tr>
<td>April 19, 2016</td>
<td>Medical Care Advisory Committee</td>
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<tr>
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<td>Assisted Living Advisory Council</td>
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<tr>
<td>April 19, 2016</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
</tr>
<tr>
<td>May 9, 2016</td>
<td>Letters mailed to Provider’s regarding settings assessment findings and remediation requests</td>
</tr>
<tr>
<td>May 10, 2016</td>
<td>Home for Individual Residential Care Advisory Council</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
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<tr>
<td>May 11, 2016</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
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<tr>
<td>May 26, 2016</td>
<td>Adult Day Health Care Advisory Council</td>
</tr>
<tr>
<td>June 8, 2016</td>
<td>Commission on Aging Senior Strategic Plan Accountability Subcommittee</td>
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<tr>
<td>June 16, 2016</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
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<tr>
<td>June 21, 2016</td>
<td>NV Governor’s Council on Developmental Disabilities</td>
</tr>
<tr>
<td>June 24, 2016</td>
<td>Heightened Scrutiny proposals posted for public comment</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>Transition Plan to CMS</td>
</tr>
<tr>
<td>July 12, 2016</td>
<td>Transition Plan posted for public comment</td>
</tr>
<tr>
<td>July 12, 2016</td>
<td>Commission on Aging Senior Strategic Plan Accountability Subcommittee</td>
</tr>
<tr>
<td>July 14, 2016</td>
<td>2nd round of letters mailed to Provider’s regarding setting assessment findings and remediation requests</td>
</tr>
<tr>
<td>July 19, 2016</td>
<td>Medical Care Advisory Committee</td>
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<tr>
<td>July 19, 2016</td>
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</tr>
<tr>
<td>October 18, 2016</td>
<td>Assisted Living Advisory Council</td>
</tr>
</tbody>
</table>
Transition Plan for Compliance

Nevada’s transition plan includes multiple phases.

Phase I (March 2014 – January 2015) includes stakeholder communication, comprehensive provider self-assessment surveys of all residential and non-residential settings that fall under 1915(c) and 1915(i) services. This self-assessment will serve as a guide to assist the State in identifying possible problem areas, and residential settings that need to be evaluated in person. This phase includes a review and analysis of existing State regulations and policies, as well as industry practices, to determine areas that are in direct conflict with the new rules. Recipient notification and self-assessment survey was also conducted. This phase is completed.

Phase II (January 2015 – December 2017) includes onsite assessments of current providers, provider education and enrollment, and Medicaid Service Manual revisions. Onsite assessments have been completed.

Phase III (June 2015 – December 2017) includes provider education and enrollment Heightened Scrutiny, Heightened Scrutiny review, Medicaid Service Manual revisions, Recipient notifications, provider compliance reviews from onsite assessments, provider compliance remediation, and monitoring. This phase includes changes needed to State regulations.

Phase IV (July 2017 – December 2017) includes recipient notification, monitoring, provider actions, ongoing monitoring, provider self-monitoring tool, and transition plans for individuals.

Phase V (March 2019 – ongoing) Procedural changes incorporated to ensure compliance with HCBS settings requirements including new Provider enrollment.
<table>
<thead>
<tr>
<th>Action Item</th>
<th>Description</th>
<th>Proposed Start</th>
<th>Proposed End</th>
<th>Documents</th>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results Report 1st Provider Survey</td>
<td>The goal of the survey is to identify the current status of residential only settings, as well as identify restrictions that may hinder compliance with the new regulations.</td>
<td>Completed</td>
<td>Completed</td>
<td>Survey Report</td>
<td>I</td>
</tr>
<tr>
<td>2nd Provider Survey and Results Report</td>
<td>The Steering Committee decided to resend the Self Assessment Survey, with explanations for each question. The main goal of this second survey was to increase the percentage of respondents from the provider community.</td>
<td>Completed</td>
<td>Completed</td>
<td>2nd Survey Report</td>
<td>I</td>
</tr>
<tr>
<td>Recipient Self Assessment</td>
<td>Recipients are welcome to attend public workshops or be involved in sub committees. Recipients are crucial in providing information on the services they receive, so a random sample of recipients were selected to complete a survey on how they view their services and choices. Recipients were asked to assess the same questions as providers.</td>
<td>Completed</td>
<td>Completed</td>
<td>Recipient Survey</td>
<td>I</td>
</tr>
<tr>
<td>Action Item</td>
<td>Description</td>
<td>Proposed Start</td>
<td>Proposed End</td>
<td>Documents</td>
<td>Phase</td>
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</tbody>
</table>
| Onsite Assessment of Current Providers | It was the State’s intent to visit at least 50% of all providers by June of 2015. Current status as of 07/24/2015 was:  
  - 50% of residential settings under the FE waiver have been reviewed.  
  - 50% of Jobs and Day Training under the ID waiver have been reviewed.  
  - 50% of supported living providers under the ID waiver have been reviewed.  
  - 50% of Adult Day Health Care providers under 1915 (i) have been reviewed.  
  - 75% of Habilitation providers under 1915 (i) have been reviewed.  
  The State chose to complete 100% on-site assessment reviews of all residential settings between April 2016 through May 2016. The DHCFP collaborated with our sister Agency ADSD to work with the Administrators or Management staff of each setting with respect to the Community Based Settings rule by reviewing the questionnaire, explaining the requirements and assisting with the outcomes of each answer.  
  Nevada Developmental Services assessed each non-residential setting for compliance between May 2015 through March 2016. Nevada Developmental staff initially worked with each provider with respect to the Community Based Settings rule by visiting each site, assisting the provider in conducting a self-assessment, and discussing options for increasing compliance with the rule. Each provider was asked to complete a self-assessment. In March 2016, Nevada Developmental Services staff re-assessed provider compliance with respect to the Community Based Settings rule. | January 2015     | Completed     | DHCFP Settings Qualities Checklist  
Home and Community Based | II               |
<table>
<thead>
<tr>
<th>Action Item</th>
<th>Description</th>
<th>Proposed Start</th>
<th>Proposed End</th>
<th>Documents</th>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heightened Scrutiny</td>
<td>The State has identified settings that may not meet settings requirements based on the location, singular diagnosis, setting size or access issues. The State has developed a tool for submission to CMS. The State has completed an assessment using this tool for each setting that is questionable and requires review by CMS. The State has submitted all questionable settings to CMS.</td>
<td>January 2016</td>
<td>June 2017</td>
<td>Heightened Scrutiny Questionnaire (Appendix D1)</td>
<td>II</td>
</tr>
<tr>
<td>Heightened Scrutiny Review</td>
<td>Upon response from CMS, the State will work with our settings to assist with compliance based on the factors identified by CMS.</td>
<td>December 2016</td>
<td>December 2017</td>
<td>Pending</td>
<td>III</td>
</tr>
<tr>
<td>Provider Education and Enrollment</td>
<td>When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to sign and submit certification that they have received, understand, and comply with these setting requirements. This will be incorporated into the provider enrollment checklist and verified initially and every three years during re-enrollment. The Fiscal Agent is responsible for all enrollment activities and provider trainings on prior authorization and billing guidelines. The State will provide education and training to the Fiscal Agent’s provider enrollment staff on new checklists and enrollment requirements. Enrollment checklists may coincide with State regulations meaning that checklists cannot be updated until regulations are updated.</td>
<td>January 2015</td>
<td>December 2017</td>
<td>Provider enrollment checklists, Certification Statement, Provider Trainings</td>
<td>II and III</td>
</tr>
</tbody>
</table>

27
<table>
<thead>
<tr>
<th>Action Item</th>
<th>Description</th>
<th>Proposed Start</th>
<th>Proposed End</th>
<th>Documents</th>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recertification Procedures</td>
<td>When Providers recertify as a Nevada Medicaid Provider, assurances need to be made to ensure new federal requirements for HCBS have been reviewed, or are in the process of remediation and completion prior to recertification approval.</td>
<td>December 2016</td>
<td>Ongoing</td>
<td>The State is in the process of developing recertification guidelines for the fiscal agent and Providers.</td>
<td>II and ongoing</td>
</tr>
</tbody>
</table>
| Medicaid Service Manual Revisions | The State will revise HCBS provider manuals, Medicaid Services Manuals, to incorporate regulatory requirements for HCBS and qualities of an HCBS setting.  

The Medicaid Services Manual (MSM) is owned by the State Medicaid Agency and there is a chapter for each Medicaid program covered within the State. The MSM is where the State outlines program requirements, provider qualifications, etc. The identified MSMs will be updated to reflect residential and non-residential settings requirements.  

The State has drafted a sample policy section to be incorporated in all 1915 (c) and 1915 (i) policy manuals. The same language will be used in all manuals. (Appendix Y)  

New language additions must go through an intensive internal review process and be presented publicly before changes are incorporated. | July 2015       | July 2017     | For six (6) programs affected                                      | II and III   |
| Recipient Notification      | The State will provide notification and education letters to recipients at various intervals during the identification and implementation stages.                                                                                                                                            | January 2016   | October 2018  | Web Announcements  

Educational Letters                                                       | III and IV     |
<table>
<thead>
<tr>
<th>Action Item</th>
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<th>Proposed Start</th>
<th>Proposed End</th>
<th>Documents</th>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Compliance Reviews – On-site Assessments Inventory Log</td>
<td>The State has developed an inventory and description of all HCBS settings (residential and non-residential) and summarized which settings meet requirements and which settings do not. The State has extended an invitation for Public Comment for these assessment findings. (Appendix E1)</td>
<td>April 2016</td>
<td>Completed</td>
<td>Remediation Tracking Log (Appendix C4)</td>
<td>III</td>
</tr>
<tr>
<td>Provider Compliance Reviews – Remediation requests</td>
<td>The State has provided Remediation correspondence to all settings which were found to need one or more areas of remediation based on the settings requirements. In addition, the State has provided a question and answer key to providers to assist with determining which area they require remediation, as well as a remediation example, on the DHCFP public facing website.</td>
<td>June 2016</td>
<td>Completed</td>
<td>Remediation Letter to Providers Providers Guide to the Remediation Letter (Appendix C2) Remediation Plan example (Appendix C3)</td>
<td>III</td>
</tr>
<tr>
<td>Action Item</td>
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<td>Proposed End</td>
<td>Documents</td>
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<tr>
<td>Provider Compliance Reviews – Provider Contact</td>
<td>This is a continuation of the “onsite assessment” milestone. A spreadsheet has been completed and is available to providers on the DHCFP public facing website. This spreadsheet identifies the areas that require remediation, or heightened scrutiny for each residential setting and Adult Day Health Care. The DHCFP has also uploaded a Non-residential settings assessment report, and Supported Living Arrangements (SLA)-Jobs and Day Training Settings Assessments which identify the same results.</td>
<td>June 2016</td>
<td>Completed</td>
<td>Residential Settings Assessments (Appendix D2) Non-Residential Settings Assessments (Appendix D3) (SLA) – Jobs and Day Training Assessments (Appendix D5)</td>
<td>III</td>
</tr>
<tr>
<td>Provider Compliance Reviews - Monitoring</td>
<td>The State has collected and analyzed data from provider compliance reviews through the initial onsite assessment and will work with providers to come into compliance either through education or corrective action plans.</td>
<td>June 2016</td>
<td>June 2017</td>
<td>Residential Settings Assessments Non-Residential Settings Assessments Supported Living Arrangements (SLA) – Jobs and Day Training Assessments</td>
<td>III</td>
</tr>
<tr>
<td>Action Item</td>
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<td>Proposed Start</td>
<td>Proposed End</td>
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<tr>
<td>Provider Compliance – Setting Approval Monitoring</td>
<td>The State has targeted those providers who do not meet residential or non-residential settings requirements during the initial onsite assessment and will assist them in either becoming compliant or being terminated as a provider of HCBS because they are unable to become compliant.</td>
<td>December 2016</td>
<td>June 2017</td>
<td>Remediation Tracking Log</td>
<td>III</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Heightened Scrutiny submission to CMS</td>
<td></td>
</tr>
<tr>
<td>Provider Remediation - Monitoring</td>
<td>The State has developed a tool to track changes made by those providers who must make some modifications during the transition process to be in compliance with the New Rule’s setting requirements.</td>
<td>June 2016</td>
<td>June 2017</td>
<td>Remediation Tracking Log</td>
<td>III</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Heightened Scrutiny submission to CMS</td>
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<tr>
<td>Provider Actions</td>
<td>If providers do not come into compliance within required time frames, they will be terminated as Medicaid providers. Providers will be given the opportunity to propose changes to come into compliance. However, if they do not accept this opportunity, or are unable to make the required changes, they will be terminated. The State will create a letter detailing the process so the providers know why they are being terminated. Providers that do not meet setting requirements will not be initially enrolled or re-enrolled.</td>
<td>June 2018</td>
<td>Ongoing</td>
<td>Provider letters</td>
<td>IV</td>
</tr>
<tr>
<td>Ongoing Monitoring</td>
<td>Once the Transition process is complete, the State will work with our providers during recertification to ensure complete compliance with the New Rule Regulations has been met.</td>
<td>June 2019</td>
<td>Ongoing</td>
<td>Recertification and re-licensure documentation</td>
<td>IV</td>
</tr>
<tr>
<td>Action Item</td>
<td>Description</td>
<td>Proposed Start</td>
<td>Proposed End</td>
<td>Documents</td>
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<tr>
<td>Provider Self-Monitoring Tool</td>
<td>Providers are willing to monitor their own progress during the remediation period through a self-monitoring process. The State will work to create a tool for providers.</td>
<td>June 2017</td>
<td>December 2017</td>
<td>Self Monitoring Tool</td>
<td>IV</td>
</tr>
<tr>
<td>Recipient Transition Plans</td>
<td>If transition of individuals is required, the State will work in collaboration across agencies to ensure that members are transitioned to settings meeting HCBS Setting requirements.</td>
<td>June 2016</td>
<td>October 2017</td>
<td>Various case management documents Provider letters Individual letters Hearing rights</td>
<td>IV</td>
</tr>
<tr>
<td>Recipient Transition Plans -</td>
<td>Notice and due process will be given to each individual affected within 45 days the State becomes aware of a transition being required. Individuals will be offered a choice of alternative settings through a person centered planning process. This includes the individual’s case manager working directly with the recipient to ensure they are making an informed decision. The Case Manager will have a current listing of possible places for this recipient to review and assist with the transition. The Case Manager will have the responsibility to ensure all critical supports/services are in place prior to an individual’s transition.</td>
<td>June 2016</td>
<td>December 2017</td>
<td>Various case management documents Current Settings Listing Individual letters</td>
<td>IV</td>
</tr>
<tr>
<td>Notification</td>
<td></td>
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<tr>
<td>Recipient Transition Plans -</td>
<td></td>
<td>June 2016</td>
<td>December 2017</td>
<td>Various case management documents</td>
<td>IV</td>
</tr>
<tr>
<td>Service</td>
<td>The State will ensure that there will be no break in services due to a potential transition.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>New Provider Enrollment</td>
<td>Effective March 2019, entities that wish to enroll as HCBS Providers will be subject to site visit verification that they meet settings requirements as part of the enrollment process.</td>
<td>March 2019 Ongoing</td>
<td>Provider enrollment checklists Certification Statement Provider Trainings New Site Assessment Form</td>
<td>V</td>
<td></td>
</tr>
</tbody>
</table>
**Regulatory Assessment**

A comprehensive review of Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC), Sections 435 and 449, was completed to compare current regulations against the requirements of the new rule. The results are as follows:

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Areas of Compliance</th>
<th>Remediation Required</th>
<th>Action Steps</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.</td>
<td>The State regulation, policy, or other standards are compliant. The State’s determination is based on: <strong>NAC 449.269</strong>: 1. A resident of a residential facility shall not be segregated or restricted in the enjoyment of any advantage or privilege enjoyed by other residents, or provided with any assistance, service or other benefit which is different or provided in a different manner from that provided to other residents, on the ground of race, color, religion, national origin or disability.</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.</td>
<td>Setting selection is not prohibited by NRS or NAC. The DHCFP requires that the ADSD Case Manager review the Statement of Understanding form with the recipient and/or their legal guardian/representative which acknowledges the recipient rights and right to choose between a home and community based living setting as opposed to a nursing facility. This form is acknowledged by the recipient and/or their legal guardian/representative and the case manager. The Case Manager is also responsible to review the choice of providers with the recipient and/or legal guardian/representative and provide additional documentation as appropriate.</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Appendix B: Participant Access and Eligibility B-
| 7: Freedom of Choice a. Procedures – This section of the NV.0152.R06.00 Waiver for the Frail Elderly and the NV.4150.R05.00 Waiver for Persons with Physical Disabilities includes language to support this regulation. |
Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

The State regulation, policy, or other standards are compliant. The State's determination is based on NAC 449.268, NAC 449.268 and NAC 449.269.

**NAC 449.268**: 1. The administrator of a residential facility shall ensure that:
   (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility;
   (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility;
   (c) The residents are treated with respect and dignity;
   (d) The facility is a safe and comfortable environment;
   (e) Residents are not prohibited from interacting socially;
   (f) Residents are allowed to make their own decisions whenever possible;
   (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner;

**NAC 449.269**: 1. A resident of a residential facility shall not be segregated or restricted in the enjoyment of any advantage or privilege enjoyed by other residents, or provided with any assistance, service or other benefit which is different or provided in a different manner from that provided to other residents, on the ground of race, color, religion, national origin or disability.

The State proposes no changes at this time.
Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

The State regulation, policy, or other standards are compliant. The State’s determination is based on NAC 449.259 and 449.260

**NAC 449.259: Supervision and treatment of residents generally. (NRS 449.0302)**

1. A residential facility shall:
   (c) Provide each resident with the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling;
   (d) Permit a resident to rest in his or her room at any time;
   (e) Permit a resident to enter or leave the facility at any time if the resident:
      (1) Is physically and mentally capable of leaving the facility; and
      (2) The resident complies with the rules established by the administrator of the facility for leaving the facility;
   3. The employees of a residential facility shall:
      (b) Respect each resident’s independence and ability to make decisions on his or her own, whenever possible.

**NAC 449.260: Activities for residents. (NRS 449.0302)**

1. The caregivers employed by a residential facility shall:
   (a) Ensure that the residents are afforded an opportunity to enjoy their privacy, participate in physical activities, relax and associate with other residents;
   (b) Provide group activities that provide mental and physical stimulation and develop creative skills and interests;
   (c) Plan recreational opportunities that are

The State proposes no changes at this time.
| Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. | The State regulation, policy, or other standards are partially compliant. The State’s determination is based on NAC 449.259 and NAC 449.2175. (NRS 449.0302)  
**NAC 449.259: Supervision and treatment of residents generally.**  
1. A residential facility shall:  
   (c) Provide each resident with the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling;  
   (d) Permit a resident to rest in his or her room at any time;  
   (e) Permit a resident to enter or leave the facility at any time if the resident:  
      (1) Is physically and mentally capable of leaving the facility; and  
      (2) The resident complies with the rules established by the administrator of the facility for leaving the facility;  
2. The administrator of a residential facility may require a resident who leaves the facility to inform a member of the staff of the facility upon his or her departure and return. | The Division of Health Care Financing and Policy (DHCFP) is working with the Department of Public and Behavioral Health (DPBH) to amend NAC 449.259 to support this regulation. Meet with DPBH to create the language: mid-late 2017 which will be after our current Legislative Session. Implementation is expected in 2018. A more detailed timeline will be provided once the meeting between DHCFP and DPBH has commenced. |
3. The employees of a residential facility shall:
   (b) Respect each resident’s independence and ability to make decisions on his or her own, whenever possible.

NAC 449.259 requires the setting to permit individuals to attend religious services of their choice and leave their rooms and the facility at any time, but does not give individuals the freedom and support to control their own schedule and implies that individuals may not have the freedom to control their scheduled beyond what is specified.

**NAC 449.2175 (7): Service of food; seating; menus; special diets; nutritional requirements; dietary consultants.**

7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals.

---

<table>
<thead>
<tr>
<th>Individuals are able to have visitors of their choosing at any time.</th>
<th>NAC 449.258: <strong>Written policies for facility; policy on visiting hours; residents’ mail; compliance with policies.</strong> <em>(NRS 449.0302)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Written policies for a residential facility that comply with the provisions of NAC 449.156 to 449.27706, inclusive, must be developed.</td>
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<tr>
<td>2. A policy on visiting hours must be established to promote contact by the residents with persons</td>
<td>The State proposes no changes at this time.</td>
</tr>
</tbody>
</table>
who are not residents of the facility. The policy regarding visits must be flexible to ensure that every resident has the opportunity to retain and strengthen ties with family and friends.

The setting is physically accessible to the individual.

The State regulation, policy, or other standards are compliant. The State’s determination is based on NAC 449.226 and NAC 449.227 and NAC 449.229

**NAC 449.226: Safety requirements for residents with restricted mobility or poor eyesight; water hazards; auditory systems for bathrooms and bedrooms; access by vehicles. (NRS 449.0302)**

1. A resident of a residential facility who uses a wheelchair or a walker must not be required to use a bedroom on a floor other than the first floor of the facility that is entirely above the level of the ground, unless the facility is designed and equipped in such a manner that the resident can move between floors without assistance.

2. Stairways, inclines, ramps, open porches and other areas that are potentially hazardous for residents who have poor eyesight must be adequately lighted.

3. If a residential facility with a resident who is mentally or physically disabled has a fishpond, pool, hot tub, jacuzzi or other body of water on the premises of the facility, the body of water must be fenced, covered or blocked in some other manner at all times when it is not being used by a resident.

4. In a residential facility with more than 10 residents:
   
   (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored

The State proposes no changes at this time.
by a member of the staff of the facility.

(b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower.

(c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility.

5. Residential facilities must be easily accessible by vehicle in the case of an emergency.

**NAC 449.227: Accommodations for residents with restricted mobility.** (NRS 449.0302) A residential facility with a resident who uses a wheelchair or a walker shall:

1. Have hallways, doorways and exits wide enough to accommodate a wheelchair or walker;
2. Have ramps to accommodate access to areas used by residents; and
3. Provide assistance to such a resident at all steps located inside the facility on the first floor that is entirely above grade.

**NAC 449.229: Requirements and precautions regarding safety from fire.** (NRS 449.0302)

1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal.

2. The Bureau shall notify the State Fire
<table>
<thead>
<tr>
<th>The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAC 435.565 is silent concerning the requirement that the agreement provide the individual with the same responsibilities and protections from eviction that tenants have under the landlord/tenant law for the State, county, city of other designated entity.</td>
</tr>
<tr>
<td>However, NRS 118A: Landlord and Tenant: Dwellings has been found to provide support to this regulation.</td>
</tr>
<tr>
<td>NRS 118A.160 “Rental agreement” defined. “Rental agreement” means any oral or written agreement for the use and occupancy of a dwelling unit or premises. (Added to NRS by 1977, 1331)</td>
</tr>
<tr>
<td>NRS 118A.200 Rental agreements: Signing; copies; required provisions; disputable presumptions; use of nonconforming agreement unlawful. 1. Any written agreement for the use and occupancy of a dwelling unit or premises must be signed by the landlord or his or her agent and the tenant or his or her agent. 2. The landlord shall provide one copy of</td>
</tr>
<tr>
<td>The Division of Health Care Financing and Policy (DHCFP) is working with the Department of Public and Behavioral Health (DPBH) to amend the language in NAC 435.565 to support this regulation.</td>
</tr>
<tr>
<td>Meet with DPBH to create the language: mid-late 2017 which will be after our current Legislative Session. Implementation is expected in 2018. A more detailed timeline will be provided once the meeting between DHCFP and DPBH has commenced.</td>
</tr>
</tbody>
</table>
any written agreement described in subsection 1 to the tenant free of cost at the time the agreement is executed and, upon request of the tenant, provide additional copies of any such agreement to the tenant within a reasonable time. The landlord may charge a reasonable fee for providing the additional copies.

3. Any written rental agreement must contain, but is not limited to, provisions relating to the following subjects:
   (a) Duration of the agreement.
   (b) Amount of rent and the manner and time of its payment.
   (c) Occupancy by children or pets.
   (d) Services included with the dwelling rental.
   (e) Fees which are required and the purposes for which they are required.
   (f) Deposits which are required and the conditions for their refund.
   (g) Charges which may be required for late or partial payment of rent or for return of any dishonored check.
   (h) Inspection rights of the landlord.
   (i) A listing of persons or numbers of persons who are to occupy the dwelling.
   (j) Respective responsibilities of the landlord and the tenant as to the payment of utility charges.
   (k) A signed record of the inventory and condition of the premises under the exclusive custody and control of the tenant.
   (l) A summary of the provisions of NRS 202.470.
   (m) Information regarding the procedure pursuant to which a tenant may report to the
appropriate authorities:

(1) A nuisance.

(2) A violation of a building, safety or health code or regulation.

(n) Information regarding the right of the tenant to engage in the display of the flag of the United States, as set forth in NRS 118A.325.

4. The absence of a written agreement raises a disputable presumption that:

(a) There are no restrictions on occupancy by children or pets.

(b) Maintenance and waste removal services are provided without charge to the tenant.

(c) No charges for partial or late payments of rent or for dishonored checks are paid by the tenant.

(d) Other than normal wear, the premises will be returned in the same condition as when the tenancy began.

5. It is unlawful for a landlord or any person authorized to enter into a rental agreement on his or her behalf to use any written agreement which does not conform to the provisions of this section, and any provision in an agreement which contravenes the provisions of this section is void.

NAC 449.2702 conflicts with the federal rule. It states that a residential facility may not allow an individual to remain in a facility if they are bedfast, require restraint, require confinement in locked quarters, or require skilled nursing or other medical supervision on a 24-hour basis. The regulation does not require the setting to give the individual the same protections from eviction that tenants have under the landlord/tenant law of the jurisdiction.
| Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. | NAC 449.2708 is non-compliant. It permits a setting to discharge an individual without his/her approval for various reasons (e.g., failure to pay his/her bill within five days after it is due) without giving the individual the same protections from eviction that tenants have under the landlord/tenant law of the jurisdiction. | The Division of Health Care Financing and Policy (DHCFP) is working with the Department of Public and Behavioral Health (DPBH) to amend the language in NAC 449.220 to support this regulation. | Meet with DPBH to create the language: mid-late 2017 which will be after our current Legislative Session. Implementation is expected in 2018. A more detailed timeline will be provided once the meeting between DHCFP and DPBH has commenced. |
| Individuals sharing units have a choice of roommates in that setting. | Setting selection is not prohibited by NRS or NAC. | The Division of Health Care Financing and Policy (DHCFP) is working with the Department of Public and Behavioral Health (DPBH) to insert into the NAC | Meeting to create the language: mid-late 2017 which will be |
| Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. | NAC 449.218 is found to conflict with the federal regulation because (1) it requires the residents to request permission to use his/her personal furniture and furnishings, (2) it implies that the setting may deny the individual’s request by the use of the words “may authorize”, and (3) it requires the individual to meet certain conditions that may not be in the individual’s lease in order to use their personal furniture and furnishings. A modification of an individual’s right to furnish and decorate their sleeping or living units within the lease or other agreement is permitted only if the setting has complied with the requirements under 42 CFR 441.301(c)(4)(vi)(F). | The Division of Health Care Financing and Policy (DHCFP) is working with the Department of Public and Behavioral Health (DPBH) to amend the language in NAC 449.218 to support this regulation. | Meeting with DPBH to create the language to support this regulation. | after our current Legislative Session. Implementation is expected in 2018. A more detailed timeline will be provided once the meeting between DHCFP and DPBH has commenced. |
In addition to the regulations outlined above, the following regulations provide support for our residential and Adult Day Health Services:

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Areas of Compliance</th>
<th>Remediation Required</th>
<th>Action Steps</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>A facility must not be operated in combination with any other medical facility or facility for the dependent unless it is licensed separately.</td>
<td>The State regulation, policy, or other standards are compliant. The State's determination is based on NAC 449.4067: <strong>Operation in combination with other medical facility or facility for the dependent.</strong> (NRS 449.0302) A facility must not be operated in combination with any other medical facility or facility for the dependent unless it is licensed as a separate and distinct unit.</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A facility must provide access to activities and services; provide free local telephone; provide at least 40 square feet of space per client; provide for free storage of personal belongings; have one toilet per ten people.</td>
<td>The State regulation, policy, or other standards are compliant. The State's determination is based on NAC 449.4074: <strong>Requirements of facility; health and sanitation; medications; exits.</strong> (NRS 449.0302) 1. The facility must: (a) Provide proper access for each client to all activities and services; (c) Have free local telephone service available for use by clients; (e) Provide for each client at least 40 square feet of space inside the facility excluding areas for maintenance of the facility; (g) Provide adequate space for storage of supplies; (h) Provide at least one toilet for every 10 clients</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>The facility may administer medications; there must be a next of kin to notify in case of emergency; client must be treated with respect and dignity and free from verbal or physical abuse; restraints or sedatives may not be used, unless the State regulation, policy, or other standards are compliant. The State’s determination is based on NAC 449.4081: <strong>Administration of medication; accidents or illnesses.</strong> (NRS 449.0302) 1. If the facility accepts a client who cannot administer his or her own medication, an employee licensed to administer medications must administer</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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| under a physicians order. | the medication to the client.  
2. The next of kin or guardian or other person responsible for the client must be notified immediately in case of any accident, injury or illness involving the client.  
3. Each client must be treated with dignity and respect and not subjected to verbal or physical abuse of any kind.  
4. Restraints or sedatives in lieu of restraints may not be used or given to any client, except by a physician’s order. |  |  |
|---|---|---|---|
| Meals must be served in a manner suitable for the client and prepared with regard for individual preferences and religious requirements. Special diets and nourishment must be provided as ordered by the client’s physician. | The State regulation, policy, or other standards are compliant. The State’s determination is based on NAC 449.4082: Service of food; dietary consultants. (NRS 449.0302)  
7. Meals must be served in a manner suitable for the client and prepared with regard for individual preferences and religious requirements. Special diets and nourishment must be provided as ordered by the client’s physician. If meals are prepared within the facility, the facility must consult with a licensed dietitian for at least 4 hours each month on the planning and serving of meals. If meals are prepared outside of and delivered to the facility, the facility shall develop and provide an alternative for any client on a special diet. The facility shall not accept a client who requires a special diet if it cannot develop an alternative which conforms to the client’s prescribed diet. | The State proposes no changes at this time. | N/A | N/A |
| A medical or ancillary service not directly provided by the facility may be provided by another person pursuant to a contract. | The State regulation, policy, or other standards are compliant. The State’s determination is based on NAC 449.4084: Contract for provision by another person. (NRS 449.0302)  
1. A medical or ancillary service not directly | The State proposes no changes at this time. | N/A | N/A |
provided by the facility may be provided by another
person pursuant to a contract.

2. The contract must:
   (a) Be in writing;
   (b) Designate the service provided, the manner
       in which it will be provided and the geographical
       area to be served;
   (c) Describe the manner in which the person
       providing the service will be supervised;
   (d) Describe how the service will be coordinated
       with other services at the facility;
   (e) Require the person providing the service to
       furnish his or her clinical notes and observations
       of a client for the file of the client;
   (f) Specify the method of determining charges
       for the service and the method for reimbursement
       by the facility;
   (g) Specify the period of the contract and how
       frequently it is to be reviewed; and
   (h) Assure that the service and any person
       providing the service meet the same qualifications
       as required for employees of and services provided
       by a facility.
System Remediation Grid for HCBS based on ICF/IID LOC

Jobs and Day Training (Day Habilitation, Pre-Vocational and Supportive Employment Services)

The Jobs and Day Training Settings operate under the Individuals with Intellectual Disabilities and Related Conditions Home and Community Based Services Waiver and are regulated by NRS 435. These regulations require jobs and day training services to keep certain records; establish procedures concerning quality assurance reviews; requirements for initial and renewal application for certification through ADSD; requirements for providers to comply with ADSD requirements; and establishes procedures to impose sanctions on providers not in compliance. Additionally, the service definition in the current waiver was updated using CMS guidance: Center for Medicaid, CHIP and Survey and Certification (CMCS) Informational Bulletin, dated September 16, 2011.

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Prevocational Services are provided in a community setting and may include volunteer work, participation in social and recreational activities, classroom style training, and job related experience.</td>
<td>The State regulation, policy, or other standards are compliant. The State’s determination is based on NRS 435.176: “Jobs and day training services” defined. “Jobs and day training services” means individualized services for day habilitation, prevocational, employment and supported employment:</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Supported employment services are individualized and may include</td>
<td>The State regulation, policy, or other standards are compliant. The State’s determination is based on</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
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</table>
person-centered employment planning, job placement, job development, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

NRS 435.176: "Jobs and day training services" defined. "Jobs and day training services" means individualized services for day habilitation, prevocational, employment and supported employment:

1. Which are provided:
   (a) For compensation;
   (b) In a division facility or in the community; and
   (c) To a person with an intellectual disability or a person with a related condition who is served by the Division; and

2. Which are designed to assist the person in:
   (a) Learning or maintaining skills;
   (b) Succeeding in paid or unpaid employment;
   (c) Increasing self-sufficiency, including, without limitation, training and habilitation services; and
   (d) Contributing to the person's community

Behavioral consultation, training and intervention services provide behaviorally-based assessment and intervention for participants, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of Individual Support Plans and/or positive behavior support plans, necessary to improve an individual's independence and inclusion in their community, increase positive

The State regulation, policy, or other standards are compliant. The State's determination is based on NRS 435.176: "Jobs and day training services" defined. "Jobs and day training services" means individualized services for day habilitation, prevocational, employment and supported employment:

1. Which are provided:
   (a) For compensation;
   (b) In a division facility or in the community; and
   (c) To a person with an intellectual disability or a person with a related condition who is served by the Division; and

2. Which are designed to assist the person in:
   (a) Learning or maintaining skills;

The State proposes no changes at this time.

N/A
alternative behaviors, and/or address challenging behavior.

(b) Succeeding in paid or unpaid employment;
(c) Increasing self-sufficiency, including, without limitation, training and habilitation services; and
(d) Contributing to the person’s community

Supported Living Services

The Supported Living Services Settings operate under the Individuals with Intellectual Disabilities and Related Conditions Waiver and are regulated by NRS 435 and NAC 435. The NAC 435 has been updated and is pending final approval from the Nevada Legislature. A public hearing will be conducted once approval is received. The proposed language is used throughout the System Remediation Grid to provide the information for the proposed regulations. The State regulation NAC 435.523 is used throughout this section, unless otherwise noted, for each regulation. The language is as follows:

NAC 435.523 - A provider of supported living arrangement services must comply with the following standards for the provision of quality care concerning supported living arrangement services:
1. Compliance with any state or federal statute or regulation required for the Division to receive state or federal funding concerning the provision of supported living arrangement services, including, without limitation, any standards of care set forth in:
   (a) The State Plan for Medicaid;
   (b) The Medicaid Services Manual established by the Division of Health Care Financing and Policy of the Department of Health and Human Services; and
   (c) The home and community-based services waiver granted pursuant to 42 U.S.C. § 1396n by the Secretary of the United States Department of Health and Human Services;

The DHCFP has provided additional supporting language from the Medicaid Services Manual for the Home and Community Based Services Waiver for Individuals with Intellectual Disabilities amendment which is expected to be approved in mid-2017, as well as from the Home and Community Based Services Waiver Application to support each regulation as outlined as a compliant regulation from NAC 435.523.

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Areas of Compliance</th>
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<tbody>
<tr>
<td>The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and</td>
<td>Setting selection is not prohibited by NRS or NAC. The DHCFP requires that the DS Service Coordinator review the Statement of Choice form with the recipient and/or their legal guardian/representative which acknowledges the recipient rights and right to choose between a home and community based living setting as opposed to</td>
<td>The State proposes no changes at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

<table>
<thead>
<tr>
<th>MSM Chapter 2100: 2103.5B Recipient Rights and Responsibility:</th>
<th>The State proposes no changes at this time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Recipients are entitled to their privacy; to be treated with respect; and be free from coercion and restraint.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Appendix B: Participant Access and Eligibility B-7: Freedom of Choice a. Procedures – This section of the NV.0125.R06.00Waiver for Individuals with Intellectuals Disabilities and Related Conditions includes language to support this regulation.

<table>
<thead>
<tr>
<th>MSM Chapter 2100: 2103.5A Provider Responsibility:</th>
<th>The State proposes no changes at this time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The provider will optimize, but not regiment, the recipient’s initiative, autonomy, and independence in making life choices by allowing the recipient the following: active participation in selecting the setting, services, supports, and providers, activities they participate in, persons whom they interact with and controls over their schedules.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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<tr>
<th>HCBS Waiver: NV.0125.R06.00; Appendix D-1.f: Prior to waiver enrollment, all participants or legal guardians read and sign a &quot;Statement of Choice&quot; form. The Statement of Choice reads, “I have actively participated in identifying my supports and preferred outcomes for the next year. I have been able to choose the provider of my support services. I am aware that I can ask for a</th>
<th>The State proposes no changes at this time.</th>
</tr>
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<tbody>
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<td>N/A</td>
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The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

435.565 NAC Written contract for provision of services. (NRS 435.333) A provider of supported living arrangement services shall enter into a written contract for the provision of supported living arrangement services with each person or his or her parent or guardian, if applicable, and the Division.

NRS 118A: Landlord and Tenant: Dwellings

NRS 118A.160 “Rental agreement” defined. “Rental agreement” means any oral or written agreement for the use and occupancy of a dwelling unit or premises.

NRS 118A.200 Rental agreements: Signing; copies; required provisions; disputable presumptions; use of nonconforming agreement unlawful.

1. Any written agreement for the use and occupancy of a dwelling unit or premises must be signed by the landlord or his or her agent and the tenant or his or her agent.

2. The landlord shall provide one copy of any written agreement described in subsection 1

| The State proposes no changes at this time. | N/A | N/A |
to the tenant free of cost at the time the agreement is executed and, upon request of the tenant, provide additional copies of any such agreement to the tenant within a reasonable time. The landlord may charge a reasonable fee for providing the additional copies.

3. Any written rental agreement must contain, but is not limited to, provisions relating to the following subjects:
   (a) Duration of the agreement.
   (b) Amount of rent and the manner and time of its payment.
   (c) Occupancy by children or pets.
   (d) Services included with the dwelling rental.
   (e) Fees which are required and the purposes for which they are required.
   (f) Deposits which are required and the conditions for their refund.
   (g) Charges which may be required for late or partial payment of rent or for return of any dishonored check.
   (h) Inspection rights of the landlord.
   (i) A listing of persons or numbers of persons who are to occupy the dwelling.
   (j) Respective responsibilities of the landlord and the tenant as to the payment of utility charges.
   (k) A signed record of the inventory and condition of the premises under the exclusive custody and control of the tenant.
   (l) A summary of the provisions of NRS 202.470.
   (m) Information regarding the procedure pursuant to which a tenant may report to the appropriate authorities:
1. A nuisance.
2. A violation of a building, safety or health code or regulation.
(n) Information regarding the right of the tenant to engage in the display of the flag of the United States, as set forth in NRS 118A.325.
4. The absence of a written agreement raises a disputable presumption that:
   (a) There are no restrictions on occupancy by children or pets.
   (b) Maintenance and waste removal services are provided without charge to the tenant.
   (c) No charges for partial or late payments of rent or for dishonored checks are paid by the tenant.
   (d) Other than normal wear, the premises will be returned in the same condition as when the tenancy began.
5. It is unlawful for a landlord or any person authorized to enter into a rental agreement on his or her behalf to use any written agreement which does not conform to the provisions of this section, and any provision in an agreement which contravenes the provisions of this section is void.

| Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. | MSM Chapter 2100: 2103.8B Residential Support Services Provider Responsibilities: The Provider will ensure the setting is physically accessible to the recipient. The Provider will ensure the units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. | The State proposes no changes at this time. | N/A | N/A |
|---|---|---|---|---|---|
| Individuals sharing units have a choice of roommates in that setting. | MSM Chapter 2100: 2103.5A Provider Responsibility: The provider will optimize, but not regiment, the recipients initiative, autonomy | The State proposes no changes at this time. | N/A | N/A |
and independence in making life choices by allowing the recipient the following: choice in their physical environment, roommates, visitors of their choosing and at times of their choosing, access to food, control over their schedules, activities they participate in.

<table>
<thead>
<tr>
<th>Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.</th>
<th><strong>MSM Chapter 2100: 2103.8B Residential Support Services Provider Responsibility:</strong> Providers must ensure the recipient has the freedom to furnish and decorate to their living area to their liking within the lease or other agreement.</th>
<th>The State proposes no changes at this time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.</td>
<td><strong>MSM Chapter 2100: 2103.5A Provider Responsibility:</strong> The provider will optimize, but not regiment, the recipients initiative, autonomy and independence in making life choices by allowing the recipient the following: choice in their physical environment, roommates, visitors of their choosing and at times of their choosing, access to food, control over their schedules, activities they participate in.</td>
<td>The State proposes no changes at this time.</td>
</tr>
<tr>
<td>Individuals are able to have visitors of their choosing at any time.</td>
<td><strong>MSM Chapter 2100: 2103.5A Provider Responsibility:</strong> The provider will optimize, but not regiment, the recipients initiative, autonomy and independence in making life choices by allowing the recipient the following: choice in their physical environment, roommates, visitors of their choosing and at times of their choosing, access to food, control over their schedules, activities they participate in.</td>
<td>The State proposes no changes at this time.</td>
</tr>
<tr>
<td>The setting is physically accessible to the individual.</td>
<td><strong>MSM Chapter 2100: 2103.8B Residential Support Services Provider Responsibilities:</strong> The Provider will ensure the setting is physically</td>
<td>The State proposes no changes at this time.</td>
</tr>
</tbody>
</table>

N/A
Based on the comprehensive review of current regulations, it has been determined that there are very few areas which are in direct conflict with the new regulations. In many cases, existing regulations do not specifically refer to setting requirements, but, neither do they prohibit setting specific requirements.

Areas which are neither supported nor prohibited will be included in policy manuals and waiver amendments which will allow regulations to continue to be useful and not overly restrictive. For example, there are no regulations requiring that the “setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS”. This language can be included in waiver amendments and policy. Additionally, the new regulations have a specific requirement for individuals to have a lease agreement which is not currently addressed in regulation, but will be added to waiver amendments and policy.

During the review of State regulations, some potential conflicts arose with the requirement of “aging in place”. The Regulatory Sub-Committee conducted a more in-depth review of these identified regulations. Some areas that were initially presumed to present barriers were found to be acceptable upon review. Other areas were determined to be correctible with the insertion of policy language in the relevant Medicaid Service Manuals (MSM).

There are two areas currently in regulation that pose potential problems with “aging in place:” the current Fire Marshal Regulations; and certain medical conditions.

- The State has begun to implement a solution for the Fire Marshal Regulations affecting an individual’s ability to age in place, if s/he is unable to self-preserve well enough to get out of the building without assistance within 4 minutes. The potential issue with aging in place due to Fire Marshall Regulations about a person’s ability to self-preserve and the level of fire suppression required has been addressed by the Fire Marshall and the HCQC. A technical bulletin from HCQC was published on October 22, 2014 addressing this issue (Appendix J1).

- Certain medical conditions were previously identified as being problematic for continued residence. After further review and collaboration with the Division of Health Care Quality Compliance it is evident that there is no conflict with this area. NAC 449.271 states, “...except as otherwise provided in NAC 449.2736...” NAC.2736 provides a mechanism to make a written request for permission to admit or retain a resident with medical conditions as long as the needs of the resident can be provided by the facility. Based on this, residents could age in place as long as there are assurances that their needs can be met.
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   A6. Home and Community Based Assessment Form – Recipient Results

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   C2. Remediation Question and Answer Key for Providers
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F3. Notice of Public Workshop 8/19/14

F4. Minutes from Public Workshop 8/19/14

F5. Notice of Public Workshop 11/10/14

F6. Minutes from Public Workshop 11/10/14

F7. AARP response to Public Workshop 11/10/14

F8. LTO response to Public Workshop 11/10/14

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G3. AHONN 4/22/16

G4. LTO Ventures 8/12/16

G5. Email response from girlieantonio@yahoo.com

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H2. Public Comment Invitation

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J. Clarification from CMS

K. Documents

K1. Statement of Choice

K2. Statement of Understanding
A. Assessment Surveys
A1. Provider Self Assessment Survey #1
## Provider Self Assessment Survey #1

<table>
<thead>
<tr>
<th>Characteristics expected to be present in all HCBS:</th>
<th>Approved Modification?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the client given a choice regarding where to live/receive services?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>2. Is the client able to choose what activities to participate in outside of the home setting and apart from the housemates with whom s/he resides?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>3. Is the client employed in the larger community?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>4. Does the client have his or her own room?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>5. If the client shares a room, was s/he given a choice of roommates?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. Do married couples share or not share a room by choice? □ N/A</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>7. Is the client able to choose his or her own schedule separate from housemate’s or other residents’ schedules?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8. Does the client have control over and access to his or her personal resources?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>9. Can the client choose what, when, where and with whom to eat?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10. Does the client have access to food whenever s/he wants?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11. Are the client's preferences incorporated into the services and supports provided?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>12. Can the client choose the provider of services and supports?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>13. Does the client have access to make private telephone calls/texts/email at his or her convenience?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>14. Is the client free from coercion?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>15. If the client has concerns, is s/he comfortable discussing them?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>16. Does the client or authorized representative have an active role in the development and updating of the client’s person-centered plan?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>17. Does the setting facilitate integration of clients within the broader community? (Ex. Banking, medical visits, beautician, church/spiritual affiliations, civic groups, volunteerism, gyms, classes, recreational events, etc.)?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>18. Is the client able to receive visitors when and where s/he wants?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>19. Do clients have choice which is not limited by State laws, regulations, requirements or facility protocols or practices?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>20. Does the setting support the client’s comfort, independence and preferences?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>21. Is the setting physically accessible?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>22. Are supports or adaptations available for the clients who need them?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>23. Are clients able to come and go at will?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>24. Do clients have access to public transportation?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>25. If public transportation is limited, are other resources provided to clients?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>26. Is the client’s PHI and other personal information kept private?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

**Characteristics expected to be present in all HCBS:**

<p>| 27. Are clients who need assistance to dress given choices and respect? | □ Yes □ No |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>28.</td>
<td>Does staff communicate with clients in a respectful and dignified manner?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>If modifications of the setting requirements for a client are made, are they supported by an assessed need and justified in the person-centered plan?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Does the plan include a description of the condition that is proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews, informed consent, and assurance that the intervention will not cause harm?</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>Do clients have privacy in their living and sleeping spaces and toileting facilities?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Is furniture arranged as the clients prefer?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Can bedroom and bathroom doors be locked?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Do staff or other residents knock before entering?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Is resident free from video monitoring/continuous monitoring?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Are clients able to furnish and decorate their sleeping and/or living units as they desire?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>Is the residence owned by someone other than the Provider or Provider’s affiliate(s)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>Is there a lease or written residency agreement?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>Does the client know his or her rights regarding housing and when s/he could be required to relocate?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Do clients know how to relocate and request new housing?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>Does the written agreement include language that provides protections to address eviction processes and appeals comparable with those provided under the jurisdiction’s landlord/tenant laws?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A2. 1\textsuperscript{st} Provider Survey Results
<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the client given a choice regarding where to live/receive services?</td>
<td>139</td>
<td>6</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. Is the client able to choose what activities to participate in outside of the home setting and apart from the housemates with whom s/he resides?</td>
<td>145</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Is the client employed in the larger community?</td>
<td>66</td>
<td>72</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Does the client have his or her own room?</td>
<td>132</td>
<td>10</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>5. If the client shares a room, was s/he given a choice of roommates?</td>
<td>49</td>
<td>6</td>
<td>62</td>
<td>28</td>
</tr>
<tr>
<td>6. Do married couples share or not share a room by choice?</td>
<td>10</td>
<td>2</td>
<td>114</td>
<td>1</td>
</tr>
<tr>
<td>7. Is the client able to choose his or her own schedule separate from housemate’s or other residents’ schedules?</td>
<td>131</td>
<td>2</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>8. Does the client have control over and access to his or her personal resources?</td>
<td>87</td>
<td>59</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Can the client choose what, when, where and with whom to eat?</td>
<td>134</td>
<td>11</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10. Does the client have access to food whenever s/he wants?</td>
<td>128</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Are the client’s preferences incorporated into the services and supports provided?</td>
<td>146</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12. Can the client choose the provider of services and supports?</td>
<td>135</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. Does the client have access to make private telephone calls/texts/email at his or her convenience?</td>
<td>140</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>14. Is the client free from coercion?</td>
<td>146</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. If the client has concerns, is s/he comfortable discussing them?</td>
<td>146</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. Does the client or authorized representative have an active role in the development and updating of the client’s person-centered plan?</td>
<td>146</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17. Does the setting facilitate integration of clients within the broader community? (Ex. Banking, medical visits, beautician, church/spiritual affiliations, civic groups, volunteerism, gyms, classes, recreational events, etc.)</td>
<td>145</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18. Is the client able to receive visitors when and where s/he wants?</td>
<td>143</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>19. Do clients have choice which is not limited by State laws, regulations, requirements or facility protocols or practices?</td>
<td>128</td>
<td>16</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20. Does the setting support the client’s comfort, independence and preferences?</td>
<td>145</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>21. Is the setting physically accessible?</td>
<td>145</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22. Are supports or adaptations available for the clients who need them?</td>
<td>144</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>23. Are clients able to come and go at will?</td>
<td>77</td>
<td>65</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>24. Do clients have access to public transportation?</td>
<td>127</td>
<td>16</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Question</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>Blank</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>25. If public transportation is limited, are other resources provided to clients?</td>
<td>144</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>26. Is the client’s PHI and other personal information kept private?</td>
<td>144</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>27. Are clients who need assistance to dress given choices and respect?</td>
<td>144</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>28. Does staff communicate with clients in a respectful and dignified manner?</td>
<td>144</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>29. If modifications of the setting requirements for a client are made, are they supported by an assessed need and justified in the person-centered plan?</td>
<td>144</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>30. Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?</td>
<td>143</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>31. Does the plan include a description of the condition that is proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews, informed consent, and assurance that the intervention will not cause harm?</td>
<td>109</td>
<td>34</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>□ N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Do clients have privacy in their living and sleeping spaces and toileting facilities?</td>
<td>144</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>33. Is furniture arranged as the clients prefer?</td>
<td>138</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>34. Can bedroom and bathroom doors be locked?</td>
<td>93</td>
<td>51</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>35. Do staff or other residents knock before entering?</td>
<td>143</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>36. Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?</td>
<td>119</td>
<td>26</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>37. Is resident free from video monitoring/continuous monitoring?</td>
<td>139</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>38. Are clients able to furnish and decorate their sleeping and/or living units as they desire?</td>
<td>144</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>39. Is the residence owned by someone other than the Provider or Provider’s affiliate(s)?</td>
<td>102</td>
<td>43</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>40. Is there a lease or written residency agreement?</td>
<td>135</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>41. Does the client know his or her rights regarding housing and when s/he could be required to relocate?</td>
<td>134</td>
<td>11</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>42. Do clients know how to relocate and request new housing?</td>
<td>129</td>
<td>15</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>43. Does the written agreement include language that provides protections to address eviction processes and appeals comparable with those provided under the jurisdiction’s landlord/tenant laws?</td>
<td>123</td>
<td>20</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>44. Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?</td>
<td>107</td>
<td>38</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
A3. Provider Self Assessment Survey #2
<table>
<thead>
<tr>
<th>Characteristics expected to be present in all HCBS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the client given a choice regarding where to live/receive services?</td>
</tr>
<tr>
<td><em>Explanation:</em> Was the client able to choose among available Supported Living Providers or Group Providers?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>2. Is the client able to choose what activities to participate in outside of the setting and apart from the housemates with whom s/he resides?</td>
</tr>
<tr>
<td><em>Explanation:</em> The recipient should be able to make choices about the activities that they want to participate in, whether the activity is within the residence or outside of the residence. This does not mean the setting must transport the client to any and all events or activities. It DOES mean that the Provider will work with the client and his or her family/support group to schedule transportation etc.</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>3. Is the client employed in the larger community?</td>
</tr>
<tr>
<td><em>Explanation:</em> This is about choice, not capability. If the client chooses to seek employment, does the Provider support this choice?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>4. Does the client have his or her own room?</td>
</tr>
<tr>
<td><em>Explanation:</em> If there are single rooms available, can the client choose to have one? Medicaid funds are not paid for room and board. This is between the recipient and the provider. If the recipient wants his or her own room, this is an agreement between the recipient and provider. If the provider cannot offer a private room, maybe another provider can. This is again about choice. If the recipient chooses a specific provider and wants that provider, but they don’t have a private room available, then the recipient made that choice.</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>5. If the client shares a room, was s/he given a choice of roommates?</td>
</tr>
<tr>
<td><em>Explanation:</em> The same explanation as above. This is about choice. Does the Provider have a system in place for residents to approve – or not – the individual who will share a room?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. Do married couples share or not share a room by choice? □ N/A</td>
</tr>
<tr>
<td><em>Explanation:</em> There are some providers who accept married couples, and if you are one of those providers - can they choose to share a bedroom?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>7. Is the client able to choose his or her own schedule separate from housemate’s or other residents’ schedules?</td>
</tr>
<tr>
<td><em>Explanation:</em> Refer to question number 2. Are all individuals living in a setting on the same schedule or do they have the right to do as they please? Note: due to cognitive or safety concerns, staff monitors so they don’t wander. This question refers to what they do within the residence.</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8. Does the client have control over and access to his or her personal resources?</td>
</tr>
<tr>
<td><em>Explanation:</em> Think about a group setting, who has control over the client’s money? It could be an authorized representative, or even the provider, with written permission. If someone else controls it, does the client have access to an allowance or money to spend on personal items?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
| 9. | Can the client choose what, when, where and with whom to eat?  
Explanation: If meal times are scheduled, can the client choose not to eat at those scheduled times, but eat at a different time. Can the client eat in his or her room if they choose? If they don't want to sit at the table with the other residents, can they sit somewhere else?  
☐ Yes ☐ No |
| 10. | Does the client have access to food whenever s/he wants?  
Explanation: Does the Provider allow the client to prepare his or her own meals, or have an outside support person come in to do so? Are clients allowed to choose with whom they sit to eat? This section assumes that the Person Centered Plan outlines restrictions imposed on the client due to medical or behavioral issues.  
☐ Yes ☐ No |
| 11. | Are the client’s preferences incorporated into the services and supports provided?  
Explanation: The client is the one in charge of his or her services. His or her input is required and should be obtained. Some individuals have guardians or representatives and they may be the decision makers if the client is unable to participate.  
☐ Yes ☐ No |
| 12. | Can the client choose the provider of services and supports?  
Explanation: This is about choice. For residential providers, the choice is the choice of living situation. Does the client have the ability to choose the provider of services, meaning the SLA or Group?  
☐ Yes ☐ No |
| 13. | Does the client have access to make private telephone calls/texts/email at his or her convenience?  
Explanation: Most community based settings have more than one resident, so do residents have the ability to make private phone calls, can they have a cell phone if they want? The provider should provide a land line; but is not obligated to provide a cell phone or computer. If the clients have those things, can they use them in private if they want?  
☐ Yes ☐ No |
| 14. | Is the client free from coercion?  
Explanation: The provider cannot talk the client into doing something they don’t want to do. If they refuse a service that day, then indicate “refused” on the log. Providers are well within their scope to cue, provide reminders, or re-direct. This is different than coercion.  
☐ Yes ☐ No |
| 15. | If the client has concerns, is s/he comfortable discussing them?  
Explanation: The provider must have a policy in place to address client concerns. Clients must have a private place to discuss concerns and clients must know they can discuss concerns.  
☐ Yes ☐ No |
| 16. | Does the client or authorized representative have an active role in the development and updating of the client’s person-centered plan?  
Explanation: This is referred to as the Individual Support Plan (ISP) or Plan of Care (POC). The client drives his or her own services and should be integral in planning and directing services, as well as decisions and changes.  
☐ Yes ☐ No |
| 17. | Does the setting facilitate integration of clients within the broader community? (Ex. Banking, medical visits, beautician, church/spiritual affiliations, civic groups, volunteerism, gyms, classes, recreational events, etc.)  
Explanation: This does not mean the setting must transport the client to any and all events or activities. It DOES mean that the Provider will work with the client and his or her family/support group to schedule transportation etc. (This is not referring to medical appointments or jobs and day training – this is social in nature).  
☐ Yes ☐ No |
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Is the client able to receive visitors when and where s/he wants?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanation: Are there restricted visiting hours? If yes, please explain why on a separate sheet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Does the setting support the client’s comfort, independence and preferences?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Can clients have their own furniture, paint their room, and make their living situation their own?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Is the setting physically accessible?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Thinking about clients who use wheelchairs or walkers, is the home accessible to them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Are supports or adaptations available for the clients who need them?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: If the client needs a ramp or grab bars, can they be installed and available for their use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Are clients able to come and go at will?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: For those clients whose health and safety would be at risk, is the restriction placed on their movement documented in the Care Plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do clients have access to public transportation?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Providers should think about rural and urban. If urban, do clients have access to public transportation? If rural, is the client given assistance to find alternate transportation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. If public transportation is limited, are other resources provided to clients?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Nevada is a rural State meaning that areas outside of the urban areas do not have public transportation. If there isn’t public transportation, are there other options for clients such as friends, family, civic organizations, etc.?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Is the client’s PHI and other personal information kept private?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Nevada’s policy is that all recipients have a file and that file is located in a locked area. This is verification that the provider keeps the client’s information locked.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Are clients who need assistance to dress given choices and respect?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: This is about choice. If the clients are able, do they help pick out their own clothes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Does staff communicate with clients in a respectful and dignified manner?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Clients must be treated with respect and dignity. Providers should offer and provide training to caregivers in how to treat clients in this manner. In addition, there should internal policies in place for this.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. If modifications of the setting requirements for a client are made, are they supported by an assessed need and justified in the person-centered plan?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: Landlords or home owners have the right to say no to a modification that is needed. If a recipient needs a modification, the landlord or owner must know that it is medically necessary and justified. This is found in the ISP or POC. If the landlord does say no, the client should be given the option to select another provider. This is all about the provider and the client working together to deal with supports that the client may need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explanation: As stated above, landlords and owners have the right to say no, and also have the right to request other interventions, such as cueing, redirecting, or actual hands on assistance, prior to making a modification. Physical modifications would be made after these have been attempted and are unsuccessful. This would be documented in the ISP or POC. This is all about the provider and the client working together to deal with supports that the client may need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Does the plan include a description of the condition that is proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews, informed consent, and assurance that the intervention will not cause harm?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> In Residential Facilities for Groups, restrictive intervention is against State law. In a Supported Living Arrangement, restrictive intervention must be justified and reviewed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do clients have privacy in their living and sleeping spaces and toileting facilities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> Clients are entitled to privacy when they are in the bathroom or in their bedroom. Are clients allowed to be in the bathroom or bedroom with privacy? A bathroom may be shared if it can be locked while occupied to allow for privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is furniture arranged as the clients prefer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> Sometimes clients have their own furniture and sometimes they use the furniture available. Can the clients arrange their room or their living space how they would like?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can bedroom and bathroom doors be locked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> Clients must have the option to lock bathroom and bedroom doors for privacy. Appropriate staff may have keys for safety reasons. This question is about the option, can clients lock those doors if they choose?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do staff or other residents knock before entering?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> This is a continuation of privacy. If a client is in the bathroom or bedroom, whether the door is locked or not, do people knock before entering?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> This is a continuation of question 34. Staff may have keys, but are staff trained in the circumstances to use those keys?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is resident free from video monitoring/continuous monitoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> This is another privacy question. Monitoring is very similar to supervision. If someone does not need supervision, then this should not happen. If someone does need supervision, it is a person who should monitor, not a video.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are clients able to furnish and decorate their sleeping and/or living units as they desire?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> This is the client's home so he or should have his or her own belongings if they choose. The provider should allow for them to do this. They should have a closet or space for their own clothes, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the residence owned by someone other than the Provider or Provider’s affiliate(s)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> This is a separation of home and business. Does the business owner also own the home? Is the enrolled Medicaid provider also the home owner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a lease or written residency agreement? If No to 39, please skip.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> For those Settings in which the Provider or Provider's affiliate owns the residence, is there a lease or written residency agreement?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the client know his or her rights regarding housing and when s/he could be required to relocate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> Medicaid does not reimburse for room and board, so the home is required to inform clients of their rights regarding housing. Does the lease or written residency agreement clearly outline the tenant's rights?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Characteristics expected to be present in all HCBS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do clients know how to relocate and request new housing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanation:</strong> The client may choose at any time to change providers. The lease agreement must be explained to the client. The client must have the choice to sign a</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>long term or month to month agreements.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>43.</strong> Does the written agreement include language that provides protections to address eviction processes and appeals comparable with those provided under the jurisdiction’s landlord/tenant laws?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Explanation:</em> Both the landlord and the client must be protected in the rental agreement. The agreement must outline eviction processes and appeals.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>
| **44.** Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?  
*Explanation:* If a client wants to spontaneously go somewhere, or has an immediate, unscheduled need, can the staff assist? This does not mean the staff has to take the person, but can they assist in facilitating these requests? | □ Yes □ No |
A4. 2\textsuperscript{nd} Provider Survey Results
<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the client given a choice regarding where to live/receive services?</td>
<td>71</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Is the client able to choose what activities to participate in outside of the home setting and apart from the housemates with whom s/he resides?</td>
<td>74</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Is the client employed in the larger community?</td>
<td>54</td>
<td>15</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4. Does the client have his or her own room?</td>
<td>71</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. If the client shares a room, was s/he given a choice of roommates?</td>
<td>57</td>
<td>1</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>6. Do married couples share or not share a room by choice?</td>
<td>26</td>
<td>1</td>
<td>47</td>
<td>1</td>
</tr>
<tr>
<td>□ N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Is the client able to choose his or her own schedule separate from housemate’s or other residents’ schedules?</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Does the client have control over and access to his or her personal resources?</td>
<td>68</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. Can the client choose what, when, where and with whom to eat?</td>
<td>73</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Does the client have access to food whenever s/he wants?</td>
<td>69</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11. Are the client’s preferences incorporated into the services and supports provided?</td>
<td>74</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12. Can the client choose the provider of services and supports?</td>
<td>71</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Does the client have access to make private telephone calls/texts/email at his or her convenience?</td>
<td>73</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14. Is the client free from coercion?</td>
<td>75</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. If the client has concerns, is s/he comfortable discussing them?</td>
<td>75</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. Does the client or authorized representative have an active role in the development and updating of the client’s person-centered plan?</td>
<td>74</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17. Does the setting facilitate integration of clients within the broader community? (Ex. Banking, medical visits, beautician, church/spiritual affiliations, civic groups, volunteerism, gyms, classes, recreational events, etc.)</td>
<td>73</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>18. Is the client able to receive visitors when and where s/he wants?</td>
<td>71</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>20. Does the setting support the client’s comfort, independence and preferences?</td>
<td>74</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>21. Is the setting physically accessible?</td>
<td>73</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>23. Are clients able to come and go at will?</td>
<td>68</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>24. Do clients have access to public transportation?</td>
<td>72</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>69</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>25.</td>
<td>If public transportation is limited, are other resources provided to clients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Is the client’s PHI and other personal information kept private?</td>
<td>75</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27.</td>
<td>Are clients who need assistance to dress given choices and respect?</td>
<td>75</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>28.</td>
<td>Does staff communicate with clients in a respectful and dignified manner?</td>
<td>75</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>29.</td>
<td>If modifications of the setting requirements for a client are made, are they supported by an assessed need and justified in the person-centered plan?</td>
<td>73</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>30.</td>
<td>Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?</td>
<td>72</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>31.</td>
<td>Does the plan include a description of the condition that is proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews, informed consent, and assurance that the intervention will not cause harm? N/A</td>
<td>52</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>32.</td>
<td>Do clients have privacy in their living and sleeping spaces and toileting facilities?</td>
<td>75</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>33.</td>
<td>Is furniture arranged as the clients prefer?</td>
<td>74</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>34.</td>
<td>Can bedroom and bathroom doors be locked?</td>
<td>55</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>35.</td>
<td>Do staff or other residents knock before entering?</td>
<td>75</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>36.</td>
<td>Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?</td>
<td>62</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>37.</td>
<td>Is resident free from video monitoring/continuous monitoring?</td>
<td>71</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>38.</td>
<td>Are clients able to furnish and decorate their sleeping and/or living units as they desire?</td>
<td>74</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>39.</td>
<td>Is the residence owned by someone other than the Provider or Provider’s affiliate(s)?</td>
<td>43</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>40.</td>
<td>Is there a lease or written residency agreement?</td>
<td>52</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>41.</td>
<td>Does the client know his or her rights regarding housing and when s/he could be required to relocate?</td>
<td>73</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>42.</td>
<td>Do clients know how to relocate and request new housing?</td>
<td>62</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>43.</td>
<td>Does the written agreement include language that provides protections to address eviction processes and appeals comparable with those provided under the jurisdiction’s landlord/tenant laws?</td>
<td>67</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>44.</td>
<td>Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?</td>
<td>73</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
A5. Home and Community Based Assessment Form – Recipient
<table>
<thead>
<tr>
<th>Characteristics expected to be present in all HCBS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you given a choice regarding where to live/receive services?</td>
</tr>
<tr>
<td>2. Can you choose whether or not to participate in group activities?</td>
</tr>
<tr>
<td>3. Do you have your own room?</td>
</tr>
<tr>
<td>4. If you share a room, were you given a choice of roommates?</td>
</tr>
<tr>
<td>5. Do you have control over and access to your personal resources?</td>
</tr>
<tr>
<td>6. Can you choose what, when, where and with whom to eat?</td>
</tr>
<tr>
<td>7. Do you have access to make private telephone calls/texts/email at your convenience?</td>
</tr>
<tr>
<td>8. Are you free from coercion?</td>
</tr>
<tr>
<td>9. If you have concerns, are you comfortable discussing them?</td>
</tr>
<tr>
<td>10. Are you able to receive visitors when and where you want?</td>
</tr>
<tr>
<td>11. Does the setting support your comfort, independence and preferences?</td>
</tr>
<tr>
<td>12. Is the setting physically accessible?</td>
</tr>
<tr>
<td>13. Are you able to come and go at will?</td>
</tr>
<tr>
<td>14. Do you have access to public transportation?</td>
</tr>
<tr>
<td>15. If public transportation is limited, are other resources provided to you?</td>
</tr>
<tr>
<td>16. If you need assistance to dress, are you given respect and a choice of what to wear?</td>
</tr>
<tr>
<td>17. Does staff communicate with you in a respectful and dignified manner?</td>
</tr>
<tr>
<td>18. Do you have privacy in your living and sleeping spaces and toileting facilities? Can the doors be locked?</td>
</tr>
<tr>
<td>19. Do staff or other residents knock before entering?</td>
</tr>
<tr>
<td>20. Do staff use a key to enter a living space only under limited circumstances previously agreed upon with you?</td>
</tr>
<tr>
<td>21. Are you free from video monitoring/continuous monitoring</td>
</tr>
<tr>
<td>22. Are you able to furnish and decorate your sleeping and/or living units as you desire?</td>
</tr>
<tr>
<td>23. Do you know your rights regarding housing and when you could be required to relocate?</td>
</tr>
<tr>
<td>24. Do you have a written agreement that includes language that provides protections to address eviction processes and appeals comparable with those provided by landlord/tenant laws?</td>
</tr>
</tbody>
</table>

Please add any comments, questions, or concerns below and on the back. Thank you.
A6. Home and Community Based Assessment Form – Recipient Results
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you given a choice regarding where to live/receive services?</td>
<td>913</td>
<td>91</td>
<td>7</td>
<td>69</td>
</tr>
<tr>
<td>2. Can you choose whether or not to participate in group activities?</td>
<td>939</td>
<td>61</td>
<td>10</td>
<td>70</td>
</tr>
<tr>
<td>3. Do you have your own room?</td>
<td>895</td>
<td>78</td>
<td>37</td>
<td>70</td>
</tr>
<tr>
<td>4. If you share a room, were you given a choice of roommates?</td>
<td>397</td>
<td>200</td>
<td>252</td>
<td>230</td>
</tr>
<tr>
<td>5. Do you have control over and access to your personal resources?</td>
<td>888</td>
<td>107</td>
<td>14</td>
<td>71</td>
</tr>
<tr>
<td>6. Can you choose what, when, where and with whom to eat?</td>
<td>906</td>
<td>77</td>
<td>19</td>
<td>78</td>
</tr>
<tr>
<td>7. Do you have access to make private telephone calls/texts/email at your convenience?</td>
<td>905</td>
<td>70</td>
<td>31</td>
<td>74</td>
</tr>
<tr>
<td>8. Are you free from coercion?</td>
<td>933</td>
<td>36</td>
<td>9</td>
<td>102</td>
</tr>
<tr>
<td>9. If you have concerns, are you comfortable discussing them?</td>
<td>912</td>
<td>50</td>
<td>16</td>
<td>93</td>
</tr>
<tr>
<td>10. Are you able to receive visitors when and where you want?</td>
<td>974</td>
<td>28</td>
<td>9</td>
<td>69</td>
</tr>
<tr>
<td>11. Does the setting support your comfort, independence and preferences?</td>
<td>968</td>
<td>27</td>
<td>6</td>
<td>76</td>
</tr>
<tr>
<td>12. Is the setting physically accessible?</td>
<td>966</td>
<td>30</td>
<td>3</td>
<td>81</td>
</tr>
<tr>
<td>13. Are you able to come and go at will?</td>
<td>839</td>
<td>141</td>
<td>23</td>
<td>77</td>
</tr>
<tr>
<td>14. Do you have access to public transportation?</td>
<td>850</td>
<td>134</td>
<td>19</td>
<td>77</td>
</tr>
<tr>
<td>15. If public transportation is limited, are other resources provided to you?</td>
<td>896</td>
<td>79</td>
<td>21</td>
<td>84</td>
</tr>
<tr>
<td>16. If you need assistance to dress, are you given respect and a choice of what to wear?</td>
<td>920</td>
<td>28</td>
<td>52</td>
<td>80</td>
</tr>
<tr>
<td>17. Does staff communicate with you in a respectful and dignified manner?</td>
<td>954</td>
<td>10</td>
<td>18</td>
<td>98</td>
</tr>
<tr>
<td>18. Do you have privacy in your living and sleeping spaces and toileting facilities? Can the doors be locked?</td>
<td>948</td>
<td>38</td>
<td>14</td>
<td>80</td>
</tr>
<tr>
<td>19. Do staff or other residents knock before entering?</td>
<td>900</td>
<td>47</td>
<td>39</td>
<td>94</td>
</tr>
<tr>
<td>20. Do staff use a key to enter a living space only under limited circumstances previously agreed upon with you?</td>
<td>658</td>
<td>191</td>
<td>105</td>
<td>123</td>
</tr>
<tr>
<td>21. Are you free from video monitoring/continuous monitoring</td>
<td>892</td>
<td>57</td>
<td>48</td>
<td>83</td>
</tr>
<tr>
<td>22. Are you able to furnish and decorate your sleeping and/or living units as you desire?</td>
<td>882</td>
<td>60</td>
<td>53</td>
<td>85</td>
</tr>
<tr>
<td>23. Do you know your rights regarding housing and when you could be required to relocate?</td>
<td>778</td>
<td>132</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>24. Do you have a written agreement that includes language that provides protections to address eviction processes and appeals comparable with those provided by landlord/tenant laws?</td>
<td>627</td>
<td>178</td>
<td>123</td>
<td>146</td>
</tr>
</tbody>
</table>
B. On Site Assessments
B1. DHCFP Settings Qualities Checklist
### DHCFP Settings Qualities Checklist

**Division of Health Care Financing and Policy**  
**Settings Qualities Checklist for**  
**Home and Community-Based Services Settings**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Address:</td>
<td></td>
</tr>
<tr>
<td>Services Provided:</td>
<td></td>
</tr>
<tr>
<td># Medicaid Beds:</td>
<td># of Private Beds:</td>
</tr>
</tbody>
</table>

**Reviewer:**

<table>
<thead>
<tr>
<th>Is the setting located in building/on grounds with institutional characteristics?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the setting in a publicly or privately operated facility that provides inpatient institutional treatment?</td>
<td></td>
</tr>
<tr>
<td>• Is the setting located in a building on the grounds of, or adjacent to, a public institution?</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>Needs/Preferences considered when settings options offered?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the setting reflect the needs and preferences of each recipient?</td>
<td></td>
</tr>
<tr>
<td>• Do recipients express satisfaction regarding the setting?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Offers a choice of non-disability specific setting and private unit?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the setting limited to use by people with disabilities?</td>
<td></td>
</tr>
<tr>
<td>• Was the setting chosen from among options that included non-disability specific settings?</td>
<td></td>
</tr>
<tr>
<td>• Are recipients offered the choice of a private room/unit where they are available for non-recipients?</td>
<td></td>
</tr>
<tr>
<td>• If recipients choose to change providers, are they given the option of receiving services in non-disability specific settings?</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>Residential options based on recipient resources for room and board?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Were the residential services offered realistic in view of the recipient resources for payment of room and board?</td>
<td></td>
</tr>
<tr>
<td>• If residential services were limited because of resources, was the matter discussed with the recipient?</td>
<td></td>
</tr>
</tbody>
</table>
### Comments:

<table>
<thead>
<tr>
<th>Are sleeping or living unit doors lockable by recipient?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can the doors to the unit be locked?</td>
<td></td>
</tr>
<tr>
<td>• Can bathroom doors be locked?</td>
<td></td>
</tr>
<tr>
<td>• Do recipients have keys to their doors?</td>
<td></td>
</tr>
</tbody>
</table>

### Comments:

<table>
<thead>
<tr>
<th>Is availability of sleeping or living unit key limited to appropriate staff?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is there a master key or are there copies of unit keys available for use if needed?</td>
<td></td>
</tr>
<tr>
<td>• Is use of the master key/unit keys limited to appropriate staff?</td>
<td></td>
</tr>
<tr>
<td>• Are the master key/unit keys used to enter units only in limited circumstances agreed upon with the recipient?</td>
<td></td>
</tr>
<tr>
<td>• Is there a policy regarding the circumstances when the master key/unit keys may be used by staff and which staff may use those keys?</td>
<td></td>
</tr>
</tbody>
</table>

### Comments:

<table>
<thead>
<tr>
<th>Is there a legally enforceable agreement specifying responsibilities and protections from eviction?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the agreement specify the responsibilities of the recipient and the provider with respect to the setting?</td>
<td></td>
</tr>
<tr>
<td>• Does the agreement specify the circumstances under which it can be terminated?</td>
<td></td>
</tr>
<tr>
<td>• Does the agreement address the steps a recipient can follow to request a review/appeal a termination of services?</td>
<td></td>
</tr>
<tr>
<td>• Does the recipient understand the terms of the agreement?</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

Does the lease/rental agreement address how recipients may furnish/decorate sleeping/living units?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Do recipients know that they may furnish and decorate their units as they please within the terms spelled out in the agreement?
- Are recipients' personal items (e.g., pictures, books, memorabilia) evident and arranged as they wish?
- Do furniture, linens, and other household items reflect personal choices?
- Do recipients' units reflect varying interests and tastes rather than having a standardized appearance?
- Is furniture arranged as recipients wish for comfort?
- Are shared rooms configured so that privacy is protected when assistance is provided to recipients?

Do recipients have a choice of roommates if sleeping or living units are shared?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Are recipients given a choice regarding roommates?
- Do recipients speak about their roommates in a positive manner?
- Do recipients express a wish to remain in a room/unit with their roommates?
- Are couples able to choose whether to share a room?
- Do recipients know that they can (and how to) request a change in roommates?

Comments:

Provides opportunities for control of personal resources?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Do recipients have bank accounts or other means to control their money?
- Does the setting facilitate/support recipients to access accounts/funds as they choose?
- If recipients work, is it clear to them that they are not required to sign over paychecks to the provider?

Comments:
**DHCFP Settings Qualities Checklist**

<table>
<thead>
<tr>
<th>Allows visitors of recipient's choosing at any time?</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Are there limitations on visiting hours or the number of visitors allowed at one time?</td>
<td></td>
</tr>
<tr>
<td>- If visiting hours are addressed in the lease/rental agreement, is the recipient made aware of limitations before moving into the residential setting?</td>
<td></td>
</tr>
<tr>
<td>- Is furniture in living areas arranged to support small group conversations?</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>Is food available to recipients at all times?</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If a recipient misses a regularly scheduled meal, are provisions made for a nutritionally-equivalent meal to be available at a time convenient to the recipient?</td>
<td></td>
</tr>
<tr>
<td>- Are there appliances for safe food storage and cooking/heating in recipients' sleeping/living units or in a common area accessible by recipients?</td>
<td></td>
</tr>
<tr>
<td>- Are snacks available anytime?</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>Is there a process for protecting recipients from coercion and restraint?</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Are recipients compelled to be absent from a setting for the convenience of the provider?</td>
<td></td>
</tr>
<tr>
<td>- Are recipients required, against their wishes, to be present in a setting in order to benefit the provider financially?</td>
<td></td>
</tr>
<tr>
<td>- Do recipients feel they can discuss concerns without fearing consequences?</td>
<td></td>
</tr>
<tr>
<td>- Are recipients informed regarding how to file a complaint?</td>
<td></td>
</tr>
<tr>
<td>- Is complaint filing information posted and understandable by recipients?</td>
<td></td>
</tr>
<tr>
<td>- Can complaint filing be done anonymously?</td>
<td></td>
</tr>
<tr>
<td>- Are staff trained in the use of restrictive interventions?</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
### DHCFP Settings Qualities Checklist

**Does it isolate recipients from broader community of individuals not receiving HCBS?**  
Yes [ ]  No [ ]

- Does the setting provide multiple types of services/activities on-site with consequent decrease in opportunities for recipient participation in broader community?
- Does the setting isolate recipients because of its nature, e.g., disability-specific farm community, gated/secure community for people with disabilities, residential school?
- Is the setting located in the community among private residences rather than in a business area?
- Does the setting operate in a manner that congregates recipients so that they live/receive services in an area separate from non-recipients?
- Does the setting use interventions/restrictions like those that might be used in institutional settings, or are deemed unacceptable in HCBS settings, e.g., seclusion, chemical restraints, locked doors?

**Comments:**

---

**Is there a process for protecting recipients’ rights to privacy, dignity and respect?**  
Yes [ ]  No [ ]

- Is health information kept private, e.g., schedules/information regarding meds, diet, PT/OT are not posted in open area for all to view?
- Do staff refrain from discussing recipient health information within hearing distance of others who do not have a need to know?
- Do recipients possess or have access to telephones or other electronic devices to use for personal communication in private and at any time?
- Are communal telephones/computers located so that privacy in communication is ensured?
- Do staff/recipients knock and receive permission to enter prior to entering a sleeping/living unit or bathroom?
- Does the setting provide assistance with grooming/hygiene as needed?
- Are recipients dressed in clothes that fit, are clean, are to their liking, and are appropriate for the time of day/season/weather?
- Do staff converse with recipients while providing assistance and during the course of daily activities?
- Do staff address recipients as individuals in the manner in which they would like to be addressed as opposed to addressing them with generic terms such as “hon” or “sweetie”?
- Do staff talk about a recipient in his/her presence as though the recipient was not present or within hearing distance?
- Are there cameras monitoring the setting?

**Comments:**
### DHCFP Settings Qualities Checklist

**Provides opportunities and support for employment in competitive, integrated settings?**

- Yes [ ]  No [ ]

- Do any recipients work in integrated community settings?
- Does the setting offer, to recipients who would like to work, information and support to ensure they are able to pursue that option?
- Does the setting support recipients that do work, e.g., planning services around the work schedule, prompting recipients when it is time to go to work, assuring transportation is available?

**Comments:**

---

**Optimizes opportunities for recipients to make choices regarding the physical environment?**

- Yes [ ]  No [ ]

- Are there barriers to movement preventing entrance to or exit from certain areas in the setting?
- Are recipients limited to a specific area for activities or able to move about to various areas?
- Are recipients able to move inside and outside the setting as they choose as opposed to being “parked” in one spot for the convenience of the provider?
- Are there requirements or a curfew regarding return to the setting if a recipient leaves?
- Are recipients assisted to access amenities (e.g., pool or gym) that are used by non-recipients?
- Are recipients restricted to meeting visitors in an area designated for that purpose?

**Comments:**
<table>
<thead>
<tr>
<th>Physically accessible for each recipient?</th>
<th>Yes ☐</th>
<th>No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Are there features that could limit mobility, e.g., raised doorways, narrow halls, shag carpets?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are there physical adaptations that counter any limiting features, e.g., ramps, stair lifts, or elevators?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are supports to facilitate mobility provided where likely to be needed, e.g., grab bars, shower seats, or hand rails?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are appliances accessible, e.g., microwave reachable without difficulty, front-loading washer/dryer useable for those with mobility devices?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are tables and chairs at convention height for recipients to access comfortably?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Is furniture placed so as not to obstruct pathways for those with mobility devices?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are there gates, locked doors, or other barriers preventing access/exit from areas in the setting?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Comments: |

<table>
<thead>
<tr>
<th>Is there a protocol for modification of residential setting conditions?</th>
<th>Yes ☐</th>
<th>No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does the setting have a process/policy addressing modification of residential setting requirements when needed for recipients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does the process/policy include the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Identification of a specific and individualized assessed need</td>
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<tr>
<td>- Documentation of positive interventions and supports before modification</td>
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<tr>
<td>- Documentation of less intrusive methods that did not work before modification</td>
<td></td>
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<tr>
<td>- Description of the condition that resulted in the need for modification</td>
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<tr>
<td>- Collection and review of data to measure effectiveness of the modification</td>
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<tr>
<td>- Specification of time frames for review of the modification to determine whether it is no longer needed or should be continued or terminated</td>
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<tr>
<td>- Informed consent of the recipient</td>
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<tr>
<td>- Assurance modification will not cause harm to the recipient</td>
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</tbody>
</table>

| Comments: |
DHCFP Settings Qualities Checklist

Facilitates choice regarding services/supports and agency staff who support them? Yes ☐ No ☐
- Do recipients know how and to whom to make a request for services?
- Are recipients aware of the fact that they can choose to receive services from other providers/staff?
- Are recipients able to identify other providers who could provide the same services?
- Does the setting assist recipients to change providers or to obtain other requested services?
- Do recipients express satisfaction with the services received?
- If a recipient is dissatisfied with/would prefer not to interact with an individual staff member, is he/she supported in the choice to receive services from a different staff person?

Comments:

Provides opportunities/support for recipient initiative, autonomy, and independence, including the ability to participate in and receive services in the community? Yes ☐ No ☐
- Do recipients have opportunities to participate regularly in meaningful non-work activities in community settings of their choice and for the period of time preferred?
- Does staff ask recipients about their needs and preferences?
- Are recipients assisted in a manner that leaves them feeling empowered to make choices and decisions?
- Are the choices and decisions supported/accommodated rather than ignored or denied?
- Does the setting make clear to recipients that they are not required to adhere to a set schedule for waking, bathing, eating, exercising, or activities?
- Is there staff sufficient to allow for scheduling variations?
- Do recipients' schedules vary from others in the same setting?
- Does the setting allow for the recipient to be alone and not participate in activities?
- Do recipients have access to typical home areas such as cooking and dining areas, laundry, and living and entertainment areas?
- Does the setting provide, or assist recipients to obtain, information on activities/services in the community?
- Are recipients able to come and go at any time, e.g., for appointments, shopping, church, entertainment, dining out?
- Is the setting located near a bus stop?
- Are bus schedules posted in a convenient location?
- Are taxis or accessible vans available to transport recipients?
- Are transportation services schedules/telephone numbers posted/available?
- Does the setting facilitate/train recipients in the use of public transportation?
- Are recipients able to talk about activities occurring outside the setting, how they accessed those activities, and who assisted in facilitating that access?

Comments:
DHCFP Settings Qualities Checklist

Meets Requirements  Yes ☐  No ☐

Provider Signature:  Date:

Reasons Requirements not Met, or Changes Needed to Meet Requirements:
C. Remediation
C1. Remediation Letter to Providers
DATE

"name"
"address"
"city", "state" "zip"

To whom it may concern,

As you are aware, a representative from either the Division of Health Care Financing and Policy (DHCFP), or Aging and Disability Services Division (ADSD) recently met with you while conducting a site visit. These site visits were made mandatory from the Centers for Medicaid and Medicare Services (CMS), as they relate to the final rules CMS 2249-F and CMS 2296-F that was made effective January 16, 2014.

The intent of this final rule is to ensure that individuals receiving long-term services and supports through Home and Community Based Services (HCBS) programs have full access to benefits of community living and the opportunity to receive services in the most integrated settings. Additionally, this final rule allows states to enhance the quality of the HCBS and provide protections to participants. Under this final rule, each state was afforded 5 years to remediate any concerns to ensure compliance by January 1, 2019.

Based on the findings of the site visits, many providers have areas that must be addressed to ensure compliance with the HCBS new rules. The intent of this letter is to identify the areas that your setting was found to need remediation and offer assistance to remain in compliance.

Please review the answers below and provide remediation to the questions in which you did not meet the settings requirements. Please note, these may be answered “yes” or “no”. A key to understanding the results is available on our website, as well as a sample remediation plan.

- Is the setting located in building/on grounds with institutional characteristics? «Q1»
- Are the recipients needs/preferences considered when settings options offered? «Q2»
- Does the setting offer a choice of non-disability specific setting and private unit? «Q3»
- Are residential options based on recipient resources for room and board? «Q4»
- Are sleeping or living unit doors lockable by recipient? «Q5»
  o Is the key available to appropriate staff? «Q6»
- Is there a lease agreement specifying eviction responsibilities and protections? «Q7»
- Does the lease agreement address furnishing/decorating sleeping/living units? «Q8»
- Do recipients have a choice of roommates? «Q9»
- Does the setting provide control for personal resources? «Q10»
- Does the setting allow visitors of recipient’s choosing at any time? «Q11»
  - Are there posted visitation hours? Are there limitations to when visitors are welcome? «Q12»
- Is food available to recipients at all times? «Q13»
- Is there a process for protecting recipient’s from coercion and restraint? «Q14»
- Does the setting isolate individuals from the community?
- Is there a process for protecting recipient rights to privacy dignity and respect?  
- Does the setting support for recipient’s to seek employment in integrated settings?  
- Does the setting optimize opportunities for recipient’s choice regarding physical environment?  
- Is the setting physically accessible for each recipient?  
- Is there a protocol for modification of residential setting conditions?  
- Does the setting facilitate choice regarding services and support staff who support them?  
- Does the setting provide support for recipient initiative, autonomy and independence to participate in and receive community services?  
- Does the setting have cameras and/or baby monitors located inside the setting?  
  *(Please note, cameras and baby monitors impede on recipients privacy, remediation must address the purpose of these inside the setting, and specifics of what they are used for)*

Remediation plans are due to the DHCFP office no later than June 10, 2016. Please respond either by email to HCBS@dhcfp.nv.gov, or mail to:

DHCFP  
Attention: Crystal Wren – LTSS  
1100 E William Street, Suite 222  
Carson City, NV 89701

For more information on the final rule, please visit https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html. The DHCFP has kept our website, http://dhcfp.nv.gov updated with the most current information from CMS related to the final rule.

Any questions or comments can be directed to Crystal Wren at crystal.wren@dhcfp.nv.gov.

Thank you,

Crystal Wren

Crystal Wren  
Social Services Program Specialist III  
DHCFP – LTSS, HCBS Waiver Unit
C2. Remediation Question and Answer Key for Providers
Is the setting located in building/on grounds with institutional characteristics?  
_This question pertains to Heightened Scrutiny. If indicated as YES, these will be submitted to CMS for further review._

Are the recipients needs/preferences considered when settings options offered?  
NO – requires remediation

Does the setting offer a choice of non-disability specific setting and private unit?  
NO – requires remediation

Are residential options based on recipient resources for room and board?  
YES – requires remediation

Are sleeping or living unit doors lockable by recipient?  
NO – requires remediation – Please note, all residential settings are required to have lockable doors on their residents sleeping and living quarters. The DHCFP understands that for some residents, it is not appropriate to have access to locking their own doors. If this is documented in their Person Centered Plan, and supported by documentation that is also included with their Person Centered Plan, the DHCFP may review this further and submit to CMS for further review.

-Is the key available to appropriate staff?  
NO – requires remediation

Is there a lease agreement specifying eviction responsibilities and protections?  
NO – requires remediation

Does the lease agreement address furnishing/decorating sleeping/living units?  
NO – requires remediation

Do recipients have a choice of roommates?  
NO – requires remediation

Does the setting provide control for personal resources?  
NO – requires remediation

Does the setting allow visitors of recipient’s choosing at any time?  
NO – requires remediation

- Are there posted visitation hours? Are there limitations to when visitors are welcome?  
_Please note, many settings demonstrated limited visitation hours. According to clarification received from CMS, this is not acceptable as residents are to be allowed visitors at the time of their choosing._

Is food available to recipients at all times?  
NO – requires remediation

Is there a process for protecting recipients from coercion and restraint?  
NO – requires remediation
Does the setting isolate individuals from the community?
   YES – requires remediation

Is there a process for protecting recipient rights to privacy dignity and respect?
   NO – requires remediation

Does the setting support for recipient’s to seek employment in integrated settings?
   NO – requires remediation

Does the setting optimize opportunities for recipient’s choice regarding physical environment?
   NO – requires remediation

Is the setting physically accessible for each recipient?
   NO – requires remediation

Is there a protocol for modification of residential setting conditions?
   NO – requires remediation

Does the setting facilitate choice regarding services and support staff who support them?
   NO – requires remediation

Does the setting provide support for recipient initiative, autonomy and independence to participate in and receive community services?
   NO – requires remediation

Does the setting have cameras and/or baby monitors located inside the setting?
   *(Please note, cameras and baby monitors impede on recipients privacy, remediation must address the purpose of these inside the setting, and specifics of what they are used for)*
   YES – requires remediation
C3. Remediation Example for Providers
<table>
<thead>
<tr>
<th>Setting name</th>
<th>ABC Provider</th>
<th>Setting Location</th>
<th>123 ABC Street  Las Vegas, NV  89123</th>
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</table>

<table>
<thead>
<tr>
<th>Remediation request</th>
<th>Timeframe for completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are sleeping or living unit doors lockable by recipient?</td>
<td>3 months</td>
</tr>
</tbody>
</table>

Remediation Plan

ABC Provider will purchase door locks for each sleeping and living unit located in our setting. This includes 16 doors. These will be purchased within 1 month and installed within 1 month. Each recipient will be given a key to their sleeping and living quarters. If it is found to be inappropriate for a recipient to have a key, this will be clearly documented in their person centered plan.

Currently, each staff does not have a key for the residents rooms as they do not have locking doors. Once the locking doors are installed, ABC Provider will ensure that a key for each resident's room is available to the lead staff person for that shift. These keys will be stored in our Administrative office and available on an as needed basis. During times when the majority of the residents are in their rooms, the keys will be with the lead staff for accessibility.

ABC Provider will remove the current visiting hours which are posted throughout the facility, and amend this posting to include the following: Visitors Welcome. Front door is open from 8:00 am - 5:00 pm, if after hours, please ring doorbell to be let in.” A copy of this is attached for your review.

<table>
<thead>
<tr>
<th>Remediation request</th>
<th>Timeframe for completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is availability of sleeping or living unit key limited to appropriate staff?</td>
<td>3 months</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Remediation request</th>
<th>Timeframe for completion</th>
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</thead>
<tbody>
<tr>
<td>Allows visitors of recipient's choosing at any time?</td>
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C4. Remediation Checklist
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<th>PROVIDER</th>
<th>region</th>
<th>RECEIVED (Y/N)</th>
<th>spreadsheet Complete (Y/N)</th>
<th>Acceptable (Y/N)</th>
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<td>Alebris Home Care Inc</td>
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D. Heightened Scrutiny
D1. DHCFP HCB Heightened Scrutiny Questionnaire
Division of Health Care Financing and Policy (DHCFP)
HCB Settings Heightened Scrutiny Questionnaire

Setting: ________________________________________________________________

Location: ______________________________________________________________

What are the licensure requirements or regulations for the setting?

How do the licensure requirements or regulations differ from institutional requirements and regulations?

Residential housing or zoning requirements.

The proximity to and scope of interactions with community settings used by individuals not receiving Medicaid funded HCBS.

Is public transportation easily accessible? Or, if public transportation is limited, what options are provided for transportation?

Provider qualifications for staff employed in the setting. Demonstrate that staff are trained specifically for HCB support in a manner consistent with the HCB settings regulations.

What services are offered in the setting? Explain how these services support community integration and/or maximize autonomy.

What procedures are used to ensure recipients are able to participate in activities in the greater community according to their preferences and interests? How is staff trained to support individual choice?
D2. Provider On site reviews/Heightened Scrutiny Questionnaire
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<td>4.1 Are there gates, Velcro strips, locked doors, fences or other barriers preventing individual’s entrance to or exit from certain areas of the setting?</td>
<td>74.00%</td>
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<td>4.2 Does the setting afford a variety of meaningful non work activities that are responsive to goals, interests and match the skills and needs of individuals?</td>
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<td>4.3 Does the setting afford opportunities for individuals to choose with whom to do activities in the setting or outside the setting or are individuals assigned only to be with a certain group of people?</td>
<td>64.00%</td>
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<td>4.4 Does the setting afford the opportunity for tasks and activities matched to individual’s skills, abilities and desires?</td>
<td>91.00%</td>
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<td>5.1 Was the individual provided a choice regarding the services, provider and settings and the opportunity to visit/understand the options?</td>
<td>83.00%</td>
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<td>86.00%</td>
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Nevada Developmental Services recognizes the need to address the above areas in a systemic manner in order to support the improvement of integrated employment and community based outcomes for individuals receiving jobs and day training services. The following items are current projects for which Nevada Developmental Services has initiated, or are soon to begin to initiate, to address the issues discussed in this report:

- Continued interagency collaboration with state agencies, community leaders, non-profit organizations and businesses to enhance and strengthen supported employment systems.
- Developing Memorandum of Understanding between school systems, Vocational Rehabilitation and Regional Centers, transportation and providers to outline roles, responsibilities and agreements.
- Work with all partners on the implementation of the Nevada Strategic Plan on Integrated Employment. Taskforce members were appointment by Governor Brian Sandoval (See attachment 1).
- Begin Career Development/Planning as a discreet waiver service to begin to prepare individuals for competitive jobs.
- Continue membership in the State Employment Leadership Network (monthly membership meeting, annual meeting, resources, webinars, and on-site visits. Nevada Developmental Services is currently working on Funding Strategies Study Recommendations for Nevada (See attachment 2). Membership with the National Employment First community of Practice to support the alignment of policy, practice, and funding streams toward prioritizing competitive non-residential providers.
- Develop state a workgroup which will consist of representative from the State Developmental Services and community non-residential providers to support continue systems change with
respect to the provision of day habilitation services that focus on community based activities, versus facility based activities.

- Continue to support community non-residential support providers in accessing training from the Direct Course – College of Employment Services.
- Continue to provide access to training and webinars for State Service Coordinators keeping the focus on community integration and competitive employment outcomes.
- Set and measure progress toward employment goals.
- Generate a list of who is in day training and who could be successful in integrated employment.
- Prepare budgets to support the ability to set a percent of people to move people out of day training services and into integrated employment over the next three years.
- Continue funding community provider pilot programs that expand integrated employment outcomes.
- State Developmental Services to revise and expand Supported Employment definition, requirement of providers and develop outcome data.
D5. Non Residential On Site Review findings spreadsheet
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E. Public Comment Invitations from the DHCFP
E1. Invitation for Public Comment regarding
On Site Reviews 4/22/16
April 22, 2016

As part of the process required by the Centers for Medicare and Medicaid Services (CMS) Final Rule for Home and Community Based Services (HCBS) for 42 CFR, the Division of Health Care Financing and Policy (DHCFP) requests public comment regarding the setting assessment findings as attached on the following two spreadsheets.

To be assured consideration, comments must be received by one of the methods provided below no later than 5:00 pm on May 23, 2016. You may submit comments in one of three ways (please choose only one of the ways listed):

- Electronically: You may email comments to hcbs@dhcfp.nv.gov. Write Residential Setting Assessments, or JDT/SLA Assessments in the subject line.

- Mail: You may mail written comments to the following address:
Division of Health Care Financing and Policy
1100 E William Street, Suite 222
ATTN: LTSS - Residential Setting Assessments, or JDT/SLA Assessments
Carson City, NV 89701

- Fax: You may fax comments to the following number:
(775) 687-8724
ATTN: LTSS - Residential Setting Assessments, or JDT/SLA Assessments

All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We will post all the comments received by the close of the comment period, as soon as possible after they have been received, on the following web site:
http://dhcfp.nv.gov/Home/WhatsNew/HCBS/

There will be a link on the page for Public Comments received.
E2. Invitation for Public Comment regarding Heightened Scrutiny 6/24/16
June 24, 2016

As part of the process required by the Centers for Medicare and Medicaid Services (CMS) Final Rule for Home and Community Based Services (HCBS) for 42 CFR, the Division of Health Care Financing and Policy (DHCFP) requests public comment regarding the Heightened Scrutiny Submissions as attached provided on http://dhcfp.nv.gov/Home/WhatsNew/HCBS/ under the Public Comment section.

To be assured consideration, comments must be received by one of the methods provided below no later than 5:00 pm on July 25, 2016. You may submit comments in one of three ways (please choose only one of the ways listed):

• Electronically: You may email comments to hcbs@dhcfp.nv.gov. Write Residential Setting Assessments, or JDT/SLA Assessments in the subject line.

• Mail: You may mail written comments to the following address:
  Division of Health Care Financing and Policy
  1100 E William Street, Suite 222
  ATTN: LTSS – Residential Setting Assessments, or JDT/SLA Assessments
  Carson City, NV 89701

• Fax: You may fax comments to the following number:
  (775) 687-8724
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All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We will post all the comments received by the close of the comment period, as soon as possible after they have been received, on the following web site:
http://dhcfp.nv.gov/Home/WhatsNew/HCBS/.

There is a link on the page for Public Comments received.
E3. Invitation for Public Comment regarding the State Transition Plan revision 7/12/16
July 12, 2016

As part of the process required by the Centers for Medicare and Medicaid Services (CMS) Final Rule for Home and Community Based Services (HCBS) for 42 CFR, the Division of Health Care Financing and Policy (DHCFP) requests public comment regarding the State Transition Plan submission dated June 28, 2016.

To be assured consideration, comments must be received by one of the methods provided below no later than 5:00 pm on August 12, 2016. You may submit comments in one of three ways (please choose only one of the ways listed):

• Electronically: You may email comments to hcbs@dhcfp.nv.gov. Subject: State Transition Plan 6/28/16.

• Mail: You may mail written comments to the following address:
Division of Health Care Financing and Policy
1100 E William Street, Suite 222
ATTN: LTSS – State Transition Plan 6/28/16
Carson City, NV 89701

• Fax: You may fax comments to the following number:
(775) 687-8724
ATTN: LTSS– State Transition Plan 6/28/16

All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We will post all the comments received by the close of the comment period, as soon as possible after they have been received, on the following web site:
http://dhcfp.nv.gov/Home/WhatsNew/HCBS/.

There will be a link on the page for Public Comments received.
E4. Health Care Quality Compliance email providing proof of Public Comment request through their list-serve, their blog and their website
Give Your Feedback on Home-Based Services Plan for Medicaid

Public input is needed on changes affecting numerous services for recipients

State regulators are asking for public input on new federal regulations regarding such issues as door locks, visiting hours, outside activities and more for Nevadans receiving home and community-based Medicaid services.

A federal program that funds these services for Medicaid recipients has changed some rules, and the state must change its plan accordingly. Under this program, individuals must be offered opportunities to seek employment and engage in community activities in the same manner as everyone else.

The federal Centers for Medicare and Medicaid Services (CMS) requires states to solicit public input as part of the changes. To remain part of the program and receive federal funding, the Nevada Division of Health Care Financing and Policy must receive input on its Medicaid State Transition Plan by 5 p.m. on Aug. 12, 2016.

Comments must be submitted by one of three methods:
- Email to: hcb@dhcfp.nv.gov
- Mail to: Division of Health Care Financing and Policy, 1100 E William Street, Suite 222, ATTN: LTSS – State Transition Plan 6/28/16, Carson City, NV 89701
- Fax to: (775) 687-8724, ATTN: LTSS– State Transition Plan 6/28/16

For more information on this topic, visit http://dhcfp.nv.gov/Home WhatsNew/HCBS/.
E5. Invitation for Public Comment regarding the State Transition Plan revision 10/1/16
October 1, 2016

As part of the process required by the Centers for Medicare and Medicaid Services (CMS) Final Rule for Home and Community Based Services (HCBS) for 42 CFR, the Division of Health Care Financing and Policy (DHCFP) requests public comment regarding the State Transition Plan dated October 1, 2016.

To be assured consideration, comments must be received by one of the methods provided below no later than 5:00 pm on October 31, 2016. You may submit comments in one of three ways (please choose only one of the ways listed):

• Electronically: You may email comments to:
  hcbs@dhcfp.nv.gov. Subject: State Transition Plan 10/1/16.

• Mail: You may mail written comments to the following address:
  Division of Health Care Financing and Policy
  1100 E William Street, Suite 222
  ATTN: LTSS – State Transition Plan 10/1/16
  Carson City, NV 89701

• Fax: You may fax comments to the following number:
  (775) 687-8724
  ATTN: LTSS– State Transition Plan 10/1/16

All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We will post all the comments received by the close of the comment period, as soon as possible after they have been received, on the following web site:
  http://dhcfp.nv.gov/Home/WhatsNew/HCBS/.

There will be a link on the DHCFP/HCBS New Rule Information page for Public Comments received.
E6. 5 E-mails to the list-serve which was developed during the beginning phases of the State Transition Plan
Good morning,

The DHCFP has revised the Nevada State Transition Plan and has posted this to our DHCFP website for public comment. I encourage all to review the changes noted on the first 2 pages of the document and review the Plan. Please provide any comments regarding the State Transition Plan by October 31, 2016. The methods of public comment delivery are explained in the attachment titled Public Comment Invitation State Transition Plan 10-1-16.

Thank you,

Crystal Wren

SSPS III - HCBS Waiver Unit | Long Term Services and Supports | DHCFP
1100 E. William St. Ste. 215 | Carson City, NV | 89701
Ph: (775) 684-3758 | Fx: (775) 684-8724 | crystal.wren@dhcfp.nv.gov
Good morning,

The DHCFP has revised the Nevada State Transition Plan and has posted this to our DHCFP website for public comment. I encourage all to review the changes noted on the first 2 pages of the document and review the Plan. Please provide any comments regarding the State Transition Plan by October 31, 2016. The methods of public comment delivery are explained in the attachment titled Public Comment Invitation State Transition Plan 10-1-16.

Thank you,

Crystal Wren

SSPS III - HCBS Waiver Unit | Long Term Services and Supports | DHCFP |
1100 E. William St. Ste. 215 | Carson City, NV | 89701
Ph: (775) 684-3758 | Fx: (775) 684-8724 | crystal.wren@dchfp.nv.gov
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Thank you,

Crystal Wren

SSPS III - HCBS Waiver Unit  Long Term Services and Supports  DHCFP
1100 E. William St. Ste. 215  Carson City, NV  89701
Ph: (775) 684-3758  Fx: (775) 684-8724  crystal.wren@dhp.nv.gov
Dear [Recipient],

Good morning,

The DHCFP has revised the Nevada State Transition Plan and has posted this to our DHCFP website for public comment. I encourage all to review the changes noted on the first 2 pages of the document and review the Plan. Please provide any comments regarding the State Transition Plan by October 31, 2016. The methods of public comment delivery are explained in the attachment titled Public Comment Invitation State Transition Plan 10-1-16.

Thank you,

Crystal Wren

SSPS III - HCBS Waiver Unit | Long Term Services and Supports | DHCFP
1100 E. William St. Ste. 215 | Carson City, NV | 89701
Ph: (775) 684-3758 | Fx: (775) 684-8724 | crystal.wren@dhcfp.nv.gov
Good morning,

The DHCFP has revised the Nevada State Transition Plan and has posted this to our DHCFP website for public comment. I encourage all to review the changes noted on the first 2 pages of the document and review the Plan. Please provide any comments regarding the State Transition Plan by October 31, 2016. The methods of public comment delivery are explained in the attachment titled Public Comment Invitation State Transition Plan 10-1-16.

Thank you,

Crystal Wren
E7. E-mail response to an individual requesting an electronic copy of the State Transition Plan
http://dhcfp.nv.gov/uploadedFiles/dhcfp.nv.gov/content/Home/WhatsNew/NV_State_Transition_Plan_10-1-16.pdf

Your welcome

Crystal Wren

SSPS III - HCBS Waiver Unit | Long Term Services and Supports | DHCFP
1100 E. William St. Ste. 215 | Carson City, NV | 89701
Ph: (775) 684-3758 | Fax: (775) 684-8724 | crystal.wren@dhcfp.nv.gov

From: Lisa Camps around [mailto:naduahs@yahoo.com]
Sent: Tuesday, October 04, 2016 2:13 PM
To: Crystal Wren
Subject: Re: State Transition Plan, 10-1-16 revision

Hi Crystal,
Do you have a link that would take me to the actual transition plan?
Thank you,
Lisa Campanaro

Sent from my iPhone

On Oct 4, 2016, at 10:04 AM, Crystal Wren <crystal.wren@dhcfp.nv.gov> wrote:

Good morning,

The DHCFP has revised the Nevada State Transition Plan and has posted this to our DHCFP website for public comment. I encourage all to review the changes noted on the first 2 pages of the document and review the Plan. Please provide any comments regarding the State Transition Plan by October 31, 2016. The methods of public comment delivery are explained in the attachment titled Public Comment Invitation State Transition Plan 10-1-16.

Thank you,

Crystal Wren

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1100 E. William St. Ste. 215 | Carson City, NV | 89701
Ph: (775) 684-3758 | Fax: (775) 684-8724 | crystal.wren@dhcfp.nv.gov

<Public_Comment_Invitation_State_Transition_Plan_10-1-16.pdf>
F. Public Workshop
F1. Notice of Public Workshop 6/6/14
NOTICE OF PUBLIC WORKSHOP

Home and Community Based Services (HCBS) Rule Changes

Date of Publication: May 21, 2014

Date and Time of Meeting: June 6, 2014 at 10:00AM

Name of Organization: The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)

Place of Meeting: Health Division
4150 Technology Way room 303 Carson City, Nevada 89701

Place of Video-Conference: The State of Nevada Medicaid District Office
1210 S. Valley View Blvd. Suite 104 Las Vegas, Nevada 89102

Agenda

1. Presentation and Public Comment regarding new regulations for the HCBS Waivers published by the Centers for Medicare and Medicaid Services (CMS).

   a. The purpose of this workshop is to introduce and explain the changes in the final rule and how they will affect Nevada’s HCBS waiver providers.

   b. Public Comment Regarding Subject Matter

2. Other Public Comment

3. Adjournment

Items may be taken out of order. Two or more agenda items may be combined for consideration. Items may be removed from the agenda or discussion of items may be delayed at any time.

Notice of this public workshop meeting and draft copies of the changes will be available on or after the date of this notice at the DHCFP Web site (dhcpp.nv.us): Carson City Central office and Las Vegas DHCFP. The agenda posting of this meeting can be viewed at the follow locations: Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Lincoln County Library; Lyon County Library; Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Humboldt County Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.
If requested, a copy of the proposal will be mailed to you. Requests and/or written comments on the proposed changes may be sent by email to Rita Mackie at mackie@dhefp.nv.gov or mailed to the Division of Health Care Financing and Policy, 1100 E. William Street, Suite 101, Carson City, NV 89701.

All persons that have requested in writing to receive the Public Workshop Agenda have been duly notified by mail or e-mail.

Note: We are pleased to make reasonable accommodations for members of the public who are physically challenged and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Division of Health Care Financing and Policy, in writing, at 1100 East William Street, Suite 101, Carson City, or call Rita Mackie at (775) 684-3681, as soon as possible, or e-mail at mackie@dhefp.nv.gov.
F2. Comments from Public Workshop 6/6/14
HEATHER KORBULIC – STATE OMBUDSMAN:
  • For those facilities not considered Home and Community Based Settings (HCBS), could we ask the Centers for Medicare and Medicaid Services (CMS) to grandfather them in?
  • Lease Agreement Subcommittee to create a uniform agreement
  • Consumer Bill of Rights
  • Person-centered care planning

PHILLIP – RAINBOW CONNECT:
  • Concerned about:
    o Alzheimer’s recipients and Fire Regulations
    o Alzheimer’s recipients and choice of roommates, menus, when and where to eat

BARRY GOLD – AARP:
  • How is PACE program affected?
  • Concerned lack of choices in rural regions would be interpreted as silos of service
  • Recommends working with Commission on Aging and Disability and Alzheimer’s Task Force

LEONE BROOKS – HIGH SIERRA:
  • Suggested consideration of external vendor for project management

ROBERT ST. JAMES:
  • Private Room
  • Waiting for Waiver

GRADY TARBUTTON – WASHOE COUNTY:
  • Appreciate flexibility in interpretation regarding institutions on campuses, etc.
  • Concerned about electron Level of Care (LOC) and concerned that recipients and families do not understand the choices available to them between HCBS and Institutional Care

JEFF KLINE – COMMISSION ON AGING:
  • Concerned about the “Unintended Consequences of our Best Efforts”
  • Do not create more silos of care
  • Already hard to access care
  • Co-location of services

CONNIE McMULLEN – COMMISSION ON AGING:
  • Concerned that individuals who truly need Nursing Facility placement will be placed in community settings

FAITH CHERE – GROUP HOME PROVIDER:
  • Concerns:
    o Scheduled Times for Visits
    o Category 1 and Category 2 differences
    o Staffing Issues

MICHELLE – RENO VALLEY RETIREMENT COMMUNITY:
  • Staffing
  • What happens to someone who has such low income we cannot take them?

ED GUTHRIE – OPPORTUNITY VILLAGE:
  • Will CMS identify “wiggle room” areas for interpretation or is everything steadfast?
  • Has CMS given feedback on waiver applications?

BETSY AiELLO:
  • Florida got 1115 waiver for HCBS with new regulations
F3. Notice of Public Workshop 8/19/14
NOTICE OF PUBLIC WORKSHOP
Home and Community Based Services (HCBS) Rule Changes

Date of Publication: August 4, 2014

Date and Time of Meeting: August 19, 2014 at 9:00AM

Name of Organization: The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)

Place of Meeting: State of Nevada Legislative Building
401 So. Carson Street Room 2134
Carson City, Nevada 89701

Place of Video-Conference: Grant Sawyer Office Building
555 E. Washington Avenue Suite 4412
Las Vegas, Nevada 89101

Agenda

1. Presentation and Public Comment on the Steering Committee’s comments regarding the new regulations for the HCBS Waivers published by the Centers for Medicare and Medicaid Services (CMS).
   a. The purpose of this workshop is to explain the changes in the final rule and how they will affect Nevada’s HCBS waiver providers.
   b. Public Comment Regarding subject matter

2. Presentation and Public Comment Regarding the Draft Transition Plan
   a. The purpose of this workshop is to review and explain the draft transition Plan.
   b. Public Comment

3. Public Comment Regarding any Other DHCFP Issue

4. Adjournment

Items may be taken out of order. Two or more agenda items may be combined for consideration. Items may be removed from the agenda or discussion of items may be delayed at any time.

Notice of this public workshop meeting and draft copies of the changes will be available on or after the date of this notice at the DHCFP Web site (dhcfp.nv.us); Carson City Central office and Las Vegas DHCFP. The agenda posting of this meeting can be viewed at the follow locations: Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Lincoln County Library; Lyon County Library;
August 4, 2014
Page 2

Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Humboldt County Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.

If requested, a copy of the proposal will be mailed to you. Requests and/or written comments on the proposed changes may be sent to Rita Mackie at the Division of Health Care Financing and Policy, 1100 E. William Street, Suite 101, Carson City, NV 89701.

All persons that have requested in writing to receive the Public Workshop Agenda have been duly notified by mail or e-mail.

Note: We are pleased to make reasonable accommodations for members of the public who are physically challenged and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Division of Health Care Financing and Policy, in writing, at 1100 East William Street, Suite 101, Carson City, or call Rita Mackie at (775) 684-3681, as soon as possible, or e-mail at rmackie@dhefp.nv.gov.
F4. Minutes from Public Workshop 8/19/14
JENNIFER FRISCHMANN (Chief, Long Term Support Services [LTSS], Division of Health Care Financing and Policy [DHCFP]):

In March 2014, the Centers for Medicare and Medicaid Services (CMS) issued new regulations that define both the settings in which it is permissible for states to pay for Medicaid Home and Community-Based Services (HCBS) and requirements for Person-Centered Planning. The main purpose of these regulations is to ensure that individuals who receive Medicaid HCBS are integrated in and have full access to the greater community and have freedom of choice regarding where they live, as well as how and from whom they receive services.

Moving forward, the State of Nevada must submit a Transition Plan to CMS detailing the steps that will be taken to bring Medicaid into compliance within the 5 years allowed. The Transition Plan is due to CMS no later than March, 2015. These Public Workshops are part of the process to create a plan that will not only meet CMS’ requirements, but address the needs of the Providers, Recipients, and Advocates. There is a Steering Committee composed of State staff, Providers, and a recipient identifying those areas of the New Rule that may need special attention. For example, the Fire Marshall regulations that, as written, might make it difficult for some recipients to age in place, and the Lease Agreement requirements. Sub-Committees focused on the Lease Agreement and other Regulatory issues have already started working to address them.

ROSEMARY (ROSE) MELARKEY (Aging and Disability Services Division [ADSD]):

Several States have already submitted Transition Plans to CMS, but none have been accepted. Additionally, the feedback indicates that a ‘Plan to Make a Plan’ is not going to be accepted. Details of what will be done and how it will be accomplished will be required.

BETSY AIELLO (Deputy Administrator, DHCFP):

Have the Providers who are here today read the CMS Plan? Do you know how it will impact you? For example, in a Group Home the New Rule requires a change from all residents engaging in the same activities at the same time, all the time, to a person-centered approach that supports individuals opting for other activities. This can be addressed through the Person Centered Plan and the Policies and Administration of the Provider.

ED GUTHRIE (Opportunity Village, Executive Director):

Who will pay for it? How will it be staffed?

BETSY AIELLO: The New Rule does not require Providers to be the only source of transportation etc., they are required to facilitate a recipient’s requests. Policies that encourage recipients to create and maintain connections with the larger community and implementation of Person Centered Planning that documents and supports a recipient’s wishes will bring a facility into compliance.

ED GUTHRIE: Disability Dominant Settings, Accessible Space for example, appear not to meet the New Rule requirements by definition since the residences are primarily for individuals with disabilities.

BETSY AIELLO: We do not have all the answers yet. We hope to meet with Accessible Space and CMS to ensure compliance.

JOE TINIO (ECHO):

What about those group homes with residents who have Alzheimer’s? These individuals are unable to make choices.
JENNIFER FRISCHMANN: If someone has no capacity to make good choices, the question then becomes, “how are they integrated into a community?” The Team that develops the Person Centered Plan becomes the responsible party.

BETSY AIELLO: A point to remember is that everyone does not have to participate in every activity at every time. The Care Plan must have more breadth; it should not be merely bathing and dressing, but must include other aspects of living a life.

ROSIE MELARKEY: Service Coordinators and Providers need training not only in the philosophy of Person Centered Planning, but also how to incorporate this philosophy into processes and routines.

ERIC DEWITT-SMITH (Sierra Regional Center):
We have developed a training program for Person Centered Planning. Starting with the basics, what does the physical plant look like? In the Individuals with Intellectual Disabilities (IIDs) community we have been moving recipients from Intermediate Care Facilities (ICF), which are institutional settings, into group homes for example. Just because a setting is smaller does not mean it does not have institutional characteristics. We want to make sure we are not just breaking up large institutions into smaller institutions. We work with the recipient’s Care Team (family members, providers, advocates, spiritual advisors, etc.) to determine how services will be delivered using the 3 ‘P’s: Priorities, Perspectives, Preferences. Some individuals will have restrictions that are necessary for their health, safety and welfare. But, within those restrictions, the attitude of service delivery should be focused on how best to support the wishes of the recipient.

JOE TINIO: Given that understanding, we can comply with those regulations.

BETSY AIELLO: Flexibility is required of State staff also.

BARRY GOLD (AARP):
Given that the CMS Regulations are the Regulations, it is my understanding that the State has the ability to interpret the New Rule for Disability Dominant settings and programs.

JENNIFER FRISCHMANN: Yes, but we need to know where the potential deficiencies are. That is why we sent out the Self-Assessment tool to providers in May.

SARINA ROSS (Humboldt Human Development Services):
I attended the Person Centered Planning Eric referred to. It was very helpful. I still did not understand the Self-Assessment form and I received calls from other Providers asking how to complete it. I would appreciate an opportunity to complete a revised assessment with more explanation of the contents and the purpose.

KATE MCCLOSKEY (Sierra Regional Center [SRC]/ADSD):
Person Centered Planning changes how we think about providing services.

BETSY AIELLO: There are a lot of facilities this will not affect, but there are some that are large and look institutional.

ROSIE MELARKEY: This is a 5 Year Transition Plan. If we start working now, we can determine if a setting does not meet the New Rule and why. How can it be changed? Whether by regulation changes or the business plan of the facility.

TAMMY RITTER (ADSD):
We are working toward meeting the regulations.
CHARLOTTE MCCLANAHAN (Dungarvin):
Bringing in family members and/or guardians can be problematic because they have pre-conceived ideas of what an individual is able to choose and expectations about what the facility will be able to do. For example, I recently encountered an individual whose guardian stated not to take the recipient on van rides even though he pointed to the picture of the van and then towards the door on numerous occasions. Education for the family regarding Person Centered Planning and individual choice is just as important as education for the recipients, providers and State staff.

WENDY SIMMONS (Nevada Health Care Association [NVHCA]):
Regarding residential care facilities, the language used may not be consistent across types of recipients and/or settings. Is the State looking for demonstration projects?

JENNIFER FRISCHMANN: The State is not formally applying to CMS to do a demonstration project. But an ‘informal’ project to find out what can be done with large facilities would help determine what waiver amendments could be written to help these facilities come into compliance with the New Rule.

WENDY SIMMONS: To re-state what you said, licensed residential facilities can set up their own demonstration projects.

JENNIFER FRISCHMANN: Yes. Contact us for help.

BETSY AIELLO: We can include a section in the Transition Plan that states Residential Providers will be working with the State as technical support to create plans for meeting the New Rule.

WENDY SIMMONS: Regarding Alzheimer’s patients, we want to work on creating processes and programs that prevent people from being placed out of state, and even to facilitate bringing them back to Nevada.

BETSY AIELLO: Different things either calm or agitate a person. You cannot say that ‘x’ is the remedy for an Alzheimer’s patient; ‘x’ may be the remedy for a given individual Alzheimer’s patient, but the same treatment would agitate another patient.

WENDY SIMMONS: Regulations have become so over-protective and rigid that it has affected the Provider mindset.

ED GUTHRIE: What is the Preliminary Transition Plan date?

JENNIFER FRISCHMANN: I would like to have the Preliminary Transition Plan posted online by September 30. There is a 30-day public comment period required.

LESTER GIBBS (CFO, Nevada Senior Services):
How is the State going to help group homes and individuals finance this?

BETSY AIELLO: The State has to implement the Person Centered Care Planning; Providers are expected to be involved. The Care Plan will be created by State staff. The Provider is not required to provide the alternative services, but must allow them to be made available. Rates for services are set by the Legislature, so, any changes in reimbursement would have to go through the legislative process.

LESTER GIBBS: But, if one resident does not want to eat at the set dinner time, the Provider has to pay the cook to stay around and be available.
BETSY AIELLO: No, CMS does not require that specifically. If a resident wants a full, cooked meal, then s/he eats when it is served. If an alternate eating schedule is part of the Care Plan, the Provider must make a shelf in the refrigerator available, for example. The Provider does not have to purchase the extra food or prepare it. The resident’s support team – family and friends – must be allowed to assist if that is necessary.

HEATHER KORBULIC (State Long Term Care Ombudsman):
First, I notice that there do not seem to be representatives from the Bureau of Health Care Quality and Compliance (HCQC) in attendance.

JENNIFER FRISCHMANN: We cannot mandate attendance, but there are HCQC representatives on the Steering Committee.

HEATHER KORBULIC: Training for all segments of the Industry is really important: State staff, Providers, Recipients, etc.

DENYSE LIZAK (HHDS):
As a rural provider, community means different things in different locations. It is also more expensive to provide services in rural areas.

SARINA ROSS: Can there be more access to these meetings for rural providers? I am here today because I had other commitments in the Reno/Sparks area, but I would normally not be able to afford to come to Carson City. Is it possible to videoconference to a site in Winnemucca or Elko?

MELANY DENNY (Organizational Development and Services Officer, High Sierra Industries):
To participate in the Person Centered Planning, we sent staff to 104 quarterly meetings. That is staff time that is not paid for. Looking at reimbursement for that time is important.

BETSY AIELLO: One aspect of the New Rule we have not discussed today is the requirement for Recipients to have Lease Agreements that afford them the same rights and responsibilities any other individual would have in the State of Nevada.
The items of particular concern that I heard in this meeting are:
Training with family and guardians about Recipient’s Rights
Training for Providers and State staff
Regulations and Licensing
Rates

ROSIE MELARKEY: The revision and clarification of the Self-Assessment document.
F5. Notice of Public Workshop 11/10/14
NOTICE OF PUBLIC WORKSHOP
Home and Community Based Services (HCBS) Rule Changes

Date of Publication: October 24, 2014
Date and Time of Meeting: November 10, 2014 at 9:00AM
Name of Organization: The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)
Place of Meeting: Health Division
4150 Technology Way Room 303
Carson City, Nevada 89706

Place of Video-Conference: The Division of Health Care Financing and Policy
(DHCFP)
1210 S Valley View Blvd Suite 104
Las Vegas, Nevada 89102
The Division of Health Care Financing and Policy
1010 Ruby Vista Drive Suite 103
Elko, Nevada 89801

Agenda

1. Presentation and Public Comment Regarding Home and Community Based Services Draft Transition Plan
   a. The purpose of this workshop is to gather Public Comment regarding the Transition Plan the State of Nevada must submit to the Center for Medicare and Medicaid (CMS) by March 15, 2015.
   b. Public Comment Regarding Subject Matter

2. Public Comment Regarding any Other Issue

3. Adjournment
Items may be taken out of order. Two or more agenda items may be combined for consideration. Items may be removed from the agenda or discussion of items may be delayed at any time.

This notice will be posted at http://admin.nv.gov.

Notice of this public workshop meeting and draft copies of the changes will be available on or after the date of this notice at the DHCFP Web site at www.dhcfp.nv.us Carson City Central office and Las Vegas DHCFP. The agenda posting of this meeting can be viewed at the follow locations: Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Esmeralda County Library; Lincoln County Library; Lyon County Library; Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Humboldt County Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.

If requested in writing, a copy of the proposal will be mailed to you. Requests and/or written comments on the proposed changes may be sent to the Division of Health Care Financing and Policy, 1100 E. William Street, Suite 101, Carson City, NV 89701 at least 3 days prior the public workshop.

All persons that have requested in writing to receive the Public Workshop Agenda have been duly notified by mail or e-mail.

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Note: We are pleased to make reasonable accommodations for members of the public who are physically challenged and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Division of Health Care Financing and Policy, in writing, at 1100 East William Street, Suite 101, Carson City, or call Rita Mackie at (775) 684-3681, as soon as possible, or e-mail at rmackie@dhcfp.nv.gov.
F6. Minutes from Public Workshop 11/10/14
LESLEY BITTLESTON, [Division of Health Care Financing and Policy (DHCFP)]: Welcome to the Public Workshop on Home and Community Based Services (HCBS) Rule Changes. This is the third Public Workshop the State has held for this purpose. The Centers for Medicare and Medicaid Services (CMS) has published this new rule establishing requirements for home and community based settings in Medicaid HCBS programs operated under the 1915(c) and 1915(i) which allows for reimbursement for services under the Medicaid program. In essence, the rule creates a more outcome oriented home and community integrations, rather than a setting based solely on location and physical characteristics. The goal of this rule is to provide individuals who receive services under HCBS programs have access to community living and receive services in the most integrated setting which provides alternatives to institutions. The final rule includes a provision requiring states offering HCBS services to develop a transition plan to ensure HCBS settings will meet the new requirements. For currently approved 1915(c) waivers and 1915(i) state plans, states must evaluate the settings currently available and determine if there are settings that do not meet the new rule and work with Providers and CMS to develop a plan to bring them into compliance. Nevada has until March 17, 2015 to submit the transition plan to CMS for approval. CMS expects the transition to full compliance to be as brief as possible and that substantial progress is demonstrated during the transition period. However, States have a maximum of five years from the date the rule was published to achieve compliance. This final deadline is Month 2019.

The draft Transition Plan was posted to the DHCFP website on October 15th for a 30 day public comment period. This draft Plan is the result of work done by State Staff and various stakeholders. The work included:

- The communication of the new rule to stakeholders at various public meetings such as the Tribal Consultation Meeting, the Medicaid Advisory Council Meeting and the Nevada Commission on Aging.
- The creation of a Steering Committee to oversee the steps needed to develop the Transition Plan.
- The creation of a Regulatory Sub-Committee which reviewed various Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) for any conflicts between current regulations and the new rule.
- The development and distribution of two Provider self-assessment surveys.

Are there any comments or questions about the Draft Transition Plan as presented?

ROSEMARY MELARKEY, [Aging and Disability Services Division (ADSD)]: The Aging and Disability Services Division has submitted updated NAC language for Supported Living Arrangements (SLA). It has been approved and is in the final editorial process. We do not anticipate there will be any conflicts between the new NAC and CMS’ New Rule. The Jobs and Day Training (JDT) regulations were changed in the NRS four years ago; the NAC for these organizations are currently being revised. The information on page 10 of the Draft Transition Plan regarding JDT is not the revised language. CMS has not created a tool for evaluating non-Residential settings such as JDT and Adult Day Health Care (ADHC), but has stated these settings must also be in compliance. Page 11 of the Draft Transition Plan states that there is potential conflict between State regulations and the concept of “aging in place,” yet indicates that changes in Medicaid Service Manual (MSM) language will be used...
to correct these conflicts. Some NAC changes will also be required and this statement should be added to that section.

GRADY TARBUTTON, [Washoe County Senior Services]: Regarding those individuals with cognitive issues who are not incompetent but who remain at risk for safety or exploitation, these factors should be taken into account.

BETSY AIELLO, [DHCFP]: There has been a work group on Person Centered Planning (PCP) and training has been developed by the Regional Centers and has begun to be implemented. Training for PCP should be a part of the Implementation section of the Transition Plan.

LESLIE BITTELSTON: Training for PCP has been taken out of the Transition Plan because CMS expects States to be doing this already. Training has been scheduled for State staff, and will continue to be done using a “Train the Trainers” model so that as many people can be trained as quickly as possible, but this will not be a part of the formal Transition Plan submitted to CMS.

DANIEL MATHIS, [Nevada Health Care Association (NVHCA)]: I support the overall matrix of medical regulations on pages 11 and 12, but would stress that some changes to NRS may need to be made.

ED GUTHRIE, [Opportunity Village (OV)]: Page 3 identifies ADHC as a potential problem area if individuals receiving HCBS are isolated from the larger community even though the setting itself may not be isolated.

ROSIE MELARKEY: Many work centers meet the New Rule. We can re-word this section and we will review the Providers on an individual basis if there is any apprehension that the setting will not be in compliance. I have concerns about both ADHC and JDT and the risks to individuals who utilize these services.

ED GUTHRIE: We are considering creating a space that will combine ADHC services on one side with JDT on the other side and in between shared space for dance studios and other activities. Do you think this would meet the criteria? Or does this violate the requirement on page 7 that “a facility must not be operated in combination with any other medical facility or facility for the dependent unless it is licensed separately?”

BETSY AIELLO: We would like to have the specific scenario in writing so we can ask CMS. It has been my experience that CMS will not answer hypothetical questions, but will often make decisions about specific proposals. My first thought is that it is not a viable proposal unless the shared space was also available to the general populace. But, it also might be perfectly acceptable.

JEFFREY KLEIN, [Nevada Senior Services (NSS)]: I would like to echo Ed Guthrie regarding ADHC. I would also like to emphasize that timeliness is important. Between 2008 and now, 50 licenses were granted for ADHC sites; there are only 18 currently operating. ADHC licenses are pending. Before granting licenses, you should ensure they will meet the New Rule requirements. There is a disconnect between the New Rule and the Affordable Care Act (ACA) which encourages co-location.

BETSY AIELLO: Please write up scenarios as quickly as possible so we may present them to CMS. Also, licensure is not the same as Medicaid enrollment. Some Providers obtain licenses and have no desire to enroll in Medicaid.

ROSIE MELARKEY: We are working with several national organizations, both Providers and Advocates, to address many of these issues with CMS.

LESLIE BITTELSTON: The next section is titled the Transition Plan for Compliance. It includes 4 Phases:
Phase I (March 2014 – October 2014) includes stakeholder communication, a comprehensive assessment of all residential and non-residential settings that fall under 1915(c) and 1915(i) services. This phase includes a review
and analysis of existing State regulations and policies, as well as industry practices, to determine areas that are in direct conflict with the new rules.

**ROSIE MELARKEY:** We should move the non-residential setting assessments to Phase II.

**BETSY AIELLO:** We should also include a review of every facility in Phase II. We need to create a single tool that can be used to evaluate the various types of settings.

**MARK OLSON**

Thank you for the opportunity to provide public comment on the HCBS Transition Plan for the State of Nevada.

I am here today in several capacities:

- Most importantly I am the only parent and legal guardian of my 19yo daughter Lindsay who has autism and likely will not be able to live completely. *(sic)* She is currently a client of the Desert Regional Center.

- I am President & CEO of LTO Ventures, a 501(c)(3) Nevada nonprofit corporation that develops live/work/play residential communities for adults with autism.

- I also am an advocate at state and federal levels on matters related to housing options for adults with autism, and co-founder of the Coalition for Community Choice, a national grassroots collaboration of persons with disabilities, families, providers, professionals, educators and legislators.

I want to first state that I believe that adults with disabilities have the human and civil right to live, work, play, socialize, recreate, learn, love, and worship in the setting and manner of their own choosing, and with the support of their parents, families, friends and caregivers.

I have been actively involved with the last 3 rounds of 1915 rule-making by CMS and authored a white paper on what the Olmstead decision meant for housing choice for persons with disabilities.

Five times over six years up to March 2014, CMS has engaged in rule-making efforts that have provided useful clarifications of certain issues encountered by the individuals served by the 1915 regulations, but each time also have included attempts by CMS to overreach the letter and spirit of the ADA and Olmstead and insert language that unnecessarily segregates specific types of residential settings from Medicaid eligibility. Five times through the public review process these attempts have been rejected by the very individuals served by these regulations and their families and caregivers.

The Final Rule, also known as CMS-2249-F and CMS-2296-F, issued on March 17, 2014, was as significant for what it did not include as for what it *(sic)* changes it did include. What the Final Rule did not include was specific settings types that would not be allowed. What it did include was an emphasis on outcomes and experiences. It also specifically identified the Person-Centered Plan as the single most important document guiding individual choice. For individuals served by these regulations and their families and caregivers this was a reasonable opportunity to educate and inform CMS and state agencies about how the waiver program should be implemented going forward.

That relief lasted 3 days. On March 20, 2014, Centers for Medicare & Medicaid Services (CMS) issued an Information Bulletin (Bulletin) entitled "Home and Community-Based Service (HCBS) 1915(c) Waiver and 1915(i) State Plan Amendment (SPA) Settings’ Requirements Compliance Toolkit". In this Bulletin, there is a two-page section entitled “Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community.”

In the Bulletin, CMS clearly seeks to continue litigating specific language rejected through the public review process.

I have four points I want to make about the Transition Plan draft proposed today.

**Non-compliance with US Administrative Procedures Act**

The Coalition for Community Choice believes CMS has exceeded the scope of its authority with the Guidance,
and key elements of the Guideline exceed the scope of the Final Rule, and therefore are non-compliant with the US Administrative Procedures Act of 1946 and a violation of federal law and the Medicare Act.

To the extent that the State of Nevada develops and implements its HCBS Waiver Transition Plan and codifies waiver changes based on specific language in the Guidance that is not expressly contained in the Final Rule, the State may find any such policy and language subject to legal challenge. I propose here that the State adhere strictly to the language of the Final Rule and ignore the Informational Bulletin and Guidance to avoid any delays or complications with its waiver programs now or in the future.

State Must Seek Out and Include Input from its Most Important Stakeholders - Recipients

I am deeply concerned, as the only parent and legal guardian of an adult Nevada resident with disabilities who presently is a client of services through the regional center and may one day require supports and services paid for through this waiver, that the State seems to have forgotten who its most important customer is.

On p. 1 of the Transition Plan document, DHCFP states that it held “two public workshops in which all members of the public were invited to learn about the new regulations and provide comments.” On p. 13, it states “the turnout was excellent and comprised a mix of providers, recipients, regulators, advocates, and state staff.” A review of the sign in sheets from both those meetings tells a different story. It shows 106 total attendees with considerable duplication of attendees between the two workshops. All the attendees, with one or two possible exceptions (it is not clear from the sign in sheets) are state agency and provider representatives.

The fact that this is the third workshop on this issue and DHCFP still has virtually no recipient input from waiver funding recipients and/or their parents and family members is unacceptable. Moreover, it fails to fulfill CMS’ directive that “States will describe their process for receiving public input and ensure that it is sufficient to provide meaningful opportunities for input from individuals served or who are eligible to be served, based on the scope of the proposed changes.”

While DHCFP may feel it has fulfilled its statutory obligation to provide notice to the public under Nevada Open Meeting law, I find it entirely unacceptable to hide behind that pathetic public notice practice for input on programs concerning the funding safety net for thousands of Nevadans with disabilities. A three- business-day advance notice posted in 19 libraries and two government buildings that would require persons to travel to those locations every day to check bulletin boards is an unacceptable burden.

Further, the DHCFP website where the agenda and plan draft was posted requires a greater than average knowledge of website navigation to find them, and again places the burden on recipients and their families to check this website daily for notices that provide only 3 business day advance notification.

Even in the Transition Plan draft 2 we are commenting on today, the State and DHCFP fail to provide for sufficient recipient and prospective recipient input. On p. 17, the Action Item “Recipient Education and Notification” is completely inadequate. The Plan states “recipients are crucial in providing information on the services they receive, so a random sample of recipients will be selected…”

The Plan should provide a process for nothing less than outreach to 100% of current and eligible recipients of waiver-funded services and DHCFP and the State should set a goal of 100% feedback as it did with the provider Self Assessment Surveys.

Therefore, I propose that DHCFP and the State do the following:

1. DHCFP take no action on the Transition Plan until it can demonstrate that it has reached 100% of Nevadans presently served by the waivers, and 100% of Nevadans currently eligible to be served by the waivers, with information in plain language that:
   a. Informs them through which waiver they receive funding or are eligible to receive funding
   b. Describes what changes are being evaluated because of the Final Rule
   c. Explains what the Final Rule is
   d. Explains what the changes could mean to them
   e. Invites them to provide public input including what actions they should take if they want to provide public input and exactly how they can do it
f. Informs them how to be put on a list to get all future notices in a way that does not require them to go to a library or government building

2. Deliver the notices via US Mail and through their case managers

3. Deliver the notices to all current Regional Center clients 18+ because they may become eligible for waiver-funded services in the next five years and these proposed changes

**Must Emphasize the Central Role of Person-Centered Planning**

CMS states in the Q&A about the Final Rule: "The expectations set forth in this final rule emphasize that individuals are most knowledgeable about their services needs and the optimal manner in which services are delivered."

Nothing in the Nevada Transition Plan or the changes Nevada proposes to its waivers should interfere with the person-centered plan of any recipient taking precedent over all other considerations, and must make it a matter of policy to honor those person-centered plans without unduly influencing recipients to a particular conclusion.

Moreover, DHCFP must make it a priority to:

- Inform and educate current and future recipients and their parents and families about exactly what a person-centered plan is and how to create one
- Explain the basis in CMS regulations for person-centered plans and their authority in the waiver-funded services process
- Provide resources about how to create an optimal person-centered plan and a list of private vendors who can help these individuals prepare proper person-centered plans

**Definition Must be as Broad as Possible and Reflect the Progressive and Independent Nature of Nevada**

CMS states "We expect states electing to provide benefits under section 1915(k), 1915(i), and/or 1915(c) to include a definition of home and community-based setting..."

In the Olmstead decision, the court used the terms "home" seven times and "community" 80 times, but never defined those terms. The Supreme Court did not define those terms because it intended individuals served by those terms to decide for themselves what home and community mean to them.

Sally Burton-Hoyle, one the nation’s most respected authorities on person-centered planning says "community is defined by the individual."

We know that the setting is not the issue. It is the design and management of those settings that is the key. Individual experiences and outcomes can be just as successful in large, well-designed settings as they can in individual homes and apartments, and conversely we know that outcomes and experiences can be just as undesirable in individual homes and apartments as in larger settings. In fact, this is supported by data from research documented in the National Core Indicators that indicates that individuals in congregate settings report feeling lonely less than those in other settings.

Therefore, I encourage the State of Nevada to adhere to the specific language of the Final Rule and avoid including any specific setting types in any definitions or Plan language and to adhere strictly to the language in the Final Rule.

**ED GUTHRIE:** On page 18, in the sections regarding NAC and MSM revisions, will there be provisions for Public Comment?

**LESLEY BITTLESTON:** Yes, all changes to MSM require Public Hearings.

**BETSY AIELLO:** There are Public Hearings scheduled every month throughout the year, and 30-day notice of agenda items are required.
MARK OLSON: My daughter has a case manager who makes monthly contacts. This could be a way to communicate with recipients.

COLLEEN LARKS [United Cerebral Palsy of Nevada (UCPNV)]: May I have a copy of Mark Olson’s statement?

LESLIE BITTLESTON: We will post all Public Comments to the website.

BARRY GOLD [American Association of Retired Persons Nevada (AARPNV)]:
My name is Barry Gold and I am the Director of Government Relations for AARP Nevada. AARP Nevada is a nonprofit, nonpartisan organization, with a membership of more than 300,000 in the state, working to help Nevadans 50+ live life to the fullest and ensure that all Nevadans have independence and choice as they age.

AARP appreciates the opportunity to review and comment on Nevada’s Draft HCBS Transition Plan and we recognize the efforts of the Division of Health Care Financing and Policy in putting this plan together in such a short timeframe. The new HCBS rules hold great promise for improving the Medicaid HCBS system in Nevada and giving consumers and their families more choice and control over the services that enable them to live in their homes and communities. Nevada’s transition plan puts forward a solid outline of how Nevada plans to come into compliance with the new HCBS rule, but there are a number of areas where we believe the state can further strengthen the plan or add more detail so that the plan can function as intended and protect consumers of HCBS.

Overall, the plan seems to rely primarily on self-assessment from the providers in determining compliance. Information from providers is crucial, but consumer input should be a stronger influence here. Although there is mention of a recipient survey (p.17), it’s not clear how the results will inform the determinations of compliance. Underscoring the need for additional consumer input is the provider self-assessment survey itself (Appendix A), in which providers are surveyed about certain things that are really only answerable by the clients. For example:

- Is the client free from coercion? (Question 14)
- If the client has concerns, is she comfortable discussing them? (Question 15)
- Do clients know how to relocate and request new housing? (Question 42)

These are important questions, but a provider’s response is only one side of the story. The state should pull in all of the tools and sources of information it can to make these determinations. We note that Iowa’s proposed transition plan, for example, plans to use provider-submitted data, consumer survey data from the Iowa Participant Experience Survey, and information gathered by state case managers and the Department of Inspections and Appeals. Although taking a more comprehensive approach in determining compliance is not an easy task, it better capitalizes on this opportunity to review and improve Nevada’s HCBS system.

In addition, there are a number of areas in the plan that were unclear in our review, or that we believe would benefit from additional detail:

- We understand that half of the 1915(c) self-assessment surveys were not completed and returned, so the state is re-sending them with additional explanations and hoping for a better response rate. Will the state release the results and analysis once additional responses are received?
- The plan identifies certain problem areas based on survey responses and in-person assessments. For example, the plan notes that sheltered workshops or work centers and provider owned and/or controlled day settings as currently operated, are presumed to be settings that isolate individuals receiving HCBS from the broader community. Does the state plan on working with these providers to bring them into compliance, or instead contesting this issue with CMS and trying to overcome this presumption of non-compliance?
Will on-site assessments (p.17) be conducted for all providers or just those that did not complete a self-assessment survey? We note the state’s intent to visit 50% of all providers by June 2015, but when will the others get visited?

The provider compliance monitoring (p. 19) seems to focus primarily on the initial task of getting providers into compliance but does not address ongoing enforcement. We believe the plan should better describe the state’s capacity and plan to evaluate compliance on an ongoing basis, even for those providers initially determined compliant.

The description of plans and protections for individuals who must be transitioned to settings that meet HCBS requirements (p.20) needs more detail. The state should more fully describe the proper notice and due process, the choices offered to the individual, the content of the person-centered planning process, and the protections to ensure that there is no break in services.

Thank you for this opportunity to comment on the state’s Draft HCBS Transition Plan. We look forward to working with the state to ensure that these rules are implemented and monitored in a way that continues to shape our HCBS system for the better.

JEFFREY KLEIN: Better connections with consumers and the public can be achieved. Some examples are:
- Using the ADSD Resource Center listservs
- Nevada Lifespan Respite Centers
- Engagement through Bureau of Health Care Quality and Compliance (HCQC) Advisory Councils
- ADSD grantees who are Community Partners could host public meetings at their facilities to get recipient participation

BETSY AIELLO: Would a newsletter or flyer mailed to recipients be a good tool?

JEFFREY KLEIN: I think the best answer is “all of the above.” Do everything you can think of to reach recipients and families. A newsletter could work if it is simple and direct.

SARINA GUSKY [Humboldt Human Development Services (HHDS)]: The Rurals have not been included. Families, guardians and recipients do not understand either PCP or the New Rules. Education about what PCP is and does is necessary for all participants.

BETSY AIELLO: We agree that we need to be working on PCP – and we are. But CMS has told us not to include it in the Transition Plan.

MARK OLSON: The second section on page 17 outlines Recipient Education and Notification. You must know where your recipients are to send them letters and surveys. Newsletters are not a good vehicle. My daughter’s case manager is not very effective, but she does contact her on a regular basis. The Coalition for Community Choice has been working with Ralph Lawlor at CMS. We are being told that CMS is pushing the decision making regarding the New Rule to the States.

ED GUTHRIE: We have Public Meeting Facilities. We would be happy to coordinate and/or host a meeting. Of the population we serve, 50% are on HCBS Waivers; the rest are either private pay or general fund paid. All potential recipients should be notified, not just those currently receiving Medicaid funded services. The Clark County School District has approximately 400 children who may need HCBS graduating every year. They and their families should be notified of the potential impact.
BETSY AIELLO: It is not that services to recipients will be disallowed, but that certain Providers may not meet requirements and may not be able to receive Medicaid payments. Regarding CMS stating that it is not up to them to make the decisions, the Transition Plan and the decisions the State makes must be approved by CMS.

MARK OLSON: Some of the Transition Plan is general.

BETSY AIELLO: The Plan is a work in progress.

ED GUTHRIE: As I understand it, the purpose of the New Rule is that those receiving HCBS have the same access to services and the community as other individuals. If that is true, then by default, Medicaid recipients at day programs meet that definition since they only make up about 15% of that population.

BETSY AIELLO: I am not as concerned with ADHC. CMS has stated they will allow senior living environments. I am concerned about sheltered workshop settings and adult disability communities.

JEFFERY KLEIN: What about PACE? If any program is at risk they are.

BETSY AIELLO: PACE is a managed care plan for the elderly CMS has approved. The funding for all of their services is under the Managed Care authority and not through HCBS.

LESLIE BITTLESTON: The document as posted on the internet and made available here at this meeting is a Draft. We are requesting your input and specific language to make it more understandable as well as to better meet the needs of Providers and Recipients in Nevada. Please email any further questions or comments to HCBS@dhp.gov.
F7. AARP response to Public Workshop
11/10/14
My name is Barry Gold and I am the Director of Government Relations for AARP Nevada. AARP Nevada is a nonprofit, nonpartisan organization, with a membership of more than 300,000 in the state, working to help Nevadans 50+ live life to the fullest and ensure that all Nevadans have independence and choice as they age.

AARP appreciates the opportunity to review and comment on Nevada’s Draft HCBS Transition Plan and we recognize the efforts of the Division of Health Care Financing and Policy in putting this plan together in such a short timeframe. The new HCBS rules hold great promise for improving the Medicaid HCBS system in Nevada and giving consumers and their families more choice and control over the services that enable them to live in their homes and communities. Nevada’s transition plan puts forward a solid outline of how Nevada plans to come into compliance with the new HCBS rule, but there are a number of areas where we believe the State can further strengthen the plan or add more detail so that the plan can function as intended and protect consumers of HCBS.

Overall, the plan seems to rely primarily on self-assessment from the providers in determining compliance. Information from providers is crucial, but consumer input should be a stronger influence here. Although there is mention of a recipient survey (p. 17), it’s not clear how the results will inform the determinations of compliance. Underscoring the need for additional consumer input is the provider self-assessment survey itself (Appendix A), in which providers are surveyed about certain things that are really only answerable by the clients. For example:

- Is the client free from coercion? (Question 14)
- If the client has concerns, is she comfortable discussing them? (Question 15)
- Do clients know how to relocate and request new housing? (Question 42)

These are important questions, but a provider’s response is only one side of the story. The State should pull in all of the tools and sources of information it can to make these determinations. We note that Iowa’s proposed transition plan, for example, plans to use provider-submitted data, consumer survey data from the Iowa Participant Experience Survey, and information gathered by State case managers and the Department of Inspections and Appeals. Although taking a more comprehensive approach in determining compliance is not an easy task, it better capitalizes on this opportunity to review and improve Nevada’s HCBS system.

In addition, there are a number of areas in the plan that were unclear in our review, or that we believe would benefit from additional detail:

- We understand that half of the 1915(c) self-assessment surveys were not completed and returned, so the State is re-sending them with additional explanations and hoping for a better response rate. Will the State release the results and analysis once additional responses are received?
- The plan identifies certain problem areas based on survey responses and in-person assessments. For example, the plan notes that sheltered workshops or work centers and provider-owned and/or controlled day settings as currently operated, are presumed to be settings that isolate individuals receiving HCBS from the broader community. Does the State plan on working with these providers to
bring them into compliance, or instead contesting this issue with CMS and trying to overcome this presumption of non-compliance?

- Will on-site assessments (p.17) be conducted for all providers or just those that did not complete a self-assessment survey? We note the State’s intent to visit 50% of all providers by June 2015, but when will the others get visited?

- The provider compliance monitoring (p. 19) seems to focus primarily on the initial task of getting providers into compliance but does not address ongoing enforcement. We believe the plan should better describe the State’s capacity and plan to evaluate compliance on an ongoing basis, even for those providers initially determined compliant.

- The description of plans and protections for individuals who must be transitioned to settings that meet HCBS requirements (p.20) needs more detail. The State should more fully describe the proper notice and due process, the choices offered to the individual, the content of the person-centered planning process, and the protections to ensure that there is no break in services.

Thank you for this opportunity to comment on the State’s Draft HCBS Transition Plan. We look forward to working with the State to ensure that these rules are implemented and monitored in a way that continues to shape our HCBS system for the better.
F8. LTO response to Public Workshop
11/10/14
Thank you for the opportunity to provide public comment on the HCBS Transition Plan for the State of Nevada. My name is Mark Olson. I am here today in several capacities:

- Most importantly I am the only parent and legal guardian of my 19yo daughter Lindsay who has autism and likely will not be able to live completely. *(sic)* She is currently a client of the Desert Regional Center.
- I am President & CEO of LTO Ventures, a 501(c)(3) Nevada nonprofit corporation that develops live/work/play residential communities for adults with autism.
- I also am an advocate at State and federal levels on matters related to housing options for adults with autism, and co-founder of the Coalition for Community Choice, a national grassroots collaboration of persons with disabilities, families, providers, professionals, educators and legislators.

I want to first State that I believe that adults with disabilities have the human and civil right to live, work, play, socialize, recreate, learn, love, and worship in the setting and manner of their own choosing, and with the support of their parents, families, friends and caregivers.

I have been actively involved with the last 3 rounds of 1915 rule-making by CMS and authored a white paper on what the *Olmstead* decision meant for housing choice for persons with disabilities.

Five times over six years up to March 2014, CMS has engaged in rule-making efforts that have provided useful clarifications of certain issues encountered by the individuals served by the 1915 regulations, but each time also have included attempts by CMS to overreach the letter and spirit of the ADA and *Olmstead* and insert language that unnecessarily segregates specific types of residential settings from Medicaid eligibility. Five times through the public review processes these attempts have been rejected by the very individuals served by these regulations and their families and caregivers.

The Final Rule, also known as CMS-2249-F and CMS-2296-F, issued on March 17, 2014, was as significant for what it did not include as for what it *(sic)* changes it did include. What the Final Rule did not include was specific settings types that would not be allowed. What it did include was an emphasis on outcomes and experiences. It also specifically identified the Person-Centered Plan as the single most important document guiding individual choice. For individuals served by these regulations and their families and caregivers this was a reasonable opportunity to educate and inform CMS and State agencies about how the waiver program should be implemented going forward.

That relief lasted 3 days. On March 20, 2014, Centers for Medicare & Medicaid Services (CMS) issued an Informational Bulletin (Bulletin) entitled "Home and Community-Based Service (HCBS) 1915(c) Waiver and 1915(i) State Plan Amendment (SPA) Settings’ Requirements Compliance Toolkit". In this Bulletin, there is a two-page section entitled "Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community."

In the Bulletin, CMS clearly seeks to continue litigating specific language rejected through the public review process.

I have four points I want to make about the Transition Plan draft proposed today.

**Non-compliance with US Administrative Procedures Act**

The Coalition for Community Choice believes CMS has exceeded the scope of its authority with the Guidance, and key elements of the Guideline exceed the scope of the Final Rule, and therefore are non-compliant with the US Administrative Procedures Act of 1946 and a violation of federal law and the Medicare Act.

To the extent that the State of Nevada develops and implements its HCBS Waiver Transition Plan and codifies waiver changes based on specific language in the Guidance that is not expressly contained in the Final Rule, the
State may find any such policy and language subject to legal challenge. I propose here that the State adhere strictly to the language of the Final Rule and ignore the Informational Bulletin and Guidance to avoid any delays or complications with its waiver programs now or in the future.

State Must Seek Out and Include Input from its Most Important Stakeholders – Recipients

I am deeply concerned, as the only parent and legal guardian of an adult Nevada resident with disabilities who presently is a client of services through the regional center and may one day require supports and services paid for through this waiver, that the State seems to have forgotten who its most important customer is.

On p. 1 of the Transition Plan document, DHCFP States that it held “two public workshops in which all members of the public were invited to learn about the new regulations and provide comments.” On p. 13, it States “the turnout was excellent and comprised a mix of providers, recipients, regulators, advocates, and State staff.” A review of the sign in sheets from both those meetings tells a different story. It shows 106 total attendees with considerable duplication of attendees between the two workshops. All the attendees, with one or two possible exceptions (it is not clear from the sign in sheets) are State agency and provider representatives.

The fact that this is the third workshop on this issue and DHCFP still has virtually no recipient input from waiver funding recipients and/or their parents and family members is unacceptable. Moreover, it fails to fulfill CMS' directive that “States will describe their process for receiving public input and ensure that it is sufficient to provide meaningful opportunities for input from individuals served or who are eligible to be served, based on the scope of the proposed changes.”

While DHCFP may feel it has fulfilled its statutory obligation to provide notice to the public under Nevada Open Meeting law, I find it entirely unacceptable to hide behind that pathetic public notice practice for input on programs concerning the funding safety net for thousands of Nevadans with disabilities. A three-business-day advance notice posted in 19 libraries and two government buildings that would require persons to travel to those locations every day to check bulletin boards is an unacceptable burden.

Further, the DHCFP website where the agenda and plan draft was posted requires a greater than average knowledge of website navigation to find them, and again places the burden on recipients and their families to check this website daily for notices that provide only 3 business day advance notification.

Even in the Transition Plan draft 2 we are commenting on today, the State and DHCFP fail to provide for sufficient recipient and prospective recipient input. On p. 17, the Action Item “Recipient Education and Notification” is completely inadequate. The Plan States “recipients are crucial in providing information on the services they receive, so a random sample of recipients will be selected...”

The Plan should provide a process for nothing less than outreach to 100% of current and eligible recipients of waiver-funded services and DHCFP and the State should set a goal of 100% feedback as it did with the provider Self Assessment Surveys.

Therefore, I propose that DHCFP and the State do the following:

1. DHCFP take no action on the Transition Plan until it can demonstrate that it has reached 100% of Nevadans presently served by the waivers, and 100% of Nevadans currently eligible to be served by the waivers, with information in plain language that:
   a. Informs them through which waiver they receive funding or are eligible to receive funding.
   b. Describes what changes are being evaluated because of the Final Rule.
   c. Explains what the Final Rule is.
   d. Explains what the changes could mean to them.
   e. Invites them to provide public input including what actions they should take if they want to provide public input and exactly how they can do it.
   f. Informs them how to be put on a list to get all future notices in a way that does not require them to go to a library or government building.
2. Deliver the notices via US Mail and through their case managers.
3. Deliver the notices to all current Regional Center clients 18+ because they may become eligible for waiver-funded services in the next five years and these proposed changes.

**Must Emphasize the Central Role of Person-Centered Planning**

CMS States in the Q&A about the Final Rule: “The expectations set forth in this final rule emphasize that individuals are most knowledgeable about their services needs and the optimal manner in which services are delivered.”

Nothing in the Nevada Transition Plan or the changes Nevada proposes to its waivers should interfere with the person-centered plan of any recipient taking precedent over all other considerations, and must make it a matter of policy to honor those person-centered plans without unduly influencing recipients to a particular conclusion. Moreover, DHCFP must make it a priority to:

- Inform and educate current and future recipients and their parents and families about exactly what a person-centered plan is and how to create one.
- Explain the basis in CMS regulations for person-centered plans and their authority in the waiver-funded services process.
- Provide resources about how to create an optimal person-centered plan and a list of private vendors who can help these individuals prepare proper person-centered plans.

**Definition Must be as Broad as Possible and Reflect the Progressive and Independent Nature of Nevada**

CMS States “We expect States electing to provide benefits under section 1915(k), 1915(i), and/or 1915(c) to include a definition of home and community-based setting…”

In the Olmstead decision, the court used the terms “home” seven times and “community” 80 times, but never defined those terms. The Supreme Court did not define those terms because it intended individuals served by those terms to decide for themselves what home and community mean to them.

Sally Burton-Hoyle, one the nation’s most respected authorities on person-centered planning says “community is defined by the individual.”

We know that the setting is not the issue. It is the design and management of those settings that is the key. Individual experiences and outcomes can be just as successful in large, well-designed settings as they can in individual homes and apartments, and conversely we know that outcomes and experiences can be just as undesirable in individual homes and apartments as in larger settings. In fact, this is supported by data from research documented in the National Core Indicators that indicates that individuals in congregate settings report feeling lonely less than those in other settings.

Therefore, I encourage the State of Nevada to adhere to the specific language of the Final Rule and avoid including any specific setting types in any definitions or Plan language and to adhere strictly to the language in the Final Rule.
G. Other Public Comments Received
G1. Accessible Space, Inc. (ASI) Case Norte
2/11/15
Accessible Space, Inc. (ASI)
Casa Norte
February 11, 2015

Accessible Space, Inc. (ASI) is a nonprofit organization incorporated in 1978 with a mission to provide accessible, affordable, assisted, supportive and independent living opportunities for persons with physical disabilities and brain injuries as well as seniors. Our mission is accomplished through the development and cost-effective management of accessible, affordable housing, assisted/supportive/independent living and rehabilitative services. We believe our “housing with care” allows individuals with various disabilities to achieve their greatest levels of independence within the community while providing a cost effective alternative to institutionalization. ASI has developed 156 buildings (3,954 units) and currently owns and manages more than 2,500 units of accessible, affordable housing throughout the nation with a variety of supportive services offered in three (3) States.

ASI opened the Nevada Community Enrichment Center (NCEP) in 1992 to provide outpatient rehabilitative services to individuals with brain injuries. In 1999, we were asked by Nevada Medicaid and the Office of Community Based Services (now Aging and Disability Services) to create long-term housing options for Nevadans with brain injuries. As a result, ASI opened two (2) accessible, affordable shared homes with supportive services located in Las Vegas, Nevada. In addition, ASI has developed 445 units in 17 accessible, affordable apartment buildings located in Las Vegas, Carson City, Reno and Henderson, Nevada for adults with physical disabilities and/or brain injuries as well as seniors. ASI currently provides 24/7/365 supportive services at three (3) apartment buildings and two (2) shared homes in Nevada.

One of the shared homes ASI developed as a result of the request of Nevada Medicaid and the Office of Community Based Services for long-term options for individuals with brain injuries is Casa Norte, a 9-bedroom home now licensed as a Residential Facility for Groups located on the Northwest side of the Las Vegas Valley. There are currently seven (7) private rooms and one (1) shared room housing nine (9) residents with brain injuries - but we are seeking funding to create nine (9) private rooms by the end of 2015.

Casa Norte provides affordable and ADA accessible housing which includes ramp entrances, widened doorways, accessible bathrooms and showers, etc., with individual modifications (such as handrails) accommodated as needed. In addition, ASI provides 24/7/365 supportive services by staff trained on the special needs of individuals who have brain injuries or neurological disabilities which may include memory loss, cognitive impairments, safety risks, seizures, language and speech impairments, behavioral impairments, and physical or mobility impairments. With access to accessible, affordable housing and 24-hour supervision and supportive service by specially trained staff, residents are successfully supported in their choice to live in an integrated setting within the community as an alternative to institutionalization.

ASI encourages each resident at Casa Norte to reach their highest level of independence and respects their rights as a tenant as well as a recipient of supportive services. Residents and their representative(s) are informed of the terms of a residential agreement prior to moving in which includes the resident and landlord rights and responsibilities, information about rent, housing guidelines and issues that may cause termination of residency. Residents are informed of the process to communicate a grievance or complaint to have issues addressed. Residents are also advised of the process to request assistance with relocation to a different setting if they choose.

ASI encourages residents to exercise meaningful choice in their lives. While some choice may be limited due to regulatory requirements, or if the individual is not their own legal guardian, residents regularly exercise choice in their daily activities. Examples of personal choice include the ability to furnish and decorate their living spaces to their personal tastes, choose meals and meal times, have visitors and private phone calls, have access to personal funds, and the ability to maintain privacy. All bedrooms have doors for privacy (and will have locks in the near future) and staff request permission before entering the units. There is no video monitoring within the house.

As a licensed Residential Facility for Groups with provision of Personal Care Service, all direct care staff receive mandated training in accordance to regulations prior to working with the residents. Training also
includes use of effective and positive communication skills, respect for choice, resident rights and service delivery with dignity and respect. Staff are trained in techniques for positive behavior management and modification focusing on developing relationships and supporting the person and not the behavior. Staff performs a variety of supportive services including:

- Personal Care Assistance such as bathing, grooming, dressing, etc.
- Activities of Daily Living (ADL) including assistance and supervision for homemaker services such as cooking, cleaning and laundry
- Instrumental activities of daily living (IADL) services such as banking, budgeting and bill paying
- Case Management service to insure that individuals have adequate access to necessary services and to remain qualified for appropriate benefits including Medicaid, Medicare, Private Health Insurance, etc.
- Support for medical needs such as scheduling medical appointments and transportation, support during medical appointments, arranging and ensuring follow up after appointments, ordering medications, providing supervision with safe medication administration, etc.
- Social and recreational planning, transportation and supervision to ensure safety in the community
- 24-hour awake staff supervision to ensure safety of individuals who have challenges with memory loss, cognitive, physical and medical conditions or impairments.
- Behavioral support to assist individuals who have diagnosis-related behavioral challenges

A person-centered plan is developed with input from the resident and all individuals involved. The resident meets with their support team as needed or at least annually to review their needs, goals and accomplishments and update the support plan.

Staff works directly with the residents to plan group activities that the residents can do inside and outside of their home but residents may also plan their own individual activities with friends, family members, community members or staff. Examples of scheduled activities include movies, concerts, college basketball and football games, professional basketball and baseball games, WWE Wrestling events, NASCAR Events, dining at casual and formal restaurants, local casino activities, hiking at the national and State parks, fishing, camping, playing pool, bowling, etc. Residents are also supported in participating in faith activities of their choice, volunteering within the community, exercise and athletic activities, voting, and visiting with family and friends. Residents may request alternative activities which are supported when staffing patterns permit. Residents who desire to work in the community are supported by staff to do so.

Residents have access to their personal funds and determine how their funds are managed. Some individuals maintain their money on their person while others choose to have their funds safely locked up with access as desired. Some individuals have designated ASI to be their Representative Payee.

The licensure for Casa Norte requires that schedules and menus for meals and snacks are posted in advance. However, residents have the option to eat at the time of their choosing and may choose the prepared menu, an alternative menu or their own personal food items. Healthy menus are planned with consideration towards resident recommendations.

Public transportation is available to residents but the nearest bus stop is located more than one (1) mile away from the property and Para Transit services to not provide door-to-door access at this address. Because of the difficulty in using public transportation, Casa Norte provides and assists with access to transportation for all residents. The residents at Casa Norte, due to their vulnerability and needs related to their brain injury, are required to have some level of supervision at all times. While individuals are able to be in their rooms and on the property without "line of site" monitoring, they are not able to come and go at will unless accompanied by a responsible party capable of providing appropriate supervision and support.

Residents may have visitors and private phone calls. There is a phone line established specifically for the residents’ use and there are no restrictions regarding resident communication. Individuals can take calls in the community space or privately in their rooms. Several of the residents have their own personal cellular devices for personal communication but it is not required.
ASI is committed to providing quality housing and service to the residents at Casa Norte. ASI fully supports community integration for all individuals with disabilities and encourages each individual to reach their highest level of independence possible. ASI is committed to accommodating any and all requirements established by the Centers for Medicare and Medicaid (CMS) final rule for Home and Community-Based Service (HCBS) settings.
G2. Position Statement from Members of AHONN in Collaboration with Residential Care Home Associate Nevada (RCHAN Southern NV)
In reference to the Final Rule from Medicaid for: The Home and Community-Based Setting Requirements for Provider Owned or Controlled Residential Settings.

We recognize that the central philosophy behind the rules is the culture change from institutionalized setting to a Person Centered Care. Person-centered care offers a humanistic and holistic approach to caring for someone. It incorporates not only physical considerations but also the person’s psychosocial and spiritual well-being. Person-centered care (PCC) is a philosophical approach to care that honors and respects the voice of clients and those working closest with them. It involves a continuing process of listening, trying new things, seeing how they work, and changing things in an effort to individualize care based on the person’s physical, mental, psychological and cognitive abilities.

In person-centered care the individual has the right to: Make decisions; Have an individual plan of care; Be included on the care planning team with the provider; Have their hopes, dreams and goals be central to their plan.

As a group of home care providers, we strongly support Person Centered Care through a person centered planning process and following a person-centered service plan. However, we find irony and contradiction to some of the requirements and expectations/goals, because they are not specific to the frail elderly with chronic physical and mental/cognitive deficits whom we serve. Our residents require supervised settings otherwise; they would have returned to their homes or placed in Independent Living facilities. They require assistance and protective supervision 24/7 in a family care setting. The nature of their illness is usually chronic and progressive. Our goal is to maximize their independence and function in a supported home-like environment given their advanced age, physical and cognitive limitations. We honor their privacy, dignity, individuality and choice to the extent possible.

We feel that some of the requirements; for example, lockable doors with keys may pose fire hazard and evacuation within 4 minutes maybe in jeopardy as required by the State Fire Marshal. Can you imagine scrambling for 6 individual keys to open the doors in case of fire? Another requirement we find posing health and safety risks is access to food at anytime. While we provide 3 meals and snacks in between meals and as needed, most of our residents are high risk for falls when accessing the refrigerator, pantry and kitchen cabinets by themselves. Health concerns also for residents on a special diet as well as sanitation and infection control issues. Visitors at anytime will normally be not reasonable because we have to allow them time for personal care, rest and sleep. We can accommodate generous visiting hours and special visiting arrangements within reason.

In conclusion, we feel that the HCBS requirements and rules should be tailored to the population served in order to truly individualize the plans and reflect realistic expectations and goals according to assessment of needs, physical and cognitive abilities of the person. We feel that the “one size fits all” concept does not support Person-centered nor individualized planning in a group home care settings.

We realize that the financial concerns that the Residential Care facilities are facing today are a separate issue than the topic at hand. However, our ability to continue with our business will depend on our ability to pay for our caregivers 24/7, expenses and making a living. Please refer to 2 samples of actual financial analysis for a 5 and 10 bed facility. Theoretically, if we accommodate only Medicaid recipients (Rates: Level 1= $20 / day; Level 2= $45 / day; Level 3= $60 / day), we will not be able to meet our operational costs at the current NV Medicaid rates of reimbursements which had not been changed since 2002. Our aim is to provide a highest quality care and services for this frail elderly people that worked hard who needs dignity, respect, and deserved a decent happy life on their remaining time. We wish that we as a homecare provider be involved in all decision making in taking care our elderly.

Thank you very much.
### Income

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(Note: Average of $2,500 / resident granting the facility is full every month)

Total Income: 150,000.00 12,500.00

### Expenses

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### Yearly Expenses

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Total Yearly Expenses: 17,492.00 1,457.67

### Transportation

<table>
<thead>
<tr>
<th>EXPENSES</th>
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<th>Monthly</th>
</tr>
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<tbody>
<tr>
<td>Vehicle 1</td>
<td>2,880.00</td>
<td>240.00</td>
</tr>
<tr>
<td>Vehicle 2</td>
<td>2,880.00</td>
<td>240.00</td>
</tr>
<tr>
<td>Maintenance/Registration Renewal</td>
<td>1,440.00</td>
<td>120.00</td>
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Total Transportation: 7,200.00 600.00

### Budget Summary

<table>
<thead>
<tr>
<th></th>
<th>Yearly</th>
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<td>Total Expenses</td>
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<td>NET</td>
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## Scenario 4 Under New Rule

### Total Income

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</thead>
<tbody>
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<td>20,000.00</td>
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### Total Expenses

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<td>Payroll Expenses</td>
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**Total EXPENSES**: 265,034.00 | 22,086.17

### Quarterly Expenses

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**Total Quarterly Expenses**: 2,976.00 | 744.00

### Yearly Expenses

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</thead>
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<td>Fire Extinguisher Maintenance</td>
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<td>Fire Alarm / Well Sprinkler Yearly Inspection</td>
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</table>

**Total Yearly Expenses**: 17,492.00 | 1,457.67

### Transportation

<table>
<thead>
<tr>
<th>Item</th>
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</tbody>
</table>

**Total TRANSPORTATION**: 7,200.00 | 600.00
April 22, 2016

Crystal Wren
SSPS III
HCBS Waiver
Long Term Services and Supports
DHCFP

Dear Ms. Wren:

Here is our position paper /some questions that would more accurately define the types of patients in our facilities and their needs.

We believe that Olmstead (a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs) was looking at this group of people, the group with disabilities who are in an institution and might move to a less monitored but still very monitored safe home and community based care setting safety and cost effectively.

We also believe that instead of privacy and locked doors residents who need protective supervision and Long Term Care need companionship, and open doors so staff can get in easily in a case of emergency. These people want companionship and want to avoid isolation in a private room when they lack social skills to come out and interact with other people. We believe they need assistance with medications and need 24 -hr staff at some level so they can get a PRN medication when needed. If they can hold their own medication and can be trusted to take them we would argue they are less Long Tenn Care residents. If they are monitored by a pill count on a daily visit is that adequate monitoring to ensure a mentally ill person is putting that pill in their mouth even if it is not in the box the next morning? For all the choice questions while that sounds good in fact congregate care and living is about cost effective care to allow the 24 hour protective supervision they need. If money was unlimited then we all can choose our own home, feed, roommates but this is about cost effective care and choices that offer needed safety, protection and care. Already Residential Facilities for Group principles of care are patient centered from their creation of home like, non-medical care, that offers dignity, respect, independence, function, and safety in the least restrictive way. All of that with the required monitoring and safety and enforcement to ensure the Long Tenn Care residents needs are met. If they did not need monitoring and supervision they would not be Long Tenn Care residents. People don't go to Skilled Nursing Facility if they don't have to and what we are looking for is cost effective, home and community based care
for those who need Skilled Nursing Facilities or high level of care for chronic illnesses that are unlikely to improve, have already plateaued with treatment.
Instead of asking about job potential and privacy we need to ask about.

Answer all with do any of the residents meet this criteria? y/n. Then how many out of the total are Long Tenn Care residents instead of independent / transitional living residents. For example, 8/10 if you have 10 beds.

-Do you have residents over age 60 who are less likely to seek work? If so how many out of the total number of residents, you have?

-What is the average age of your resident?

-What is the average ADL level of your residents? Total independent, need some help, need a lot of help.

-Do they wear briefs or depends y/n

-Number that use a walker or adaptive device or don't walk at all?

-Do any of the residents have chronic mental, cognitive or other physical illness that limit their practically ever living alone or getting a job?

-Would getting a job or living on their own without 24-hour supervision put the safety of that resident at risk?

-List some of the diagnosis that your population suffers from that limit their ability to work, live alone?

-How many of your residents have already received therapy for their illness and still can't live alone or seek employment?

-Would locking the door to the room put your residents at risk in case of a fire or in case their mood changed quickly and needed assistance by the supervising person?

-Would taking your resident out in the community potentially agitate them and stress them cognitively or physically?

-Would leaving your resident alone in a room or at home without some level of monitoring put them at risk of bad events?

-Is there any scenario you can envision medically where your residents will with treatment medical or behavioral be able to live alone, work or live without protective supervision?

-If you had to average or guess would you describe your residents as independent living / transitional living or tending more toward Long Tenn care residents who are closer to needing a nursing home than living on their own even with assistance, training and
- Improvement in their health condition?

- What type of irreversible illnesses do your resident typically have?
- Given the age and expected progression of needs for your residents is it likely any will improve enough to where they can be independent even with community supportive services?

- Would you agree that your residents might not get the needed supervision, protective supervision, and care they need if they get care in an independent living / transitional living setting where they have less than 24 hour care and a place that can give pm medication 24 hours a day when needed?

- Does your care setting offer coordination of medications?

- Does your staff ensure the residents take their medication? If so do they do it on an ongoing basis or through a one visit a day pill count? If it is by a pill count once a day how do you ensure the resident took the pills?

- If the doctor called in a medication change does the resident process that including drop the prescription off and pick it up from the phannacy and record it?

- If not do you have staff to do this for the resident?

As discussed, we believe that this information will help us get the data we need to open up the discussion with CMS so that we can protect the Long Tenn Care residents we serve some of whom may be mislabeled as transitional living / independent living and exposed to care setting with less monitoring and supervision than they need.

While it is a good idea to consider lumping all residents into one group in fact doing so by definition means one groups needs will not be addressed. The more independent who need privacy, jobs, and job training are very different from those needing long term care, many of whom have chronic mental, cognitive or combinations of mental and physical disabilities that need companionship more than privacy, supervision for safety and care more than independence and who can be upset by false hope of working again when that is not practical. We need to comply with CMS or better yet to help educate CMS with our data and response to these questions to help protect the disabled and to build / improve upon programs like the Residential Facilities for Group industry in Nevada that is a national leader in Olmstead compliant, community based, safe, monitored, cost effective care.

With the data and responses from Residential Facilities for Group (big and small) to a fair set of questions like the ones above we think we can apply for a grant to expand and build upon our national leading regulations that protect and empower seniors who have Long Tenn care needs to help them SAFELY remain in the residential communities where they are used to live in spite of their disabilities and to help keep them out of
institutions. Indeed, we believe Residential Facilities for Group in Nevada are already
Olmstead compliant in this effort and already offer patient centered care, safety, but with monitoring and enforcement that is needed to ensure these disabled people get the care they need when they are unable to protect themselves.

We are hopeful that we can work with you and the strategic plan at expanding and modifying the next question list including building in a purpose for those questions to support our state plan and response to CMS. As you know lumping people into one group as CMS is requesting is coming under a lot of concern. Indeed, we can envision reaching out to other groups, senior research groups in Nevada to help as well to add credibility and help fund the next questionnaire. If we are working together with AHONN in the North, RCHICAN / ECHO in the South and NvAlc it is likely we can get a very high response rate to the next questionnaire.

We can be the leaders in suggesting cost effective changes that allow and promote those who need and benefit from it and building in a real cost effective, home and community based care option for those who are Long Tenn Care residents. We have many ideas on ways to have cost effective care that can grow that also promotes individual self-determination and responsibility. The good news is Nevada is already a leader in cost effective, Olmstead compliant, home and community based care in Residential Facilities for Groups under NRS 449.

We would like to work with you to help build the two systems to help the two very different groups of people independent living / transitional living and Long Tenn Care residents which we believe are the target group Olmstead is looking at. So far the questions and plan missed to see the safe, cost-effective care that the state can hope to fund as the number and demand for Long Tenn Care service increases. Paying 6K / resident / month for low acuity independent / transitional living residents is not cost effective but we believe there are many very safe, cost effective plan possible.

The regulations we are expected to follow right now from the BHCQC is mostly opposite of what CMS is asking the group homes to do. First and foremost, we would humbly suggest that the Department of Health and Human Services align these regulations with the requirements of BHCQC so that everyone is on the same page. It should be very clear that our recipients do not fall in the category CMS is talking about. Plain and simple, our residents are all long tenn care.

We hope we can work with you and the department concern to explore ways the state can offer choices in care, promote patient / family self-determination, and build in monitoring that helps reduce cost while allowing choice.

Sincerely,

AHONN Executive Board

c.c:

*Marta Jensen - Acting Administrator, Department of Health and Services*  
*Jane Gruner - Administrator, Aging and Disability Services Division*
G4. LTO Ventures 8/12/16
August 12, 2016

State of Nevada
Division of Health Care Financing and Policy

Attn: LTSS – State Transition Plan 6/28/16
1100 E. William Street, Suite 222
Carson City, NV 89701

Dear Acting Administrator:

Thank you for the opportunity to comment on the Nevada State Transition Plan (STP) 6/28/16. We appreciate the considerable effort and amount of work that has gone into the NV STP in the time period allotted by CMS. Our specific concerns are as follows:

Public Comment Process
We have documented our concerns about the public comment process employed by DHCFP for the development of the STP beginning with our public comment on Nov. 10, 2014 (Attachment G2 to the "STP 6/28/16"). Those concerns continue with the "STP 6/28/16."

Example #1: On June 24, 2016, DHCFP posted a request for public comment regarding Heightened Scrutiny Submissions, with a 30-day deadline to receive comments no later than July 25, 2016. This was a very significant part of the STP process because it was the list of settings that DHCFP proposed to submit to CMS for Heightened Scrutiny review, a process that could result in settings being denied eligibility to use HCBS waiver funding, as well as be significantly burdensome to providers in staff time and expense that they otherwise might not have had to endure.

To our knowledge, none of the 56 settings included in the proposed submission to CMS received the notice of public comment directly via email, fax or US Mail. To our knowledge, none of the residents of the 56 settings and/or their families or legal guardians received the notice. The STP Advisory Council did not receive a notice, nor did the A-Team, the largest organization of adults with intellectual and developmental disabilities in the state, nor did the State of Nevada Association of Providers (SNAP). As a result, the public comment period expired without a single comment.

It should be noted that CMS has made it clear to states that the public input on settings the state has flagged for heightened scrutiny is essential to the STP process.

• CMS issued a Q&A document on June 26, 2015 entitled Home and Community-Based Settings Requirements which contained this statement under A7:
  - "In addition, states are expected to solicit public input on settings the state has flagged for heightened scrutiny, as part of the Statewide Transition Plan."

1
CMS held a SOTA webinar on Nov. 4, 2015 entitled Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process in which it stated the following:

- Public notice associated with settings for which the state is requesting heightened scrutiny should:
  - Be included in the Statewide Transition Plan or addressed in the waiver or state plan submission to CMS
  - List the affected settings by name and location and identify the number of individuals served in each setting
  - Be widely disseminated
  - Include all justifications as to why the setting is home and community-based
  - Provide sufficient detail such that the public has an opportunity to support or rebut the state's information
  - State that the public has an opportunity to comment on the state's evidence

- CMS expects that states will provide responses to those public comments in the Statewide Transition Plan or submission to CMS

Example #2: On July 12, 2016, DHCFP posted a request for public comment on the "STP 6/28/16" itself, with a 30-day deadline to receive comments no later than August 12, 2016. In fact, DHCFP had already submitted the "STP 6/28/16" to CMS on June 30, 2016, two weeks prior to the publication of the notice seeking public comment. As stated in Example #1, no key stakeholders or stakeholder organizations, formal or informal, appear to have received the notice of public comment. Our organization discovered the notice serendipitously while researching another issue on the DHCFP website, and we believe this letter herein will be the only public comment received in this period. We believe that is not CMS' expectation of the public input process.

Heightened Scrutiny Assessment Tool
We are deeply concerned about assessment tool developed and used by DHCFP for determining most of the settings submitted to CMS for heightened scrutiny review.

One of the most important statements in the Final Rule CMS-2249-F/CMS-2296-F issued in January 2014 was contained in the preamble: "These final regulations establish a more outcome-oriented definition of HCBS settings, rather than one based solely on a setting's location, geography, or physical characteristics."

We strongly support this position by CMS and worked hard through multiple Notices of Proposed Rulemaking by CMS to argue for it.

In "STP 6/28/16", Appendix 02. Provider On Site reviews/Heightened Scrutiny Questionnaire (referenced on the DHCFP website as "HCBS Residential Settings Assessments"), is a table based on the tool used by DCHFP to make its assessments and containing the findings of the on-site settings reviews using that tool. We have the following concerns:

- The tool itself was not made available for public comment or review prior to its use.
- The very first criterion is "More than 10 beds" which has no relation to the Final Rule. There is no reference anywhere in the Final Rule to specific number of beds as a criterion for heightened scrutiny, nor in any of the guidance from CMS pursuant to the Final Rule.
• DHCFP offers no explanation about how it determined that "more than 10 beds" would be a major criterion of the tool, nor does DHCFP present any evidence supporting its relevance to the Final Rule or STP.
• No other place in the "STP 6/28/16" is there even a mention of "More than 10 beds."

**Action Requested**

1. We request DHCFP recall from CMS the version of the "STP 6/28/16" submitted June 30, 2016 until such time as the required stakeholder involvement and public comment can be obtained and properly included.

2. We request DHCFP re-schedule and re-open the public comment periods for settings DHCFP seeks Heightened Scrutiny review and for the "STP 6/28/16." As part of this new comment period, we request DHCFP conduct meetings in Clark County, Washoe County and rural Nevada to explain the STP and seek direct input from stakeholders.

3. We request that DHCFP actively and deliberately notify directly all affected and interested parties about the new public comment periods.

4. We request that DHCFP remove the "More than 10 beds" criterion from the heightened scrutiny assessment tool and not include any criterion related to number of beds or number of residents.

5. We request that DHCFP evaluate and implement email and text notification systems so all parties interested in being part of the public comment process for this process and others that require stakeholder involvement can be notified in a timely fashion.

6. We request that DHCFP publish notices and explanatory information about the Final Rule, Nevada STP and the Heightened Scrutiny process in plain language and in at least English and Spanish.

7. We request that DHCFP publish all correspondence from CMS and to CMS about the Nevada STP on the DHCFP website and label it in a way that it's easy to identify what each document is and when it was received or sent.

Thank you again for the opportunity to provide this public comment. We look forward to working with DHCFP to effectively and fairly implement the Nevada State Transition Plan.

Sincerely,

Mark L. Olson
President & CEO
G5. Email response from
girlieantonio@yahoo.com
Here is my feedback regarding the Home-Based Services Plan for Medicaid:

I support the Medicaid State Transition Plan. The person centered care will allow the residents to maintain their independence by making decisions for themselves. My only concern is, how the new plan applies to residents that are unable to express themselves or make decisions independently. I would like to suggest more trainings for this particular subset to provide the best quality of care.

Thank you.

Maria Antonio
Administrator
The Victorian Center, LLC I & II
H. Proposals to the DHCFP
H1. Betty’s Village Proposal
OPPORTUNITY VILLAGE

Betty’s Village

The world has changed. Throughout history, people with intellectual disabilities have lived very short lives. Today, medical and social advances have enabled those with disabilities to live longer, healthier and more productive lives. Now, we must tackle the consequence of this good news. Where will people with disabilities live?

Opportunity Village is developing Betty’s Village to assist in meeting the ever increasing need for choice in housing options for people with intellectual disabilities. Based on the live, work, play, learn and create philosophy, Betty’s Village is a place where everyone knows each other, people can follow their dreams and are encouraged and supported to become the best they possibly can be. Betty’s Village will be the first of its kind in Nevada. As referenced in the Nevada State HCBS Transition Plan, the Olmstead Act emphasizes community as something that is defined by the individual, specifically, what is the definition of community to one person? Definitions will vary from person to person, but it is about individual choice.

Currently, in Southern Nevada, the home and community-based housing options for individuals with intellectual disabilities are primarily the Intensive Supported Living Arrangement (ISLA) and the Intermittent SLA. These options, while physically integrated in Southern Nevada neighborhoods do not foster social interaction within the communities. ISLAs are small group homes where 3 to 4 individuals with intellectual and developmental disabilities live and these houses usually have 24-hour (awake) staffing. These homes are physically distant from other ISLAs and cannot support the number of staff necessary for community integration activities because the staff spends all their time addressing activities of daily living (e.g. cooking, cleaning, personal grooming, etc.). ISLAs have therefore physically integrated into the community, but socially isolated their residents. Betty’s Village will provide individuals another residential choice to the current residential options including non-disability specific settings being provided. Opportunity Village believes that each person should make “their choice” of “their home.”

Betty’s Village will be built on approximately 6.5 acres and will promote an active life that is close to work options, community resources, peers, family, and friends. The Village is centrally located with easy access to public transportation, freeways and major cross streets. Betty’s Village will be integrated in and support full access of individuals receiving Medicaid Home and Community-Based Services (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

Opportunity Village is about progress and supporting people with intellectual disabilities to reach their maximum potential and enhance their lives. The current Supported Living system does not always take into account where the person has lived for the majority of their life, only the circumstances for the placement. Individuals who have lived at home with their parents or other family members are usually not ready to move into a home that is in a different neighborhood, with other housemates that they do not know, and staff who may not know their needs and that
change regularly. Individuals moving directly from the family home generally take a lot of time to adjust before feeling comfortable in their new environment.

Opportunity Village will provide an “Enlightened Living” model that is informed, open minded, progressive, and independent. The model will have three levels of supports that individuals can choose from depending on their skills and the required level of supports. The three levels of residential supports are: a home that provides a 24/7 level of care including awake overnight supervision, an intermediate home that provides a 24/7 level of care with overnight staff availability and allows the individual to have some approved alone time, and semi-independent living with intermittent supports in their own apartment. A live-in “Resident Advocate” will support individuals in the intermediate home model who have a goal of moving into semi-independent living. The advocate will be a friend, sidekick, and developer to increase the individual’s personal, community, home and work skills to progress to the next living arrangement. A person living at home for the majority of their lives most likely start at a 24/7 level of care but after they have accomplished required living skills may choose to move to the next living model. Once an individual has accomplished independent living skills the person may choose to move into semi-independent living at the village apartments with intermittent supports. Opportunity Village would also support an individual that has the skills and chooses to move out of the village into a home or apartment. Opportunity Village will also support an individual that chooses not to move into the next level of living despite being eligible to make the next step. Opportunity Village recognizes that individuals may move from an intermittent support living situation to a higher level of supervision depending on their health needs or current issues. Opportunity Village will provide for each individual to “age in place” for as long as possible in the village.

Betty’s Village will be comprised of apartments and homes to make up a community for approximately 100 residents. The studio and one-bedroom apartments will be combined in a building that will include spaces for work training opportunities and areas for activities and socialization. The homes will be clustered together similar to a custom home cul-de-sac and share common visiting areas and outdoor spaces. The apartments and homes will be directed by a Qualified Intellectual Disability Professional (QIDP) who will assist the individual to develop and coordinate the person-centered plan and services. A live-in house parent/manager will manage day to day operations of the program and supervise direct staff who will provide the hands on daily support and training. Other professional staff will include nursing staff to support with health care needs, an activity/volunteer coordinator that will organize activities and develop new partnerships with the community for volunteer participation and community activity opportunities, resident finances to ensure proper spending of funds and maintenance of benefits, and maintenance staff to ensure proper operation of equipment, landscaping, and timely repairs.

A community center will provide individuals with daily opportunities to socialize, make new friends and participate with others through playing video games, classes (exercise, dance etc.), and just “hang out.” The general public will be welcomed at the village to interact and participate in activities with individuals, and make friendships.

Betty’s Village will be built with a traditional Tuscan design and accommodate the individual needs of each resident through a continuum of care provided in the various living models. Each
residence will be “home” for its residents. Meals will be prepared in each home, meet all requirements for nutrition and special diets and served family style. Staff will eat with the individuals and promote conversation and appropriate table manners. All homes will have an open floor plan with common living and dining areas that are tastefully decorated. Areas for visiting with family and friends will be available in each home. Every resident will have a private bedroom with in-suite bath that can be decorated according to their own style. Outdoor living areas will include comfortable covered patios with outdoor seating for visiting with family and friends, areas for exercise, sports, water play, hobbies, and BBQs. The Village will have advanced security and technology features that will create a safe not locked environment to enhance safety and independence.

Opportunity Village demands that each individual be treated with dignity and respect and be free from coercion and restraint and protected from abuse, neglect and exploitation at all times. Staff will be trained in non-violent physical crisis intervention using the Crisis Prevention Institute training. Staff will use positive behavior supports to de-escalate individuals engaging in inappropriate behavior by following written behavior programs that use a progressive prompting sequence to de-escalate inappropriate behavior. Staff will use positive reinforcement to reward appropriate behavior and use positive behavior supports for instances of inappropriate behavior. All behavior programming will include a teaching component and redirection. Staff will only use restraint procedures if the individual is a danger to him/herself or others and follow the person-centered plan approved emergency crisis procedure. All medication used to assist with behavior management will be monitored closely by the prescribing physician. Any use of medications or any restrictive component in a behavior plan will be approved by the Human Rights/Behavior Intervention Committee annually.

Every individual will be assessed and evaluated for health concerns initially and annually. Individuals will receive coordinated medical services from a primary physician of their choice. Nursing staff will provide nursing supports and follow up services. A medical management system will ensure that all medical needs are met. OV staff will be trained on the health care support needs of each individual and continuously monitor individuals for signs and symptoms of health issues. OV staff will support individuals to schedule and attend all medical appointments. Staff will ensure that all information from the appointment is documented and filed. Communication following each appointment will take place with family members, guardians and all appropriate individuals. Individuals taking routine medication will be evaluated on their ability to self-medicate. Individuals that are unable to self-medicate will have their medications administered by staff that is certified through a State of Nevada Division of Aging and Disability Services approved medication administration training curriculum. Opportunity Village will ensure that all protected health information is safeguarded.

Each individual’s human rights will be upheld and respected by ensuring that staff is trained, and knowledgeable about individual rights, educating individuals about their rights, and providing opportunities to exercise their rights and make choices responsibly. Each month staff will document a “right” that was trained and discussed with the individuals. Individuals may have some rights restricted depending on their abilities and guardian instruction. All rights restrictions will be approved by the guardian and ISP team and documented in the annual person centered plan. If a right is restricted without due process a Denial of Rights form will be completed and
submitted. All individual rights and restrictions will be reviewed annually by a Human Rights and Behavior Intervention Committee.

The Village will be staffed according to the individual’s needs and supports as identified through the admission process, person-centered plan, and on-going evaluation. Through careful screening and hiring practices, continuing education, initial and on-going staff training, Opportunity Village will ensure that each staff member is well qualified, meets the requirements of the job, and is competent to implement the person-centered plan (PCP) and to support the resident’s needs, routines and schedules. All staff will be very knowledgeable about each resident’s likes, dislikes, and health and warning signs to identify signs of possible concern before they become a major issue.

The person-centered plan (PCP) is the blueprint for programming for each individual. The PCP process will address each person’s array of home and community needs based on personal goals, preferences, community and family supports, financial resources, staff evaluation, and other areas important to the person. The PCP will facilitate individual choice regarding services and supports and who provides them. The PCP optimizes individual initiative, autonomy, and independence in making life choices. The individual receiving services will direct the PCP team and process to the maximum extent possible. The person may designate an advocate to assist them with the development of the plan. The PCP will provide services to be delivered in a manner that promotes/supports community integration to the extent of the individuals’ preferences and desired outcomes. The PCP will assist each person with constructing and articulating a vision for the future, while considering various paths, engaging in decision making and problem solving, monitoring progress, and making needed adjustments to goals in a timely manner. The team will assist to identify a unique mix of paid and natural community supports that will help the person to meet progress toward accomplishing their goals. The PCP process will conduct frequent, ongoing assessment of the individual’s needs and identify the individual’s strengths, goals, preferences, needs (medical, daily living skills and home/community), and desired outcomes. Monthly data on programs, goals, and objectives will be taken, reviewed and summarized. The PCP will be updated on an annual basis however, the person may request a meeting to update the PCP at any time.

Opportunity Village will ensure full community integration and enjoyment of community life through planned activities in the community, intentional neighbors, and use of volunteer groups, family members and friends. Opportunity Village recognizes the importance of family in each resident’s life and will make routine family involvement and interactions an expectation and priority. The Activity/Volunteer coordinator will create a monthly calendar of events that individuals can participate in during the month. Activities will be held in and outside of the village and the number of participants will vary according to the activity. Individuals may add individual activities to the calendar and participate in unplanned spontaneous outings of their choice. Some activities may include but not be limited to: shopping, special community events, concerts, plays, dining out, sporting events, church, and volunteer projects. During all activities, each resident will have opportunities to spend their money and learn money management skills in the process. Residents will be interacting with members of the community on all activities and at community businesses that they frequent. Other community participation may come through programs like Best Buddies that will provide one on one activity. Staff will engage the
individuals in hobbies of interest, interactive activities and community gatherings to celebrate holidays, birthdays and special events. Opportunity Village will promote personal choice for each person to choose their daily routines including times they want to eat and when to have visitors. Opportunity Village respects the individual’s right to refuse to participate, however, staff will continue to provide opportunities and encouragement to the individual to participate. Individuals will access the community through public transportation, parents, family members, and company vans. Opportunity Village will provide vacation opportunities for residents to places of interest following the individual’s desires and documented in the person centered plans.

Betty’s Village will be culturally-responsive and inclusive. Opportunity Village will support the culture and beliefs of the individual to attend or not attend religious services, observing specific food preferences or dietary restrictions related to culture or ethnicity, and celebration of holidays and special events.

Betty’s Village will be flexible and nimble in its service system to move and react quickly and address emerging needs of each individual and their family. Opportunity Village desires each individual, their family members and interested parties to be satisfied with their support services. OV residential staff will regularly discuss services and satisfaction with individuals and family members. If a problem exists, individuals and their families have the ability to meet at any time with OV administrative staff to discuss issues. Families can complete a satisfaction survey annually and may communicate at the annual person-centered planning meeting.

Opportunity Village will maintain and develop a wide range of community stakeholders to offer support networks to the individuals. Visitors and volunteers to Betty’s Village will spend “meaningful time” interacting and socializing with the individuals. Service clubs such as Rotary, Lions club and Boy Scouts will be invited to volunteer and spend a night with individuals watching movies, playing games and other community based activities. Opportunity Village supports four (4) Miracle League Baseball teams that provide one non-disabled player to each disabled player. Opportunity Village will invite groups and clubs to speak to the individuals about their organization with the possibility that the individual can become a member of their organization. Opportunity Village will reach out to faith based communities so individuals have a chance to participate in their activities. The Opportunity Village grandparent program will match active seniors and individuals to develop friendships and participate in community activities such as art, theatre and dance. The Activity/Volunteer coordinator will perform community outreach to develop new corporate volunteer groups that will support the individuals in enrichment classes such as cooking, art, crafts, exercise, yoga and community activities. Individuals will have opportunities to participate in community volunteer projects to benefit other community organizations.

Opportunity Village is committed to enhancing the lives of people with intellectual disabilities and their families. Through respect, fiscal responsibility, team building and professional, high quality services residents will fulfill their dreams and live a high quality of life.
Pod 1
4 Rooms
First Floor

- Office
- I.T. Server Room
- Training Room: Coffee and Bakery
- Dining Event Space
- Maintenance
- Reception/Check In
- Training Room: Gift Shop
- Training Room: Art Gallery
- Training Room: Hair and Nails
- Training Room: Pet Grooming/Pet Therapy
- Training Room: Future Growth
- Laundry

First Floor: 21,968 SF
Total: 41,142 SF

- 17 One-Bedroom Apartments
- 14 Studio Apartments

Betty's Village Concept Progress: July 23rd, 2015

Opportunity Village
Las Vegas' Favorite Charity

KGA Architecture
SECOND FLOOR: 19,174 SF
TOTAL: 41,142 SF

- 17 One-Bedroom Apartments
- 14 Studio Apartments

BETTY'S VILLAGE CONCEPT PROGRESS: July 23rd, 2015
Enlarged Floor Plan - Main Building - Second Floor

West Wing
H2. Public Comment Invitation
The Final Rule for Home and Community Based Services (HCBS) states that the service setting for HCBS must meet specific community based requirements in order to receive Medicaid funding. CMS has developed a process of Heightened Scrutiny that can be used for a setting that appears to be institutional or isolating but other setting attributes make this assumption appear incorrect. There are multiple steps in this process, and the inclusion of public comment is an important element.

As part of the process required by the Centers for Medicare and Medicaid Services (CMS) Final Rule for Home and Community Based Services (HCBS) for 42 CFR, the Division of Health Care Financing and Policy (DHCFP) requests public comment about the following proposal by Opportunity Village. Opportunity Village has developed plans for a community living site for individuals with intellectual disabilities called Betty’s Village. Although the proposed community will be disability-specific, thus creating the presumption the residents would be isolated and therefore the setting would not meet the requirements of the HCBS final rule, the placement of the setting within a larger community context and the planned involvement of the residents with outside activities overcomes much of the supposed isolation of the disability-specific setting.

To be assured consideration, comments must be received by one of the methods provided below no later than 5:00 pm on October 2, 2015. You may submit comments in one of three ways (please choose only one of the ways listed):

- **Electronically.** You may email comments to hcbs@dhcfp.nv.gov. Write Betty’s Village in the subject line.

- **Mail.** You may mail written comments to the following address:
  
  Division of Health Care Financing and Policy
  
  1100 E William Street, Suite 222
  
  ATTN: Long Term Support Services – Betty’s Village
  
  Carson City, NV 89701

- **Fax.** You may fax comments to the following number:

  (775) 687-8724
  
  ATTN: Long Term Support Services – Betty’s Village

All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We will post all the comments received by the close of the comment period, as soon as possible after they have been received, on the following web site:

http://dhcfp.nv.gov/Home/WhatsNew/HCBS/.

There will be a link on the page for Public Comments received.
H3. Public Comment Summary
DHCFP received a total of 74 comments regarding Betty’s Village: 56 in support; 18 in opposition.

Of the 56 in support, 39 of them self-identified as employees, Board Members, clients or parents of clients of Opportunity Village. Two organizations besides Opportunity Village expressed support: LTO Ventures and Nevada HAND.

Of the 18 in opposition, 4 self-identified as parents of children with disabilities, 4 self-identified as people with disabilities, and 9 were submitted on behalf of the following organizations:

- NDALC – Nevada Disability Advocacy & Law Center
- NGCDD – Nevada Governor’s Council on Developmental Disabilities
- AAPD – American Association of People with Disabilities
- ASAN – Autistic Self-Advocacy Network
- NNCIL – Northern Nevada Center for Independent Living
- Boston CIL – Boston Center for Independent Living
- TASH
- United Spinal Association
- National Council on Independent Living

The comments in opposition included references to CFRs, sections of CMS’ New Rule and the Supreme Court decision Olmstead v. L.C.

42 C.F.R. § 441.301(c)(4)(vi)
42 C.F.R. § 441.530(a)(1)(vi)
42 C.F.R. § 441.530(a)(2)

42 C.F.R. § 441.710 (a) (1) (i)
42 C.F.R. § 441.710 (a) (1) (iii)
42 C.F.R. § 441.710 (a) (1) (v)
42 C.F.R. § 441.710(a)(1)(vi)
42 C.F.R. § 441.710 (a) (1) (vi) (A)
42 C.F.R. § 441.710(a)(1)(vi)(B)
42 C.F.R. § 441.710(a)(1)(vi)(C)
42 C.F.R. 441.710 (a) (1) (vi) (D)
The following language was used in many of the submissions. If a comment did not state the individual was a board member, former board member, employee, client or parent of a client, but used the following language, I counted it as coming from an Opportunity Village source.

To Whom It May Concern:
I have reviewed the proposed Opportunity Village development and am more than pleased to offer my support of Betty’s Village as a community based residential setting for people with disabilities. The residents of Betty’s Village will engage in an active life, be integrated in society, have support of individual choice, and be encouraged to foster independence to the highest degree possible. Based on the live, work, play, learn and create philosophy, Betty’s Village is a place where everyone knows each other, people can follow their dreams and are encouraged and supported to become the best they possibly can be. Betty’s Village will promote an active life that is close to work options, community resources, peers, family, and friends. The Village is centrally located with easy access to public transportation, freeways and major cross streets. Betty’s Village will be integrated in and support full access of individuals receiving Medicaid Home and Community-Based Services (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Encouraging interaction, independence and self-determination is the key to a full and fulfilling life. Betty’s Village includes the many components needed to encourage greater independence and self-direction while ensuring the appropriate supports are available. I am in full support of the project.

To Whom It May Concern:
I have reviewed the proposed Opportunity Village development and am pleased to offer my support of Betty's Village as a community based residential setting for people with disabilities. The residents of Betty's Village will engage in an active life, be integrated in society, have support of individual choice, and be encouraged to foster independence to the highest degree possible. Encouraging interaction, independence and self-determination is the key to a full and fulfilling life. Betty's Village includes the many components needed to encourage greater independence and self-direction while ensuring the appropriate supports are available. I am in support of the project.

Sincerely,
Name
I. Medicaid Services Manual (MSM) Revisions for all 1915(c) and 1915(i) Programs
Medicaid Services Manual Revisions for all 1915(c) and 1915(i) Prog.-ams

Home and Community Based Settings (HCBS):

A. HCBS must have the following qualities:

1. It is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid services;

2. It is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting;

3. It ensures individual rights of privacy, dignity, and respect and freedom from coercion and restraint;

4. It optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and

5. It facilitates individual choice regarding services and supports, and who provides them.

B. Providers must ensure:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity

2. Individuals have privacy in their living or sleeping units

3. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed

4. Individuals sharing units have a choice of roommate in that setting

5. Individuals can furnish and decorate their own units within the limits of the lease or agreement

6. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time

7. Individuals can have visitors of their choosing at any time

8. The setting is physically accessible to the individual.
C. Provider Responsibilities

1. Providers must have policy and procedure in place that addresses each of the eight requirements listed above.

   Providers must have a signed lease agreement with each individual resident to include eviction criteria for non-payment of room and board or non-compliance with house rules.

2. Providers must ensure health, safety, and welfare of all residents.

3. Providers must document positive interventions and support used to redirect behavior as well as methods that did not work.

4. Providers must have a copy of the current care plan.

D. State Responsibilities

1. Case managers will develop a person centered care plan which is individualized for each Medicaid recipient and will identify the following:
   
   o A clear description of the recipient’s condition that is directly proportionate to the specific assessed need;
   
   o An established time limit for periodic review to determine if the care plan is appropriate or needs modification;
   
   o Informed consent of the individual; and
   
   o A written description of behavior modifications that are acceptable, if applicable.

2. Case managers will develop a new person centered care plan annually, or more often as needed.

3. Case managers will provide a copy of the current care plan to providers.

4. Case managers and/or review staff will review providers periodically to include policy and procedure and individual lease agreements.
J. Clarification from CMS
Clarifications from CMS

Clarification required from CMS:

1. Group and assisted living settings can be home and community based, and meets all requirements of the HCBS settings requirements, with exception of population segregation and size. Many of these providers are population specific of 65 years of age or greater, and may be larger than four recipients. There are two questions: 1) the segregation of individuals, who are aged 65 and older, and 2) the size of the facilities?

2. Nevada is largely a rural State and there is access to care issues in rural Nevada. Group facilities that are found in rural areas are utilized to the maximum. Nevada has a few group facilities located in rural areas that are either on the campus of a nursing facility or within the same building as a nursing facility. If these facilities are not accepted as home and community based, it would displace many individuals receiving waiver services with no other qualified providers available. The question is: are there exceptions to what is considered home and community based for rural areas that have access to care issues?

3. Another concern is settings that have 24 hour supportive services. All of these settings are located within the community, and are comprised of two to four people, but staffing is usually one to four, or two to four, meaning there is not enough staff to accommodate those spontaneous activities that recipients may want to do. In addition, transportation is not part of this service, so recipients must rely on family, friends, or public transportation.

4. Nevada does not have a Traumatic Brain Injury (TBI) Waiver, nor does it have adequate resources for individuals with TBI. There is one provider in Nevada who provides out-patient habilitation services for individuals with TBI who reside in their own homes. However, some individuals with TBI are unable to live in the community without 24-hour supervision, assistance with basic needs, and management of medications. These individuals require a group setting which provides these services. Nevada currently has one setting that houses nine individuals with TBI. All of these individuals are male, and the home is located with an urban setting. The provider is currently building another facility in an urban setting that will have individual apartments and will be open to both males and females. The question is: the segregation of individuals with TBI?
K. Documents
K1. Statement of Choice
STATEMENT OF Choice

I have actively participated in identifying my supports and preferred outcomes for the next year. I have been able to choose the provider of my support services. I am aware that I can ask for a change of state service coordinator or provider agency if I am not satisfied with the help I am getting. If I am eligible for Medicaid, I understand that I may select any available Medicaid provider. I understand I may request changes in services and service provider at any time.

_____________________________  ________________________
Person/Legal Representative      Date

FOR WAIVER SERVICES COMPLETE THE FOLLOWING:

CHOICE OF SERVICE

I have been advised that I may choose either Home and Community-Based Waiver services or an Intermediate Care Facility for Person’s with Intellectual and Developmental Disabilities (ICF/IDD). I have been informed of alternatives available under the Waiver and I choose:

☐ Home and Community-Based Waiver Services  ☐ ICF/IDD Services

_____________________________  ________________________
Person/Legal Representative      Date

☐ I have received and been advised of my responsibilities as a recipient of Home and Community Based Waiver Services.

_____________________________  ________________________
Person/Legal Representative      Date

FAIR HEARINGS

I have been informed of the right to a fair hearing if I have not been able to choose Home and Community-Based Services instead of placement in an ICF/IDD or Medicaid Home and Community-Based Services are denied, reduced, suspended, or terminated. I understand I must submit a written request for a fair hearing which must be sent to the Medicaid Central Office at 1100 E. William Street, Suite 101, Carson City, NV within 90 days of the date of the decision. If I have any questions regarding this decision, I may call (702) 486-3000, ext. 43602 in the Las Vegas area or I may call 1-800-992-0900, ext. 43602 or (775) 684-3602 in the Carson City area.

In the event I have a complaint about the duration, scope, delivery, or quality of service (including the service provider), I understand I may file a grievance with my Service Coordinator from the Aging and Disability Services Division.

I understand I may be represented by legal counsel, a friend, relative, other person, or I may represent myself.

_____________________________  ________________________
Person/Legal Representative      Date

DS REGIONAL CENTER
INDIVIDUAL SUPPORT PLAN

Name:
Case #:
ISP Date:

DS-ISP 3 Rev. 9/24/2013
K2. Statement of Understanding
Recipient Name: __________________________

As an alternative to placement in an institutional setting (i.e. a long term care facility or medical facility), I have the option to choose a less restrictive environment remain in a home and community-based setting (i.e. my own home or assisted living). To assist me with this, I may be eligible for transition services to return to the community or may be eligible for a Home and Community-Based Services (HCBS) Waiver program, which will provide me with additional needed services in a community-based setting.

Please choose one:

☐ I choose a home and community-based setting.
☐ I choose an institutional setting.

If my choice includes a home and community-based setting, then: (Select all three)

☐ I choose to participate in the HCBS Waiver. I understand that my participation is conditional based on my initial and ongoing eligibility for Medicaid and waiver services. _____ (Initial)

☐ I verify that I have been given a list of qualified HCBS Waiver providers. _____ (Initial)

☐ I verify that I participated in the identification of my service needs that will be used to develop my HCBS Waiver Plan of Care. I will actively participate in the development of all future Plans of Care. _____ (Initial)

☐ I understand that my services are developed using person centered planning. _____ (Initial)

I would like to communicate with my case manager in these ways (pick all that apply):
☐ Phone   ☐ Email   ☐ Text Messaging   ☐ In-person

I live in: ☐ My Own Home  ☐ An Apartment  ☐ A Residential Group Home/Assisted Living
☐ With Family  ☐ Other: __________________________

I know that I can change case managers if I am not happy. ☐ Yes  ☐ No

My Responsibilities for Participation in a HCBS Waiver:

I understand I, or legal or designated representative, have/has the responsibility to:

➢ Notify my provider(s) and case manager of a change in my Medicaid eligibility.

➢ Notify my provider(s) of my current insurance information, including the name of other insurance coverage, such as Medicare.
Notify my provider(s) and case manager of changes in my medical status, service needs, address, and location, or of changes of status of my legal or designated representative.

Treat all staff and providers appropriately.

Sign my provider’s daily log to verify services were provided.

Notify my provider when scheduled visits cannot be kept or services are no longer required.

Notify my provider agency of missed visits by provider agency staff.

Notify my provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.

Furnish my provider agency with a copy of my Advance Directive, if applicable.

Establish a back-up plan in case my waiver attendant is unable to work at the scheduled time.

Understand a provider may not perform services or work more hours than authorized in my service plan.

Understand a provider may not work or clean for my family, household members or others.

Contact my case manager to request a change of provider agency.

Sign all required forms.

I further understand:
➢ I may be responsible for payment of a portion of the Home and Community-Based Services cost (called patient liability) based on financial eligibility. If patient liability is established, failure to pay may result in the loss of Home and Community-Based Services.

➢ I may request a hearing from the Division of Health Care Financing and Policy (DHCFP) if I have not been given a choice of Home and Community-Based Services as an alternative to a long-term-care facility placement, if I am denied this service, or if services are reduced, suspended or terminated. A written request for a hearing must be sent to: DHCFP, 1100 E. William Street, Suite 102, Carson City, NV 89701, within 90 calendar days from the Notice of Decision date.

➢ I may obtain representation by legal counsel, or a friend, relative or other person, or I may represent myself.
Division of Health Care Financing and Policy (DHCFP)
Aging and Disabilities Services Division (ADSD)
Comprehensive
Statement of Understanding

☐ I, or my legal or designated representative, have read the Statement of Understanding and understand it.

OR

☐ The Statement of Understanding was read to me.

AND

☐ I will establish the frequency of ongoing contacts with my case manager, but understand that the contacts must be sufficient to address my individual health and safety needs. Contacts may be made by any form of communication available to both the case manager and to me or my legal or designated representative.

Recipient Signature __________________________________________________________ Date __________

Printed Name of Legal Guardian/Legally Responsible Individual/Designated Representative ____________________________________________

Reason for Legal/Designated Representation _______________________________________

Legal Guardian/Legally Responsible Individual/Designated Representative Signature __________________________________________ Date __________

Case Manager Signature __________________________________________________________ Date __________