

## **Changes made to the Nevada Transition Plan in response to CMS letter dated February 29, 2016.**

The Centers for Medicare and Medicaid Services (CMS) requested additional detail be included in the State Transition Plan amendment regarding the systemic assessment, site-specific assessments, monitoring of settings, remedial actions, heightened scrutiny, relocation of beneficiaries, and public input. 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 June 28, 2016 State Transition Plan revision:

### **Waivers and Settings included in the STP:**

- Specific settings were identified for all HCBS.
- The term Community Care Facility has been included as part of the definition of Assisted Living Services
  - A timeline to remove Partial Hospitalization from the 1915(i) State Plan has been included.

### **Systemic Assessment:**

- The Jobs and Day Training systemic assessment has been amended to include federal and state regulations that demonstrate support or direct conflict with the new Settings requirements.
  - The regulations for Jobs and Day Training have been referenced as appropriate.
  - Additionally, all systemic assessment responses have been reviewed and any that were found to be Silent or in direct conflict have been amended to include a remediation plan.
- CMS requested NAC 449.258 be amended to reflect current language supporting visitation hours for individuals in residential settings. The State was unable to include this revision into the current Legislative Session, however, the State is in the process of this revision and this will be submitted during the next Legislative Session.
- Additional information has been included regarding conflicting regulations from the Fire Marshall and continued residence related to aging in place.
- The section regarding Medical Conditions in Residential Settings for Groups has been omitted from the State Transition Plan as it was found to not be relevant in relation to specifics surrounding the New Rule.

### **Site-Specific Assessments:**

- The State has conducted 100% on-site assessments of all residential and Adult Day Health Care settings.
  - Included in this section are the on-site assessment questionnaire and the findings.
  - The calculations for Adult Day Health Care settings has been amended to reflect accurate data.
- A complete review of the Provider self-assessments has been included.
- Provider self assessments and on-site reviews were included for non-residential settings and supported living arrangement providers. Detail surrounding these findings has been included in this submission.
- On-site reviews have been completed for all residential settings and Adult Day Health Care settings. Detail surrounding these findings has been included in this submission.
- Additional language has been included regarding the term Augmented Personal Care and Group Home settings relation.

### **Monitoring of Settings:**

- Additional details have been included regarding the monitoring process including updated timelines and licensure and certification processes.
- Timelines have been reformatted to include Mon/date/year format.
- Clarifying language was included regarding the provider self-assessments.
- Timelines have been updated throughout the milestones section.

### **Remedial Actions:**

- Remedial steps have been included regarding conflicting or silent determinations of federal standards for all of the new regulations supports.
- Site-specific assessments have been broken out into separate actions under the Provider Compliance Reviews section.
- Deadlines have been updated.

**Heightened Scrutiny:**

- Language regarding Adult Day Health Care providers has been omitted from the State Transition Plan. This language read “The state will discourage any new Adult Day Health Care providers from applying for reimbursement if a provider is located on the same campus, or within the same building, as an institutional provider is located on the same campus, or within the same building, as an institutional provider as identified above.” The State finds that this language is inappropriate as this sort of action would be determined at the time of Provider enrollment or recertification if not identified during the on-site assessments.
- The State has prepared all Heightened Scrutiny submissions for CMS to review. These were made available for public comment on the State Medicaid public website.

**Relocation of Beneficiaries:**

- Specific timeframes have been included regarding this element.

**Public Input:**

- All comments received to date have been included in the submitted State Transition Plan dated October 1, 2016.
- Clarification regarding each comment has been documented within the State Transition Plan as well as any changes that resulted from public comment.

**State of Nevada Department of Health and Human  
Services (DHHS) Division of Health Care Financing and  
Policy (DHCFP) Aging and Disability Services Division  
(ADSD)  
Home and Community Based Services (HCBS) Settings Transition Plan  
February 2015**

### **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://dhcftp.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:**

- **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.
- **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.
- **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:**

Service	Service Description
<i>These services are thought to fully comply with the HCBS rule requirements because they are provided in the recipients private home in which individuals are allowed full access to the community and choice of all services and supports.</i>	
Behavioral Consultation Training and Intervention	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.
Career Planning	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.
Nursing Services	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.
Counseling Services	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.
Non-Medical Transportation	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.
Nutrition Counseling	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.

Residential Support Management	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.
Residential Support Services	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. These 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.
<i>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.</i>	
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

Service	Service Description
<i>These services are thought to fully comply with the HCBS rule requirements because they are provided in the recipients 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.</i>	
Case Management	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.
Respite Services	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.
Homemaker Services	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.

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	<p>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.</p> <p>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.</p> <p>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.</p>
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 inpatient setting which make them acceptable.

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

Service	Service Description
<i>These services are thought to fully comply with the HCBS rule requirements because they are provided in the recipients 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.</i>	
Case Management	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.
Respite Services	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.
Homemaker Services	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.

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.
Attendant Care	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.
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.
Home Delivered Meals	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.
Specialized Medical Equipment and Supplies	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.
Environmental Modifications	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.
Assisted Living Service (Augmented Personal Care)	Augmented Personal Care Services provided by Assisted Living Facilities include assistance with basic self care and activities of daily living (ADL), homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. This care is over and above the mandatory service provision required by regulation for residential facilities for groups.  This waiver utilizes disability specific apartments.

#### IV. Adult Day Health Care Services

<i>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.</i>	
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 inpatient setting.

**V. Home Based Habilitation Services**

<i>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.</i>	
Home Based Habilitation Services	<p>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.</p> <p>One concern is that some campuses do have acute care hospitals or rehabilitation clinics, which are inpatient. This needs to be addressed further.</p> <p>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</p>

**VI. Partial Hospitalization**

<i>The State has not evaluated this program.</i>	
Partial Hospitalization	This service will be removed from 1915 (i) upon response from CMS. As of this date, the DHCFF 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 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.

### **State Specific Analysis:**

#### *Group Homes and Supported Living Arrangements:*

Home and Community based waiver programs are population specific which means they target individuals who are elderly, intellectually or developmentally disabled, or physically disabled. In theory, HCBS isolates individuals by target population, but does not necessarily isolate them from the greater community. Many of these individuals live in a home or apartment within the community, but some live in group home or supported living arrangement settings.

The State has one group home setting, and minimal supported living arrangements that are located on a campus with an institution, or provide inpatient services.

#### *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.

#### *Jobs and Day Training:*

This is a service provided to all adults who are eligible for services from Nevada's Development Services. These services vary in type and intensity of supports to allow individual vocation choices. Supports range from day habilitation activities, pre-vocational services and vocational training in a supervised and structured setting; to include supervised work groups in the community and supported employment activities to sustain paid competitive integration. Nevada's Development Services contracts with private non-profit organizations to manage community training centers and other qualified providers that offer choices to the individual based on their interest and skill level.

The state has completed a non-residential assessment based on on-site visits which evaluated compliance with HCBS regulations.. Emphasis of the assessment has focused on assuring services are supporting people to have opportunities to participate in integrated community settings and to seek opportunities for employment, and are not isolated and segregated from the broader community. Additionally, JDT service providers must submit quarterly outcome information to the State which addresses the individual's employment plan.

#### *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. One outpatient provider is located on a campus like setting that include other medical providers, such as rehabilitation clinics, who provide an array of outpatient services.

The State is concerned about outpatient type services that may be on the campus of an acute care hospital. The State is working with current and prospective Home Based Habilitation Providers to open a new setting in our larger community, Las Vegas. Upon further discussion, this prospective setting is familiar with the New Regulations regarding home and community based settings and is prepared to support these regulations with this proposal.

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 need a greater level of service, which includes 24 hour supervision, cueing, and medication management, in order to be successful in a community setting.

## ***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 2<sup>nd</sup> 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 two providers of this service and both providers were assessed in person.

The first 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 second provider is a 24-hour residential setting. The main office is located on a campus like setting similar to provider number one. This 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.

## **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.

## **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.

## 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:

### **Residential Facilities for Groups/Frail Elderly Group Settings:**

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
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.	1915(c) Appendix C	Setting selection is not prohibited by NRS or NAC; however, the State approved 1915(c) Waiver for the Frail Elderly supports this requirement.
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.	1915(c) Appendix C	Setting selection is not prohibited by NRS or NAC; however, the State approved 1915(c) Waiver for the Frail Elderly supports this requirement.
Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	NAC 449.268	This is supported by regulation.
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.	NAC 449.259 449.260	This is supported by these regulations.
Facilitates individual choice regarding services and supports, and who provides them.	1915(c) Appendix A2	This is not prohibited by NRS or NAC; however, the State approved 1915(c) Waiver for the Frail Elderly supports this requirement.
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.	NAC 435.565  NAC 449.2702  NAC 449.2708	Agreements are in place between providers and individuals. Individuals may be discharged from the facility for a number of reasons, including being bedfast.  There are no specific requirements for a lease agreement.
Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	NAC 449.220	Lockable doors are supported.  Appropriate staff having keys is not prohibited.

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
Individuals sharing units have a choice of roommates in that setting.	NAC 449.268(f)	Having a choice of roommates is not prohibited, however NAC 449.268(f) specifies that residents are allowed to make their own decisions whenever possible.
Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	NAC 449.218	Residents may use personal furniture and furnishings.
Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.	NAC 449.259	Schedule control is supported. Access to food at any time is not prohibited in general. Restrictions may exist for individuals for health and safety reasons; these are documented in the PCP.
Individuals are able to have visitors of their choosing at any time.	NAC 449.258	Conflicting. The State has started the process of amending this NAC to meet the language supported by the HCBS Settings requirement.
The setting is physically accessible to the individual.	NAC 449.226 NAC 449.227 NAC 449.229	Physical accessibility is supported.

**Adult Day Health Care Services:**

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
A facility must not be operated in combination with any other medical facility or facility for the dependent unless it is licensed separately.	NAC 449.4067	Community integrated, not on a campus setting.
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.	NAC 449.4074	Individuality and personal space are supported.
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 under a physicians order.	NAC 449.4081	Respect and dignity, abuse, and restraints are covered.

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
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.	NAC 449.4082	Meals are covered.
A medical or ancillary service not directly provided by the facility may be provided by another person pursuant to a contract.	NAC 449.4084	This is already in place.
Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time Choice of providers; Physically accessible:	NAC 449.260	Residents are afforded an opportunity to participate in, or decline participation in group activities which provide mental and physical stimulation and develop skills and interests. Participants are encouraged to participate in the development of their activity schedules.

### **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 Waiver and are regulated by NRS 435. The Nevada Administrative Code 435 has been updated and is pending final approval from the Nevada Legislature. A public hearing will be conducted once approval is received. 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.

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
Prevocational Services are designed to create a path to integrated employment in the community by providing employment related goals in their person-centered ISP. Services include teaching concepts of attendance, task completion, problem solving, interpersonal relations and safety and communication with customers, co-workers or supervisors.	NRS 435.176	Individualized services in the community which are designed to assist learning skills and increase self sufficiency while contributing to the person's community.
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.	NRS 435.176	Individualized services in the community which are designed to assist learning skills and increase self sufficiency.
Supported employment services are individualized and may include 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	This is supported by regulation.

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
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 alternative behaviors, and/or address challenging behavior.	NRS 435.176	This is supported by regulation.

### 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. These regulations do not specifically address the New Rule requirements; however they are addressed through Developmental Services Standards of Service Provisions and through the 915(c) Waiver for Individuals with Intellectual Disabilities and Related Conditions.

<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>
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.	DS-QA-01(ii)(1.21.14)  NAC 435.5082  1915(c) Waiver for Individuals with Intellectual Disabilities and Related Conditions (ID Waiver) Appendix C  Medicaid Services Manual (MSM)	Developmental Services Standards of Service Provision (DSSSP), Section F.2, F.10 and F.11 detail these expectations.  NAC 435.5082 provides supporting verbiage for this requirement as does Appendix C of the approved ID Waiver and in the MSM.
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.	ID Waiver Appendix C  MSM 2103.5A	Setting selection is not prohibited by NRS or NAC; however, the State approved ID Waiver and in the MSM.
<b>Specific Requirement</b>	<b>Regulation</b>	<b>Outcome</b>

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	DS-QA-01(ii)(1.21.14)  ID Waiver Appendix C	This is supported, DSSSP F.2 and in the ID Waiver.
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.	DS-QA-01(ii)(1.21.14)  ID Waiver Appendix C  MSM 2103.5	This is supported, DSSSP F.2, F.10 and F.11 and in the ID Waiver and in the MSM.
Facilitates individual choice regarding services and supports, and who provides them.	DS-QA-01(ii)(1.21.14)  MSM 2103.5	This is supported in DSSP F.13 and in the MSM.
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.	MSM 2103.5A  ID Waiver Appendix C	Addressed through Developmental Services Standards of Service Provisions, in the MSM and in the ID Waiver
Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	DS-QA-01(ii)(1.21.14)	Lockable doors are supported.  Appropriate staff having keys is not prohibited but is being addressed by the staff and will be included in the MSM which is currently being revised with an anticipated release date of October 2016.
Individuals sharing units have a choice of roommates in that setting.	DS-QA-01(ii)(1.21.14)	This will be included in the MSM which is currently being revised with an anticipated release date of October 2016.

Specific Requirement	Regulation	Outcome
Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	Silent	Not directly addressed or prohibited by NRS or NAC but is being addressed by the staff and will be included in the MSM which is currently being revised with an anticipated release date of
Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.	DS-QA-01(ii)(1.21.14)  MSM 2103.10	Schedule control is supported, DSSP F.10 Access to food is supported, DSSP D.7.a to D.7.h
Individuals are able to have visitors of their choosing at any time.	Silent	Not directly addressed but encouraged, and is not prohibited by NRS or NAC. Is being addressed by the staff and will be included in the MSM which is currently being revised with an anticipated release date of October
The setting is physically accessible to the individual.	DS-QA-01(ii)(1.21.14)	This will be included in the MSM which is currently being revised with an anticipated release date of October 2016.

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.

## **Summary of Public Comments**

Notices of Public Workshops were posted on the DHCFP website in the section for Public Notices: <http://dhcftp.nv.gov/Public/AdminSupport/PublicNotices/> as well as on the page devoted to the HCBS New Rule: <http://dhcftp.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 "wobble 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.

## **Summary of Public Comments (continued)**

### **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

## **Summary of Public Comments (continued)**

### **Public Workshop January 16, 2015**

- Focus groups should be incorporated since the recipient survey didn't capture resources that people can't access.
- Various community stakeholders have offered to host focus groups.
- The surveys should be translated into Spanish.
- Establish a formal complaint process.
- 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.
- 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.
- Request to indicate State resources needed for full compliance with the transition plan.
- Question regarding timeline and if it the work can be completed prior to 2019.
- The State will hold another public workshop once feedback from CMS is received.
- Public comment in writing has been added, Appendix G3 and G4.

## 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 DHCFF.

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 DHCFF. The DHCFF 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 “wobble 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 locking 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 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;
- 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 type 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 from 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 dated 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 an 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 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 DHCFP 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.

<b>List of Public Meetings</b>	
<b>Date</b>	<b>Meeting Type</b>
January 15, 2014	Committee on Senior Citizens, Veterans and Adults with Special Needs
February 25, 2014	NV Governor's Council on Developmental Disabilities
March 17, 2014	HCBS Committee Meeting (State Staff)
April 2014	Letter to Provider
April 2014	Provider Self Assessment Survey
April 7, 2014	HCBS Committee Meeting (State Staff)
April 8, 2014	Tribal Consultation
April 11, 2014	Commission on Aging Senior Strategic Plan Accountability Subcommittee
April 23, 2014	Task Force on Alzheimer's Disease
April 28, 2014	HCBS Committee Meeting (State Staff)
April 29, 2014	NV Commission on Services for People with Disabilities
May 7, 2014	Commission on Aging Senior Strategic Plan Accountability Subcommittee
June 6, 2014	Public Workshop #1
June 9, 2014	HCBS Committee Meeting
June 11, 2014	Commission on Aging Senior Strategic Plan Accountability Subcommittee
June 12, 2014	Southern Nevada Association of Providers Presentation
June 24, 2014	HCBS Steering Committee Meeting
July 1, 2014	Draft #1 of Transition Plan
July 8, 2014	HCBS Lease Agreement Sub-Committee Meeting
July 8, 2014	HCBS Regulatory Sub-Committee Meeting
July 17, 2014	HCBS Steering Committee Meeting
July 22, 2014	HCBS Lease Agreement Sub-Committee Meeting
July 22, 2014	HCBS Regulatory Sub-Committee Meeting
August 8, 2014	HCBS Regulatory Sub-Committee Meeting
August 11, 2014	Nevada Health Care Association Meeting
August 14, 201	Commission on Aging Senior Strategic Plan Accountability Subcommittee
August 14, 2014	Adult Day Health Care Advisory Council
August 19, 2014	Public Workshop #2
August 21, 2014	HCBS Combined Steering Committee and Sub-Committee Meeting
August 25, 2014	HCBS Regulatory Sub-Committee Meeting
September 1, 2014	HCBS Committee Meeting (State Staff)
September 8, 2014	HCBS Regulatory Sub-Committee Meeting
September 10, 2014	Aging and Disability Services Division Conference
September 22, 2014	HCBS Committee Meeting (State Staff)
September 23, 2014	Commission on Aging Senior Strategic Plan Accountability Subcommittee
September 29, 2014	HCBS Combined Steering Committee and Sub-Committee Meeting
October 8, 2014	Annual NV Medicaid Conference
October 15, 2014	Draft Transition Plan Posted for 30 Day Public Comment
October 16, 2014	Annual NV Medicaid Conference
October 21, 2014	Commission on Aging Senior Strategic Plan Accountability Subcommittee
October 21, 2014	Medical Care Advisory Committee (MCAC)
November 10, 2014	Public Workshop #3
November 12, 2014	Adult Day Health Care Advisory Council
November 19, 2014	Home for Individual Residential Care Advisory Council
December 2014	Letter to Recipients
December 1, 2014	Draft #2 of Transition Plan
December 4, 2014	NV Governor's Council on Developmental Disabilities
December 11, 2014	Commission on Aging Senior Strategic Plan Accountability Subcommittee
January 15, 2014	Medical Care Advisory Committee
January 16, 2015	Public Workshop #4

January 20, 2015	Assisted Living Advisory Council
January 29, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
February 2015	Transition Plan to CMS
February 9, 2015	Committee on Senior Citizens, Veterans and Adults with Special Needs
February 10, 2015	Home for Individual Residential Care Advisory Council
February 12, 2015	Adult Day Health Care Advisory Council
February 19, 2015	NV Governor's Council on Developmental Disabilities
March 18, 2015	Transition Plan to CMS
March 19, 2015	NV Governor's Council on Developmental Disabilities
March 24, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
April 21, 2015	Medical Care Advisory Committee
April 21, 2015	Assisted Living Advisory Council
April 21, 2015	NV Governor's Council on Developmental Disabilities
May 12, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
May 12, 2015	Home for Individual Residential Care Advisory Council
May 19, 2015	NV Governor's Council on Developmental Disabilities
May 28, 2015	Adult Day Health Care Advisory Council
June 16, 2015	NV Governor's Council on Developmental Disabilities
July 20, 2015	NV Governor's Council on Developmental Disabilities
July 21, 2015	Assisted Living Advisory Council
July 28, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
August 11, 2015	Home for Individual Residential Care Advisory Council
August 16, 2015	Transition Plan to CMS
August 18, 2015	NV Governor's Council on Developmental Disabilities
August 27, 2015	Adult Day Health Care Advisory Council
September 15, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
September 15, 2015	NV Governor's Council on Developmental Disabilities
October 7, 2015	Annual NV Medicaid Conference
October 20, 2015	Assisted Living Advisory Council
October 22, 2015	Annual NV Medicaid Conference
October 27, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
November 10, 2015	Home for Individual Residential Care Advisory Council
November 17, 2015	NV Governor's Council on Developmental Disabilities
November 18, 2015	Adult Day Health Care Advisory Council
December 16, 2015	Commission on Aging Senior Strategic Plan Accountability Subcommittee
January 19, 2016	Medical Care Advisory Committee
January 19, 2016	Assisted Living Advisory Council
January 19, 2016	NV Governor's Council on Developmental Disabilities
January 28, 2016	NV Governor's Council on Developmental Disabilities
February 9, 2016	Home for Individual Residential Care Advisory Council
February 16, 2016	NV Governor's Council on Developmental Disabilities
February 22, 2016	Committee on Senior Citizens, Veterans and Adults with Special Needs
February 24, 2016	Commission on Aging Senior Strategic Plan Accountability Subcommittee
February 25, 2016	Adult Day Health Care Advisory Council
March 2-3, 2016	NV Governor's Council on Developmental Disabilities
March 15, 2016	NV Governor's Council on Developmental Disabilities
April 19, 2016	Medical Care Advisory Committee
April 19, 2016	Assisted Living Advisory Council
April 19, 2016	NV Governor's Council on Developmental Disabilities
May 9, 2016	Letters mailed to Provider's regarding settings assessment findings and remediation requests
May 10, 2016	Home for Individual Residential Care Advisory Council

May 11, 2016	NV Governor's Council on Developmental Disabilities
May 26, 2016	Adult Day Health Care Advisory Council
June 8, 2016	Commission on Aging Senior Strategic Plan Accountability Subcommittee
June 16, 2016	NV Governor's Council on Developmental Disabilities
June 21, 2016	NV Governor's Council on Developmental Disabilities
June 24, 2016	Heightened Scrutiny proposals posted for public comment
June 28, 2016	Transition Plan to CMS
July 12, 2016	Transition Plan posted for public comment
July 12, 2016	Commission on Aging Senior Strategic Plan Accountability Subcommittee
July 14, 2016	2 <sup>nd</sup> round of letters mailed to Provider's regarding setting assessment findings and remediation requests
July 19, 2016	Medical Care Advisory Committee
July 19, 2016	Assisted Living Advisory Council
July 28, 2016	NV Governor's Council on Developmental Disabilities
August 9, 2016	Home for Individual Residential Care Advisory Council
August 16, 2016	NV Governor's Council on Developmental Disabilities
August 19, 2016	Commission on Aging Senior Strategic Plan Accountability Subcommittee
August 25, 2016	Adult Day Health Care Advisory Council
September 20, 2016	NV Governor's Council on Developmental Disabilities

## **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.

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Results Report 1 <sup>st</sup> Provider Survey	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.	Completed	Completed	Survey Report	I
2 <sup>nd</sup> Provider Survey and Results Report	<p>The Steering Committee decided to resend the Self Assessment Survey, with explanations for each question.</p> <p>The main goal of this second survey was to increase the percentage of respondents from the provider community.</p>	Completed	Completed	2nd Survey Report	I
Recipient Self Assessment	<p>Recipients are welcome to attend public workshops or be involved in sub committees.</p> <p>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.</p>	Completed	Completed	Recipient Survey	I

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Onsite Assessment of Current Providers	<p>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:</p> <ul style="list-style-type: none"> <li>• 50% of residential settings under the FE waiver have been reviewed.</li> <li>• 50% of Jobs and Day Training under the ID waiver have been reviewed.</li> <li>• 50% of supported living providers under the ID waiver have been reviewed.</li> <li>• 50% of Adult Day Health Care providers under 1915 (i) have been reviewed.</li> <li>• 75% of Habilitation providers under 1915 (i) have been reviewed.</li> </ul> <p>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.</p> <p>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.</p>	January 2015	Completed	DHCFP Settings Qualities Checklist  Home and Community Based	II

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Heightened Scrutiny	<p>The State has identified settings that may not meet settings requirements based on the location, singular diagnosis, setting size or access issues.</p> <p>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.</p> <p>The State has submitted all questionable settings to CMS.</p>	January 2016	June 2017	Heightened Scrutiny Questionnaire (Appendix D1)	II
Heightened Scrutiny Review	<p>Upon response from CMS, the State will work with our settings to assist with compliance based on the factors identified by CMS.</p>	December 2016	December 2017	Pending	III
Provider Education and Enrollment	<p>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.</p> <p>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.</p> <p>Enrollment checklists may coincide with State regulations meaning that checklists cannot be updated until regulations are updated.</p>	January 2015	December 2017	<p>Provider enrollment checklists</p> <p>Certification Statement</p> <p>Provider Trainings</p>	II and III

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Recertification Procedures	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.	December 2016	Ongoing	The State is in the process of developing recertification guidelines for the fiscal agent and Providers.	II and ongoing
Medicaid Service Manual Revisions	<p>The State will revise HCBS provider manuals, Medicaid Services Manuals, to incorporate regulatory requirements for HCBS and qualities of an HCBS setting.</p> <p>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.</p> <p>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)</p> <p>New language additions must go through an intensive internal review process and be presented publicly before changes are incorporated.</p>	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

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
<p>Provider Compliance Reviews – On-site Assessments Inventory Log</p>	<p>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.</p> <p>The State has extended an invitation for Public Comment for these assessment findings. (Appendix E1)</p>	<p>April 2016</p>	<p>Completed</p>	<p>Remediation Tracking Log (Appendix C4)</p>	<p>III</p>
<p>Provider Compliance Reviews – Remediation requests</p>	<p>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.</p> <p>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.</p>	<p>June 2016</p>	<p>Completed</p>	<p>Remediation Letter to Providers</p> <p>Providers Guide to the Remediation Letter (Appendix C2)</p> <p>Remediation Plan example (Appendix C3)</p>	<p>III</p>

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Provider Compliance Reviews – Provider Contact	<p>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.</p>	June 2016	Completed	Residential Settings Assessments (Appendix D2) Non-Residential Settings Assessments (Appendix D3) (SLA) – Jobs and Day Training Assessments (Appendix D5)	III
Provider Compliance Reviews - Monitoring	<p>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.</p>	June 2016	June 2017	Residential Settings Assessments Non-Residential Settings Assessments Supported Living Arrangements (SLA) – Jobs and Day Training Assessments	III

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Provider Compliance – Setting Approval Monitoring	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.	December 2016	June 2017	Remediation Tracking Log Heightened Scrutiny submission to CMS	III
Provider Remediation - Monitoring	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.	June 2016	June 2017	Remediation Tracking Log Heightened Scrutiny submission to CMS	III
Provider Actions	<p>If providers do not come into compliance within required time frames, they will be terminated as Medicaid providers.</p> <p>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.</p> <p>The State will create a letter detailing the process so the providers know why they are being terminated.</p> <p>Providers that do not meet setting requirements will not be initially enrolled or re-enrolled.</p>	June 2018	Ongoing	Provider letters	IV
Ongoing Monitoring	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.	June 2019	Ongoing	Recertification and re-licensure documentation	IV

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Provider Self-Monitoring Tool	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.	June 2017	December 2017	Self Monitoring Tool	IV
Recipient Transition Plans	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.	June 2016	October 2017	Various case management documents Provider letters Individual letters Hearing rights	IV
Recipient Transition Plans - Notification	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.	June 2016	December 2017	Various case management documents Current Settings Listing Individual letters	IV
Recipient Transition Plans - Service	The State will ensure that there will be no break in services due to a potential transition.	June 2016	December 2017	Various case management documents	IV

New Provider Enrollment	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.	March 2019	Ongoing	Provider enrollment checklists Certification Statement Provider Trainings New Site Assessment Form	V
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Milestone	Start date	End date
<b>Phase I</b>		
Results Report 1st Provider Survey	-	Completed
2nd Provider Survey and Results Report	-	Completed
Recipient Self-assessment	-	Completed
<b>Phase II</b>		
Onsite Assessments of Current Providers	-	Completed
Heightened Scrutiny	January 1, 2016	June 30, 2016
Provider Education and Enrollment	January, 1 2015	December 31, 2017
Recertification Procedures	December 1, 2016	Ongoing
Medicaid Service Manual Revisions	July 1, 2015	December 31, 2017
<b>Phase III</b>		
Provider Compliance Reviews – Onsite Assessments Inventory Log	-	Completed
Provider Compliance Reviews – Remediation requests	-	Completed
Provider Compliance Reviews – Provider Contact	-	Completed
Provider Compliance Reviews – Monitoring	June 1, 2016	June 30, 2017
Provider Compliance – Setting Approval Monitoring	December 31, 2016	June 30, 2017
Provider Remediation – Monitoring	June 1, 2016	December 31, 2016
<b>Phase IV</b>		
Provider Actions (Medicaid termination)	June 1, 2018	Ongoing
Ongoing Monitoring	June 1, 2019	Ongoing
Provider Self-monitoring tool	June 1, 2017	December 31, 2017
Recipient Transition Plans	June 1, 2016	October 31, 2017
Recipient Transition Plans - Notification	January, 1 2016	December 31, 2017
Recipient Transition Plans – Services	January, 1 2016	December 31, 2017
Medicaid Service Manual Revisions	July 1, 2015	December 31, 2017
<b>Phase V</b>		
New Provider Enrollment	March 1, 2019	Ongoing

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## A. Assessment Surveys

# A1. Provider Self Assessment Survey #1

**Provider Self Assessment Survey #1**

<b>Characteristics expected to be present in all HCBS:</b>		<b>Approved Modification?</b>
1.	Was the client given a choice regarding where to live/receive services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Is the client employed in the larger community? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Does the client have his or her own room? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	If the client shares a room, was s/he given a choice of roommates? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Do married couples share or not share a room by choice? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Is the client able to choose his or her own schedule separate from housemate's or other residents' schedules? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Does the client have control over and access to his or her personal resources? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Can the client choose what, when, where and with whom to eat? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	Does the client have access to food whenever s/he wants? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11.	Are the client's preferences incorporated into the services and supports provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12.	Can the client choose the provider of services and supports? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13.	Does the client have access to make private telephone calls/texts/email at his or her convenience? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14.	Is the client free from coercion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15.	If the client has concerns, is s/he comfortable discussing them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16.	Does the client or authorized representative have an active role in the development and updating of the client's person-centered plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
18.	Is the client able to receive visitors when and where s/he wants? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19.	Do clients have choice which is not limited by State laws, regulations, requirements or facility protocols or practices? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20.	Does the setting support the client's comfort, independence and preferences? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21.	Is the setting physically accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
22.	Are supports or adaptations available for the clients who need them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
23.	Are clients able to come and go at will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
24.	Do clients have access to public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25.	If public transportation is limited, are other resources provided to clients? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26.	Is the client's PHI and other personal information kept private? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Characteristics expected to be present in all HCBS:</b>		<b>Approved Modification?</b>
27.	Are clients who need assistance to dress given choices and respect? <input type="checkbox"/> Yes <input type="checkbox"/> No	

28.	Does staff communicate with clients in a respectful and dignified manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30.	Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
32.	Do clients have privacy in their living and sleeping spaces and toileting facilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
33.	Is furniture arranged as the clients prefer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
34.	Can bedroom and bathroom doors be locked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
35.	Do staff or other residents knock before entering?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
36.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
37.	Is resident free from video monitoring/continuous monitoring?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38.	Are clients able to furnish and decorate their sleeping and/or living units as they desire?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
39.	Is the residence owned by someone other than the Provider or Provider's affiliate(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
40.	Is there a lease or written residency agreement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
41.	Does the client know his or her rights regarding housing and when s/he could be required to relocate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
42.	Do clients know how to relocate and request new housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
44.	Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## A2. 1<sup>st</sup> Provider Survey Results

### 1<sup>st</sup> Provider Survey Results

	Question	Y	N	N/A	Blank
1.	Was the client given a choice regarding where to live/receive services?	139	6	0	1
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?	145		1	0
3.	Is the client employed in the larger community?	66	72	0	0
4.	Does the client have his or her own room?	132	10	0	1
5.	If the client shares a room, was s/he given a choice of roommates?	49	6	62	28
6.	Do married couples share or not share a room by choice? <input type="checkbox"/> N/A	10	2	114	1
7.	Is the client able to choose his or her own schedule separate from housemate's or other residents' schedules?	131	2	13	0
8.	Does the client have control over and access to his or her personal resources?	87	59	0	0
9.	Can the client choose what, when, where and with whom to eat?	134	11	0	1
10.	Does the client have access to food whenever s/he wants?	128	18	0	0
11.	Are the client's preferences incorporated into the services and supports provided?	146	0	0	0
12.	Can the client choose the provider of services and supports?	135	11	0	0
13.	Does the client have access to make private telephone calls/texts/email at his or her convenience?	140	4	0	2
14.	Is the client free from coercion?	146	0	0	0
15.	If the client has concerns, is s/he comfortable discussing them?	146	0	0	0
16.	Does the client or authorized representative have an active role in the development and updating of the client's person-centered plan?	146	0	0	0
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.?)	145	1	0	0
18.	Is the client able to receive visitors when and where s/he wants?	143	3	0	0
19.	Do clients have choice which is not limited by State laws, regulations, requirements or facility protocols or practices?	128	16	1	1
20.	Does the setting support the client's comfort, independence and preferences?	145	0	0	1
21.	Is the setting physically accessible?	145	1	0	0
22.	Are supports or adaptations available for the clients who need them?	144	0	0	2
23.	Are clients able to come and go at will?	77	65	0	3
24.	Do clients have access to public transportation?	127	16	0	2

	Question	Y	N	N/A	Blank
25.	If public transportation is limited, are other resources provided to clients?	144	0	0	2
26.	Is the client's PHI and other personal information kept private?	144	0	0	2
27.	Are clients who need assistance to dress given choices and respect?	144	0	0	2
28.	Does staff communicate with clients in a respectful and dignified manner?	144	0	0	2
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?	144	0	0	2
30.	Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?	143		1	2
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? <input type="checkbox"/> N/A	109		34	3
32.	Do clients have privacy in their living and sleeping spaces and toileting facilities?	144	1	0	1
33.	Is furniture arranged as the clients prefer?	138	3	0	1
34.	Can bedroom and bathroom doors be locked?	93	51	0	2
35.	Do staff or other residents knock before entering?	143	1	1	1
36.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?	119	26	0	1
37.	Is resident free from video monitoring/continuous monitoring?	139	4	2	1
38.	Are clients able to furnish and decorate their sleeping and/or living units as they desire?	144	1	0	1
39.	Is the residence owned by someone other than the Provider or Provider's affiliate(s)?	102	43	0	1
40.	Is there a lease or written residency agreement?	135	6	3	1
41.	Does the client know his or her rights regarding housing and when s/he could be required to relocate?	134	11	0	1
42.	Do clients know how to relocate and request new housing?	129	15	0	2
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?	123	20	0	3
44.	Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?	107	38	0	1

## A3. Provider Self Assessment Survey #2

**Provider Self Assessment Survey #2**

<b>Characteristics expected to be present in all HCBS:</b>	
1.	<p>Was the client given a choice regarding where to live/receive services?  <i>Explanation: Was the client able to choose among available Supported Living Providers or Group Providers?</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
2.	<p>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?  <i>Explanation: 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.</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
3.	<p>Is the client employed in the larger community?  <i>Explanation: This is about choice, not capability. If the client chooses to seek employment, does the Provider support this choice?</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
4.	<p>Does the client have his or her own room?  <i>Explanation: 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.</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
5.	<p>If the client shares a room, was s/he given a choice of roommates?  <i>Explanation: 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?</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
6.	<p>Do married couples share or not share a room by choice? <input type="checkbox"/>N/A  <i>Explanation: There are some providers who accept married couples, and if you are one of those providers - can they choose to share a bedroom?</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
7.	<p>Is the client able to choose his or her own schedule separate from housemate's or other residents' schedules?  <i>Explanation: 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.</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
8.	<p>Does the client have control over and access to his or her personal resources?  <i>Explanation: 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?</i></p> <p align="right"><input type="checkbox"/>Yes <input type="checkbox"/>No</p>

Characteristics expected to be present in all HCBS:		
9.	Can the client choose what, when, where and with whom to eat? <i>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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Does the client have access to food whenever s/he wants? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Are the client's preferences incorporated into the services and supports provided? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Can the client choose the provider of services and supports? <i>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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Does the client have access to make private telephone calls/texts/email at his or her convenience? <i>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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Is the client free from coercion? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	If the client has concerns, is s/he comfortable discussing them? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Does the client or authorized representative have an active role in the development and updating of the client's person-centered plan? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> 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.) <i>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).</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Characteristics expected to be present in all HCBS:		
18.	Is the client able to receive visitors when and where s/he wants? <i>Explanation: Are there restricted visiting hours? If, yes, please explain why on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Does the setting support the client's comfort, independence and preferences? <i>Explanation: Can clients have their own furniture, paint their room, and make their living situation their own?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Is the setting physically accessible? <i>Explanation: Thinking about clients who use wheelchairs or walkers, is the home accessible to them?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.	Are supports or adaptations available for the clients who need them? <i>Explanation: If the client needs a ramp or grab bars, can they be installed and available for their use?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.	Are clients able to come and go at will? <i>Explanation: For those clients whose health and safety would be at risk, is the restriction placed on their movement documented in the Care Plan?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.	Do clients have access to public transportation? <i>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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.	If public transportation is limited, are other resources provided to clients? <i>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.?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
26.	Is the client's PHI and other personal information kept private? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
27.	Are clients who need assistance to dress given choices and respect? <i>Explanation: This is about choice. If the clients are able, do they help pick out their own clothes?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
28.	Does staff communicate with clients in a respectful and dignified manner? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
30.	Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications? <i>Explanation: As Stated above, landlords and owners have the right to say no, and also have the right to request other interventions, such as cuing, 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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Characteristics expected to be present in all HCBS:		

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? <input type="checkbox"/> N/A <i>Explanation: In Residential Facilities for Groups, restrictive intervention is against State law. In a Supported Living Arrangement, restrictive intervention must be justified and reviewed.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
32.	Do clients have privacy in their living and sleeping spaces and toileting facilities? <i>Explanation: 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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
33.	Is furniture arranged as the clients prefer? <i>Explanation: 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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
34.	Can bedroom and bathroom doors be locked? <i>Explanation: 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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
35.	Do staff or other residents knock before entering? <i>Explanation: 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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
36.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client? <i>Explanation: This is a continuation of question 34. Staff may have keys, but are staff trained in the circumstances to use those keys?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
37.	Is resident free from video monitoring/continuous monitoring? <i>Explanation: 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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
38.	Are clients able to furnish and decorate their sleeping and/or living units as they desire? <i>Explanation: This is the client's home so he or should have his or her own belongings if they so choose. The provider should allow for them to do this. They should have a closet or space for their own clothes, etc.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
39.	Is the residence owned by someone other than the Provider or Provider's affiliate(s)? <i>Explanation: 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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
40.	Is there a lease or written residency agreement? If No to 39, please answer, if Yes to 39, please skip. <input type="checkbox"/> N/A <i>Explanation: For those Settings in which the Provider or Provider's affiliate owns the residence, is there a lease or written residency agreement?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
41.	Does the client know his or her rights regarding housing and when s/he could be required to relocate? <i>Explanation: 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?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Characteristics expected to be present in all HCBS:</b>		
42.	Do clients know how to relocate and request new housing? <i>Explanation: 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</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<i>long term or month to month agreements.</i>	
43.	<p>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?</p> <p><i>Explanation: Both the landlord and the client must be protected in the rental agreement. The agreement must outline eviction processes and appeals.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
44.	<p>Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?</p> <p><i>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?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

## A4. 2<sup>nd</sup> Provider Survey Results

**2<sup>nd</sup> Provider Survey  
Results**

	Question	Y	N	N/A	Blank
1.	Was the client given a choice regarding where to live/receive services?	71	3	1	0
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?	74	1	0	0
3.	Is the client employed in the larger community?	54	15	2	4
4.	Does the client have his or her own room?	71	2	1	1
5.	If the client shares a room, was s/he given a choice of roommates?	57	1	12	5
6.	Do married couples share or not share a room by choice? <input type="checkbox"/> N/A	26	1	47	1
7.	Is the client able to choose his or her own schedule separate from housemate's or other residents' schedules?	7	0	1	0
8.	Does the client have control over and access to his or her personal resources?	68	4	1	2
9.	Can the client choose what, when, where and with whom to eat?	73	1	1	0
10.	Does the client have access to food whenever s/he wants?	69	5	0	1
11.	Are the client's preferences incorporated into the services and supports provided?	74	0	0	1
12.	Can the client choose the provider of services and supports?	71	3	1	0
13.	Does the client have access to make private telephone calls/texts/email at his or her convenience?	73	1	1	0
14.	Is the client free from coercion?	75	0	0	0
15.	If the client has concerns, is s/he comfortable discussing them?	75	0	0	0
16.	Does the client or authorized representative have an active role in the development and updating of the client's person-centered plan?	74	1	0	0
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.?)	73	1	1	0
18.	Is the client able to receive visitors when and where s/he wants?	71	3	1	0
20.	Does the setting support the client's comfort, independence and preferences?	74	0	0	1
21.	Is the setting physically accessible?	73	2	0	0
23.	Are clients able to come and go at will?	68	5	1	1
	Question	Y	N	N/A	Blank
24.	Do clients have access to public transportation?	72	3	0	0

25.	If public transportation is limited, are other resources provided to clients?	69	4	2	0
26.	Is the client's PHI and other personal information kept private?	75	0	0	0
27.	Are clients who need assistance to dress given choices and respect?	75	0	0	0
28.	Does staff communicate with clients in a respectful and dignified manner?	75	0	0	0
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?	73	0	2	0
30.	Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications?	72	0	2	1
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? <input type="checkbox"/> N/A	52	0	20	2
32.	Do clients have privacy in their living and sleeping spaces and toileting facilities?	75	0	0	0
33.	Is furniture arranged as the clients prefer?	74	0	1	0
34.	Can bedroom and bathroom doors be locked?	55	18	1	1
35.	Do staff or other residents knock before entering?	75	0	0	0
36.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client?	62	9	1	1
37.	Is resident free from video monitoring/continuous monitoring?	71	3	1	0
38.	Are clients able to furnish and decorate their sleeping and/or living units as they desire?	74	0	1	0
39.	Is the residence owned by someone other than the Provider or Provider's affiliate(s)?	43	31	1	0
40.	Is there a lease or written residency agreement?	52	1	17	4
41.	Does the client know his or her rights regarding housing and when s/he could be required to relocate?	73	0	1	1
42.	Do clients know how to relocate and request new housing?	62	10	1	2
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?	67	6	1	1
44.	Does the facility have adequate staff to accommodate specific, spontaneous requests from residents?	73	0	1	1

# A5. Home and Community Based Assessment Form – Recipient

**Home and Community Based Services (HCBS) Assessment Form - Recipient**

<b>Characteristics expected to be present in all HCBS:</b>		
1.	Were you given a choice regarding where to live/receive services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Can you choose whether or not to participate in group activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you have your own room?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	If you share a room, were you given a choice of roommates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you have control over and access to your personal resources?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Can you choose what, when, where and with whom to eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have access to make private telephone calls/texts/email at your convenience?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you free from coercion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	If you have concerns, are you comfortable discussing them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are you able to receive visitors when and where you want?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Does the setting support your comfort, independence and preferences?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is the setting physically accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are you able to come and go at will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Do you have access to public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	If public transportation is limited, are other resources provided to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	If you need assistance to dress, are you given respect and a choice of what to wear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Does staff communicate with you in a respectful and dignified manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Do you have privacy in your living and sleeping spaces and toileting facilities? Can the doors be locked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Do staff or other residents knock before entering?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Are you free from video monitoring/continuous monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.	Are you able to furnish and decorate your sleeping and/or living units as you desire?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.	Do you know your rights regarding housing and when you could be required to relocate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please add any comments, questions, or concerns below and on the back. Thank you.

## A6. Home and Community Based Assessment Form – Recipient Results

### Home and Community Based Services (HCBS) Recipient Results

	Question	Yes	No	N/A	Blank
1.	Were you given a choice regarding where to live/receive services?	913	91	7	69
2.	Can you choose whether or not to participate in group activities?	939	61	10	70
3.	Do you have your own room?	895	78	37	70
4.	If you share a room, were you given a choice of roommates?	397	200	252	230
5.	Do you have control over and access to your personal resources?	888	107	14	71
6.	Can you choose what, when, where and with whom to eat?	906	77	19	78
7.	Do you have access to make private telephone calls/texts/email at your convenience?	905	70	31	74
8.	Are you free from coercion?	933	36	9	102
9.	If you have concerns, are you comfortable discussing them?	912	59	16	93
10.	Are you able to receive visitors when and where you want?	974	28	9	69
11.	Does the setting support your comfort, independence and preferences?	968	27	6	76
12.	Is the setting physically accessible?	966	30	3	81
13.	Are you able to come and go at will?	839	141	23	77
14.	Do you have access to public transportation?	850	134	19	77
15.	If public transportation is limited, are other resources provided to you?	896	79	21	84
16.	If you need assistance to dress, are you given respect and a choice of what to wear?	920	28	52	80
17.	Does staff communicate with you in a respectful and dignified manner?	954	10	18	98
18.	Do you have privacy in your living and sleeping spaces and toileting facilities? Can the doors be locked?	948	38	14	80
19.	Do staff or other residents knock before entering?	900	47	39	94
20.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with you?	658	191	105	123
21.	Are you free from video monitoring/continuous monitoring	892	57	48	83
22.	Are you able to furnish and decorate your sleeping and/or living units as you desire?	882	60	53	85
23.	Do you know your rights regarding housing and when you could be required to relocate?	778	132	70	100
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?	627	178	123	146

## B. On Site Assessments

## B1. DHCP Settings Qualities Checklist

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

Date:

Provider Name:

Provider Address:

Services Provided:

# Medicaid Beds:

# of Private Beds:

Reviewer:

<p>Is the setting located in building/on grounds with institutional characteristics?    Yes <input type="radio"/>    No <input type="radio"/></p> <ul style="list-style-type: none"> <li>• Is the setting in a publicly or privately operated facility that provides inpatient institutional treatment?</li> <li>• Is the setting located in a building on the grounds of, or adjacent to, a public institution?</li> </ul>
<p>Comments:</p>
<p>Needs/Preferences considered when settings options offered?    Yes <input type="radio"/>    No <input type="radio"/></p> <ul style="list-style-type: none"> <li>• Does the setting reflect the needs and preferences of each recipient?</li> <li>• Do recipients express satisfaction regarding the setting?</li> </ul>
<p>Offers a choice of non-disability specific setting and private unit?    Yes <input type="radio"/>    No <input type="radio"/></p> <ul style="list-style-type: none"> <li>• Is the setting limited to use by people with disabilities?</li> <li>• Was the setting chosen from among options that included non-disability specific settings?</li> <li>• Are recipients offered the choice of a private room/unit where they are available for non-recipients?</li> <li>• If recipients choose to change providers, are they given the option of receiving services in non-disability specific settings?</li> </ul>
<p>Comments:</p>
<p>Residential options based on recipient resources for room and board?    Yes <input type="radio"/>    No <input type="radio"/></p> <ul style="list-style-type: none"> <li>• Were the residential services offered realistic in view of the recipient resources for payment of room and board?</li> <li>• If residential services were limited because of resources, was the matter discussed with the recipient?</li> </ul>

DHCFP Settings Qualities Checklist

Comments:

Are sleeping or living unit doors lockable by recipient? Yes  No

- Can the doors to the unit be locked?
- Can bathroom doors be locked?
- Do recipients have keys to their doors?

Comments:

Is availability of sleeping or living unit key limited to appropriate staff? Yes  No

- Is there a master key or are there copies of unit keys available for use if needed?
- Is use of the master key/unit keys limited to appropriate staff?
- Are the master key/unit keys used to enter units only in limited circumstances agreed upon with the recipient?
- 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?

Comments:

Is there a legally enforceable agreement specifying responsibilities and protections from eviction?

Yes  No

- Does the agreement specify the responsibilities of the recipient and the provider with respect to the setting?
- Does the agreement specify the circumstances under which it can be terminated?
- Does the agreement address the steps a recipient can follow to request a review/appeal a termination of services?
- Does the recipient understand the terms of the agreement?

DHCFP Settings Qualities Checklist

Comments:

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

Yes  No

- 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? Yes  No

- 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? Yes  No

- 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

Allows visitors of recipient's choosing at any time? Yes  No

- Are there limitations on visiting hours or the number of visitors allowed at one time?
- If visiting hours are addressed in the lease/rental agreement, is the recipient made aware of limitations before moving into the residential setting?
- Is furniture in living areas arranged to support small group conversations?

Comments:

Is food available to recipients at all times? Yes  No

- 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?
- Are there appliances for safe food storage and cooking/heating in recipients' sleeping/living units or in a common area accessible by recipients?
- Are snacks available anytime?

Comments:

Is there a process for protecting recipients from coercion and restraint? Yes  No

- Are recipients compelled to be absent from a setting for the convenience of the provider?
- Are recipients required, against their wishes, to be present in a setting in order to benefit the provider financially?
- Do recipients feel they can discuss concerns without fearing consequences?
- Are recipients informed regarding how to file a complaint?
- Is complaint filing information posted and understandable by recipients?
- Can complaint filing be done anonymously?
- Are staff trained in the use of restrictive interventions?

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/secured 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:

DHCFP Settings Qualities Checklist

Physically accessible for each recipient? Yes  No

- Are there features that could limit mobility, e.g., raised doorways, narrow halls, shag carpets?
- Are there physical adaptations that counter any limiting features, e.g., ramps, stair lifts, or elevators?
- Are supports to facilitate mobility provided where likely to be needed, e.g., grab bars, shower seats, or hand rails?
- Are appliances accessible, e.g., microwave reachable without difficulty, front-loading washer/dryer useable for those with mobility devices?
- Are tables and chairs at convention height for recipients to access comfortably?
- Is furniture placed so as not to obstruct pathways for those with mobility devices?
- Are there gates, locked doors, or other barriers preventing access/exit from areas in the setting?

Comments:

Is there a protocol for modification of residential setting conditions? Yes  No

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

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



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY**

1100 East William Street, Suite 101  
Carson City, Nevada 89701  
Telephone (775) 684-3676 • Fax (775) 687-3893  
<http://dhcfp.nv.gov>

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»
  - 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?
- Is food available to recipients at all times? «Q12»
- Is there a process for protecting recipient's from coercion and restraint? «Q13»
- Does the setting isolate individuals from the community? «Q14»

- Is there a process for protecting recipient rights to privacy dignity and respect? «Q15»
- Does the setting support for recipient's to seek employment in integrated settings? «Q16»
- Does the setting optimize opportunities for recipient's choice regarding physical environment? «Q17»
- Is the setting physically accessible for each recipient? «Q18»
- Is there a protocol for modification of residential setting conditions? «Q19»
- Does the setting facilitate choice regarding services and support staff who support them? «Q20»
- Does the setting provide support for recipient initiative, autonomy and independence to participate in and receive community services? «Q21»
- Does the setting have cameras and/or baby monitors located inside the setting? «Q22»
  - \*(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](mailto: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

<b>Setting name</b>	ABC Provider	<b>Setting Location</b>	123 ABC Street Las Vegas, NV 89123
---------------------	--------------	-------------------------	------------------------------------

		Timeframe for completion?	Remediation Plan
<b>Remediation request</b>	Are sleeping or living unit doors lockable by recipient?	3 months	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 thier person centered plan.
<b>Remediation request</b>	Is availability of sleeping or living unit key limited to appropriate staff?	3 months	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 residents 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.
<b>Remediation request</b>	Allows visitors of recipient's choosing at any time?	1 month	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.

## C4. Remediation Checklist

PROVIDER	region	RECEIVED (Y/N)	spreadsheet Complete (Y/N)	Acceptable (Y/N)	SENT TO CMS
A NEW DAY ADULT DAYCARE AND OUTPATIENT T	day				
SILVER STATE ADULT DAYCARE	day				
WASHOE CO SENIOR SERVICES DAYBREAK ADULT	day				
Angelicas Loving Home Care	north	Y	Y		
Aprils Villa LLC	north				
Bee Hive Homes Fernley	north	Y	Y		
Bee Hive Homes Of Lovelock LLC	north	Y	Y		
Carson Valley Senior Living LLC	north	Y	Y		
Cessabella Residential Suite LLC	north	Y	Y		
Corinthian Place LLC	north	Y	Y		
Diamond Residential	north	Y	Y		
Eagle Valley Care Center, LLC	north				
Evergreen Residence	north	Y	Y		
Family Home Care RHL	north	Y	Y		
Golden Manor	north	Y	Y		
Golden Valley Group Care I	north				
Golden Valley Group Care II	north				
Golden Years Castle 2	north				
Golden Years Castle Group Care	north				
Good Samaritan Adult Family Home	north	Y	Y		
Graceful Living	north	Y	Y		
Harmony Homes Of Reno LLC	north				
Healthy Lifestyle Residence	north				
Highland Village of Fallon	north				
Holy Child Residential Care	north	Y	Y		
Holy Family Home Care	north	Y	Y		
Horizon Hills Residential Group Care I	north	Y	Y		
Horizon Hills Residential Group Care III	north	Y	Y		
Kings Row Residence	north	Y	Y		
Krystons Home Care	north				
Krystons Home Care II	north				
L & N Home Care	north				
Limestoneshire LLC	north				
Little Angel Care Home	north				
Longevity Residential Care	north	Y	Y		
Love & Joy Residence	north				
Mar Von Senior Care	north	Y	Y		
Mason Valley Residence LLC	north	Y	Y		
Mothers Love & Care Center LLC	north				
Oasis Place	north				
Our Home Adult Living	north				

Pleasant Care Group Home III LLC	north				
Providence Home Care	north	Y	Y		
Reeds Manor	north				
Reed's Manor I	north				
Royal Heights LLC	north				
Serenity Senior Care	north				
Sierra Manor Care Home	north	Y	Y		
Skyline Estates	north				
Spanish Springs Home For Elderly Care	north				
St Anne Group Home	north				
St Anthony Family Home Care	north				
St Paul Home Care II	north				
St Paul Home Care III	north				
Summerdale Homes @ Riata LLC	north				
Summerdale Homes @ Ribeiro LLC I	north				
The Homestead	north				
Touch Of Class Care Home	north				
Van Ness Home Care	north	Y	Y		
Van Ness Home Care II	north	Y	Y		
Vista Adult Care II	north	Y	Y		
Vista Adult Care III	north	Y	Y		
Wagoneer Group Care	north				
A & J Care Home	south				
Adult Comfort and Care Home 2	south				
Advanced Care For The Elderly, LLC	south	Y			
Alebris Home Care Inc	south	Y	Y		
Alzheimers Luxury Care	south				
Ameery Care	south	Y	N		
Angel Care Residential Home	south	Y	Y		
As Time Goes By III	south				
As Time Goes By V	south				
As Time Goes By VII	south				
Bee Hive Homes Of Paradise Valley Inc	south				
Bella Estate Care Home	south				
Carmela Homes	south	Y	Y		
Chutney Residential Home	south				
CJ Homes	south				
CNC Alzheimers Home Care	south				
Desert Inn Residential Care	south				
Diamond Retirement Living	south	Y	N		
Dignified Care Manor	south				
Dignity Care Home LLC	south				
Emeritus At Spring Valley	south				
Emeritus At the Plaza	south				
Faith Shari Adult Care II	south				

Florence Senior Care Home	south				
Forget Me Not Home Care I	south				
Garden Breeze Alzheimer Villa	south				
Gentle Breeze Care Home	south				
Gentle Spring Care Home	south				
Golden Lake Care Home	south				
Golden Villa Care Home	south				
Golden Years Memory Care LLC	south				
Grace of Monaco Section 10	south	Y	Y		
Hacienda Hill Manor	south				
Happy Adult Care	south				
JCR Home Care, Inc	south				
Las Vegas Alzheimers & Memory Care I	south				
Las Vegas Alzheimers & Memory Care II	south				
Life Share Care Home Nevada	south	Y			
Meadows Care Home	south	Y	Y		
Miracle Care Home LLC	south				
Monthill Palms	south				
Morning Glory Alzheimers Home	south				
Morning Star Care Home	south				
Mothers Best Care For Elderly	south				
Mystic Haven	south				
Nazarene Senior Care Home	south	Y	Y		
Olive Grove Residential Care	south				
Paradise Crest Home Care	south				
Paradiso	south	Y	Y		
Quality Health Center	south				
Quinns Desert Home #1	south				
Quinn's Desert Home 2	south				
R & L Adult Care Home 2	south	Y	Y		
R & L Adult Care Home Inc	south				
Rainbow Connections Group Care Home	south	Y	Y		
Red Rock Residential Care Center	south				
Ross Senior Residence	south				
Royal Palace	south				
Sachele Senior Guest Home	south				
Sachele Senior Guest Home II	south				
San Vicente Home Care LLC	south				
Senior Residential Care - Centennial	south	Y	N		
Silver Sky Assisted Living	south				
Spruce Oak Residential Care Facility	south				

ST Jean Senior Care	south				
Summerlin Retirement Home	south				
The Charleston Residential	south				
The Victorian Center LLC	south	Y	Y		
The Victorian Center LLC, II	south	Y	Y		
The Wentworth of Las Vegas-Senior Mgmt	south				

## 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

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?	74.00%
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?	65.00%
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?	64.00%
4.4 Does the setting afford the opportunity for tasks and activities matched to individual's skills, abilities and desires?	91.00%
5.1 Was the individual provided a choice regarding the services, provider and settings and the opportunity to visit/understand the options?	83.00%
5.2 Was the individual provided an opportunity to visit and understand their options?	86.00%

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

Sierra Regional Center Providers					
Provider	Compliant	Remediated	Add. Review	Institutional	Heightened Scrutiny
Abe's Care Home	X				
Able Abilities Group	X				
Able Abilities Group	X				
Able Abilities Group		X			
AMI Health Care Services	X				
AMI Health Care Services	X				
Betal					
Betal	X				
Betal					
Chrysalis		X			
Chrysalis					
Chrysalis	X				
Chrysalis	X				
Chrysalis					
Chrysalis	x				
Chrysalis		X			
Chrysalis	X				
Confidence Health Resources		X			
Confidence Health Resources					
Confidence Health Resources	X				
Confidence Health Resources					
Confidence Health Resources		X			
CPNN	X				
CPNN		X			
Disability Resources					
Disability Resources					
Going Places	X				
Going Places	X				
Going Places					
Going Places	X				
Hand in Hand	X				
Hand in Hand	X				
Helping Hands	X				
High Sierra Industries					
Hope Health Care		X			
Hope Health Care		X			
Hope Health Care	X				
Hope Health Care		X			
Hope Health Care	X				
Hope Health Care			X		
Key Learning Concepts					
Key Learning Concepts					
Key Learning Concepts	X				
Key Learning Concepts	X				
Key Learning Concepts					
Mt. Olive	X				
Mt. Olive	X				
Mt. Olive	X				
Mt. Olive	X				
Mt. Olive		X			
Team Care Plus					
Team Care Plus	X				
Team Care Plus	X				
Trinity					
Trinity					
Trinity			X		
Trinity					
Trinity	X				
Trinity			X		
Trinity					
Trinity			X		

Rural Regional Center Providers					
Provider	Compliant	Remediated	Add. Review	Institutional	Heightened Scrutiny
Chrysalis	X				
Chrysalis	X				
Chrysalis	X				
Chrysalis	X				
Chrysalis	X				
Dungarvin	X				
Dungarvin	X				
Dungarvin	X				
Femfol		X			
Going Places	X				
Going Places		X			
Going Places		X			
Going Places	X				
Going Places	X				
Going Places	X				
Going Places	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
HHDS	X				
HHDS	X				
HHDS	X				
HHDS	X				
HHDS	X				
HHDS	X				
HHDS					
HHDS	X				
HHDS	X				
Tungland	X				
Tungland		X			
Tungland	X				
Tungland	X				



Danville	X				
Danville	X				
Danville	X				
Danville		X			
Danville		X			
Danville		X			
Danville	X				
Danville	X				
Dungarvin	X				
Dungarvin	X				
Dungarvin	X				
Dungarvin	X				
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Dungarvin	X				
Dungarvin	X				
Dungarvin	X				
Dungarvin	X				
Dungarvin	X				
Dungarvin		X			
Journeys	X				
Journeys	X				
KNR	X				
KNR	X				
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Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
Holdsworth	X				
New Vista	X				
New Vista	X				
New Vista					
New Vista	X				
New Vista	X				
New Vista					
New Vista	X				
New Vista					
New Vista	X				
New Vista	X				



## E. Public Comment

# E1. Invitation for Public Comment regarding On Site Reviews 4/22/16

BRIAN SANDOVAL  
*Governor*



RICHARD WHITLEY, MS  
*Director*

MARTA JENSEN  
*Acting Administrator*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY  
1100 East William Street, Suite 101  
Carson City, Nevada 89701  
Telephone (775) 684-3676 • Fax (775) 687-3893  
<http://dhcfnv.gov>

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@dhcfnv.gov](mailto:hcbs@dhcfnv.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://dhcfnv.gov/Home/WhatsNew/HCBS/>.

There will be a link on the page for Public Comments received.

## E2. Invitation for Public Comment regarding Heightened Scrutiny 6/22/16

BRIAN SANDOVAL  
*Governor*



RICHARD WHITLEY, MS  
*Director*

MARTA JENSEN  
*Acting Administrator*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY  
1100 East William Street, Suite 101  
Carson City, Nevada 89701  
Telephone (775) 684-3676 • Fax (775) 687-3893  
<http://dhcfp.nv.gov>

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](mailto: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 is a link on the page for Public Comments received.

## F. Public Workshop

## F1. Notice of Public Workshop 10/24/14



BRIAN SANDOVAL  
Governor

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY  
1100 E. William Street, Suite 101  
Carson City, Nevada 89701  
(775) 684-3600

ROMAINE GILLILAND  
*Director*

LAURIE SQUARTSOFF  
*Administrator*

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

(DHCFP ) 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
-

October 24, 2014

Page 2

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](http://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](mailto:rmackie@dhcfp.nv.gov)

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## F2. Notice of Public Workshop 8/4/14



BRIAN SANDOVAL  
Governor

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY

1100 E. William Street, Suite 101  
Carson City, Nevada 89701  
(775) 684-3600

ROMAINE GILLILAND  
Director

LAURIE SQUARTSOFF  
Administrator

**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 ([dhcfnv.us](http://dhcfnv.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 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.

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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@dncfp.nv.gov](mailto:rmackie@dncfp.nv.gov)

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## F3. Notice of Public Workshop 5/21/14



BRIAN SANDOVAL  
Governor

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**DIVISION OF HEALTH CARE FINANCING AND POLICY**

1100 E. William Street, Suite 101  
Carson City, Nevada 89701  
(775) 684-3600

MICHAEL J. WILLDEN  
Director

LAURIE SQUARTSOFF  
Administrator

**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 ([dhcfp.nv.us](http://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; 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 [rmackie@dhefp.nv.gov](mailto:rmackie@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.

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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@dhefp.nv.gov](mailto:rmackie@dhefp.nv.gov)

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## G. Public Comments

# G1. DHCFP Workshop 11/10/14 – AARP



## **DHCFP Workshop – November 10, 2014**

### **Home and Community Based Services Rule Changes**

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.

## G2. DHCFP Workshop 11/10/14 – LTO



DHCFP Workshop – November 10, 2014

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 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 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.

## G3. DHCFP Workshop 1/16/15

## DHCFP Public Workshop January 16, 2015

Easter Seals Nevada would like to express an opinion for the record at the Public Workshop that is to be held today. We did not receive notification of this public workshop until this morning from another provider and are, therefore, unable to attend.

First and foremost, the choice of the individual with a disability must be respected. All of the individuals who participate in Easter Seals Nevada programs are there by their own choice. We believe that the ultimate goal for people with disabilities is employment. However, there are other factors that come into play which cannot be ignored such as behavioral issues which prohibit these individuals from participating in competitive employment. The alternative cannot be to stay at home. They are learning skills, developing relationships, earning wages and being productive in Community Training Center environments – whether it is center based or community based.

Easter Seals Nevada bases the rate of pay for each job performed at higher than minimum wage. This means that those individuals who work to full productivity earn more than minimum wage, no matter what type of work they are performing or where the work is performed. This program is necessary and beneficial for those individuals who are not capable of becoming competitively employed, even with reasonable accommodations. It is a program they choose to be in and it allows them to earn wages commensurate to those paid for the same job in the community.

All participants in our programs have the opportunity to work in our facility, in the community and to enroll in our Employment Solutions program to receive job development services, based on their needs and abilities.

### **Comments by Ed Guthrie from Opportunity Village:**

Unfortunately, I did not receive notification of the tomorrow's public workshop until around 1:00 PM today and will be unable to attend. May I give some written comments?

- **JOBS & DAY TRAINING AS "ISOLATED" SITES:** There has been a tendency to refer to Jobs and Day Training sites as sites that "isolate" individuals with disabilities because they are often "disability specific" sites. However, CMS has clarified that "People may receive services with other people who have either the same or similar disabilities, but must have the option to be served in a setting that is not exclusive to people with the same or similar disabilities." (HCBS Final regulations 42 CFR Part 441: Questions and Answers regarding Home and Community-Based Settings Question #6 on page #5)
- **JOBS & DAY TRAINING AS "SHELTERED WORKSHOPS" I:** On page #8 of the plan, Jobs and Day Training services are "... provided during the day for individuals who choose to work in the community. This type of service can be compared to a sheltered workshop..." However, many people who receive day training services have no vocational component to the service and it could more accurately be compared to "Adult Day Health Care Services".
- **JOBS & DAY TRAINING AS "SHELTERED WORKSHOPS" II:** Many of the people served in Opportunity Village's Jobs & Day Training sites do have a vocational component to their day but it serves as more of a "work activity" which serves as an alternative to a Day Training or "Adult Day Health Care Services" rather than a place of employment. People in certified "Community Training Centers" are not considered employees according to Nevada's labor laws.

People with severe disabilities may choose this option for a number of reasons:

1. The facility-based program offers them (and their caregivers) a consistent daytime schedule (e.g. 7:30 a.m. - 3:30 p.m.) so they can enjoy evenings and weekends; and allows their caregivers to also remain employed.
2. The facility-based program provides more support and is more tolerant of disruptive behavior (e.g. hugging everyone who enters the room) than a community work site.

3. The facility-based program also serves individuals who cannot meet normal industrial standards, even with reasonable accommodations, and therefore, cannot perform the essential functions of the job. The facility-based program provides extra accommodations and often loses money on contracts so people with severe disabilities have the opportunity to earn a paycheck.
- JOBS & DAY TRAINING AS “SHELTERED WORKSHOPS” III: The document also that, “The problem with sheltered workshops is that the pay is sometimes not comparable to jobs in the community, there is no room for advancement and some employees are not able to branch out into the greater community.” I have to disagree. If an individual’s disability does not keep them from reaching a normal level of productivity, the individual can make a wage commensurate to the wages paid for the same job in the community. At Opportunity Village all individuals are offered the option of community employment unless the individual cannot meet normal industrial standards, even with reasonable accommodations, and therefore, cannot perform the essential functions of the job.
  - JOBS & DAY TRAINING AS “SHELTERED WORKSHOPS” IV: The document therefore concludes that, “The emphasis of a sheltered workshop should be short-term and emphasize job training...”. I respectfully disagree. Many individuals choose Opportunity Village’s Jobs & Day Training sites for the reasons that I have outlined above. Their informed choice must be respected.

G4. 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 do 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.

G5. Position Statement from Members of  
AHONN in Collaboration with Residential Care  
Home Associate Nevada (RCHAN Southern  
NV)

**POSITION STATEMENT FROM MEMBERS OF ASSOCIATION OF HOME CARE OWNERS OF  
NORTHERN NEVADA (AHONN) IN COLLABORATION WITH RESIDENTIAL CARE HOME  
ASSOCIATION 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.

5 Beds Homecare Yearly /Monthly Income Expenses  
Scenario 3 Under New Rule

INCOME	Yearly	Monthly
Bed 1	30,000.00	2,500.00
Bed 2	30,000.00	2,500.00
Bed 3	30,000.00	2,500.00
Bed 4	30,000.00	2,500.00
Bed 5	30,000.00	2,500.00
(Note: Average of \$2,500 / resident granting the facility is full every month)		0.00
		0.00
<b>Total INCOME</b>	<b>150,000.00</b>	<b>12,500.00</b>

4. BUDGET SUMMARY		
	Yearly	Monthly
<b>Total Income</b>	<b>150,000.00</b>	<b>12,500.00</b>
<b>Total Expenses</b>	<b>271,877.00</b>	<b>22,656.42</b>
<b>NET</b>	<b>(121,877.00)</b>	<b>(10,156.42)</b>

EXPENSES	Yearly	Monthly
Mortgage Payment	32,000.00	2,666.67
NV Energy	2,872.00	239.33
TMWA	467.00	38.92
Cable	2,387.00	198.92
Cellphone	3,247.00	270.58
Landline Telephone	755.00	62.92
Computer	1,500.00	125.00
Office Supplies	1,800.00	150.00
Repairs/Maintenance	4,000.00	333.33
Payroll Expenses	1,800.00	150.00
	0.00	0.00
	0.00	0.00
?Food & Supplies (\$20/day x 5 Res) x 30 days	35,000.00	3,000.00
Laundry expenses	3,600.00	300.00
Book Keeper / Accountant	4,800.00	400.00
Tax Preparer	750.00	62.50
	0.00	0.00
Salary 2 Caregivers Shift 1 (7 daysx8hrsx\$8.25)	44,352.00	3,696.00
Salary 2 Caregivers Shift 2 (7 daysx8hrsx\$8.25)	44,352.00	3,696.00
Salary 2 Caregivers Shift 3 (7 daysx8hrsx\$8.25)	44,352.00	3,696.00
	0.00	0.00
<b>Total EXPENSES</b>	<b>229,034.00</b>	<b>19,086.17</b>

MISC. EXPENSES	Yearly	Monthly
Charitable Contributio	1,500.00	\$125.00
Uniform (2 caregivers)	150.00	\$12.50
Postage and Delivery	395.00	\$32.92
Printing Expenses	320.00	\$26.67
Advertisement	450.00	\$37.50
Subscriptions / Newsp	360.00	\$30.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
<b>Total MISC. EXPENSES</b>	<b>3,175.00</b>	<b>264.58</b>

	Yearly	Monthly
?Salary of the Owner	6,000.00	500.00
?Salary of the Administra	6,000.00	500.00
<b>Total</b>	<b>12,000.00</b>	<b>1,000.00</b>

Quarterly Expenses	Paid Quarterly	Monthly
Property Tax	1,800.00	450.00
Sewer	352.00	88.00
Waste Management	329.00	82.25
Employment Security Division	399.00	99.75
Fire Alarm Monitoring Exp	96.00	24.00
<b>Total Quarterly Expenses</b>	<b>2,976.00</b>	<b>744.00</b>

Computation for Salary of Caregivers under New Rule  
7 days x 8 hours a day = 56 x \$ 8.25 = \$462 weekly  
times 4 weeks = \$ 1,848 x 2 caregivers at a time = \$ 3,696 monthly  
There are 3 shifts

Yearly Expenses	Yearly	Monthly
City Business License Renewal	215.00	17.92
Workmen's Comp Insurance	6,164.00	513.67
General Liability Insurance	8,559.00	713.25
State Business License Renewal	350.00	29.17
BHCQC Facility License Renewal	1,693.00	141.08
Surety Bond	100.00	8.33
Fire Extinguisher Maintenance	36.00	3.00
Fire Alarm /Wet Sprinkler Yearly Inspection	375.00	31.25
<b>Total Yearly Expenses</b>	<b>17,492.00</b>	<b>1,457.67</b>

TRANSPORTATION	Paid Annually	Monthly
Vehicle 1	2,880.00	240.00
Vehicle 2	2,880.00	240.00
Maintenance/Registration Renewal	1,440.00	120.00
		0.00
		0.00
<b>Total TRANSPORTATION</b>	<b>7,200.00</b>	<b>600.00</b>

### Scenario 4 Under New Rule

INCOME	Yearly	Monthly
Bed 1	24,000.00	2,000.00
Bed 2	24,000.00	2,000.00
Bed 3	24,000.00	2,000.00
Bed 4	24,000.00	2,000.00
Bed 5	24,000.00	2,000.00
Bed 6	24,000.00	2,000.00
Bed 7	24,000.00	2,000.00
Bed 8	24,000.00	2,000.00
Bed 9	24,000.00	2,000.00
Bed 10	24,000.00	2,000.00

(Note: Average of \$2,000 / resident granting the facility is full every month)

Total INCOME 240,000.00 20,000.00

EXPENSES	Yearly	Monthly
Mortgage Payment	32,000.00	2,666.67
NV Energy	2,872.00	239.33
TMWA	467.00	38.92
Cable	2,387.00	198.92
Cellphone	3,247.00	270.58
Landline Telephone	755.00	62.92
Computer	1,500.00	125.00
Office Supplies	1,800.00	150.00
Repairs/Maintenance	4,000.00	333.33
Payroll Expenses	1,800.00	150.00
	0.00	0.00
	0.00	0.00
?Food & Supplies (\$20/day x 10 Res) x 30 days	72,000.00	6,000.00
Laundry Expenses	3,600.00	300.00
Book Keeper / Accountant	4,800.00	400.00
Tax Preparer	750.00	62.50
	0.00	0.00
Salary 2 Caregivers Shift 1 (7 daysx8hrsx\$8.25)	44,352.00	3,696.00
Salary 2 Caregivers Shift 2 (7 daysx8hrsx\$8.25)	44,352.00	3,696.00
Salary 2 Caregivers Shift 3 (7 daysx8hrsx\$8.25)	44,352.00	3,696.00
	0.00	0.00
<b>Total EXPENSES</b>	<b>265,034.00</b>	<b>22,086.17</b>

Quarterly Expenses	Paid Quarterly	Monthly
Property Tax	1,800.00	450.00
Sewer	352.00	88.00
Waste Management	329.00	82.25
Employment Security Division	399.00	99.75
Fire Alarm Monitoring Exp	96.00	24.00
<b>Total Quarterly Expenses</b>	<b>2,976.00</b>	<b>744.00</b>

Yearly Expenses	Yearly	Monthly
City Business License Renewal	215.00	17.92
Workmen's Comp Insurance	6,164.00	513.67
General Liability Insurance	8,559.00	713.25
State Business License Renewal	350.00	29.17
BHCQC Facility License Renewal	1,693.00	141.08
Surety Bond	100.00	8.33
Fire Extinguisher Maintenance	36.00	3.00
Fire Alarm /Wet Sprinkler Yearly Inspection	375.00	31.25
<b>Total Yearly Expenses</b>	<b>17,492.00</b>	<b>1,457.67</b>

TRANSPORTATION	Paid Annually	Monthly
Vehicle 1	2,880.00	240.00
Vehicle 2	2,880.00	240.00
Maintenance/Registration Renewal	1,440.00	120.00
		0.00
		0.00
<b>Total TRANSPORTATION</b>	<b>7,200.00</b>	<b>600.00</b>

4. BUDGET SUMMARY		
	Yearly	Monthly
Total Income	240,000.00	20,000.00
Total Expenses	307,853.00	25,654.42
<b>NET</b>	<b>(67,853.00)</b>	<b>(5,654.42)</b>

MISC. EXPENSES	Yearly	Monthly
Charitable Contributions	1,500.00	\$125.00
Uniform (2 caregivers)	150.00	\$12.50
Postage and Delivery	395.00	\$32.92
Printing Expenses	320.00	\$26.67
Advertisement	450.00	\$37.50
Subscriptions / Newspaper	336.00	\$28.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
		\$0.00
<b>Total MISC. EXPENSES</b>	<b>3,151.00</b>	<b>262.58</b>

	Yearly	Monthly
?Salary of the Owner	6,000.00	500.00
?Salary of the Administrator	6,000.00	500.00
<b>Total</b>	<b>12,000.00</b>	<b>1,000.00</b>

Computation for Salary of Caregivers under New Rule  
 7 days x 8 hours a day = 56 x \$ 8.25 = \$462 weekly  
 times 4 weeks = \$ 1,848 x 2 caregivers at a time = \$ 3,696 monthly  
 There are 3 shifts

G6. AHONN 4/22/16



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**BOARD OF DIRECTORS:**

Malou Alano

Armando Gestoso

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Joseline Castillo

Thelma Frias

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.



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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?



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-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 support 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 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 pharmacy 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 Term 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 group's 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 term 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



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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, RCHCAN / 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*

*ECHO*  
*RCHCAN*

## G7. LTO Ventures 8/12/16



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 Suite 1126  
 Henderson, NV 89052-2994  
 T (702) 353-6540  
 F (877) 209-0495  
 www.ltoventures.org  
 facebook.com/LTOVentures

LTO Ventures is a 501(c)(3)  
 non-profit company that develops  
 hve / work / play intentional  
 communities for adults with  
 Autism Spectrum Disorder

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."

- 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 HCB 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 is 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:

H. Medicaid Services Manual  
(MSM) Revisions for all 1915(c) and  
1915(i) Programs

## Medicaid Services Manual Revisions for all 1915(c) and 1915(i) Programs

### 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.

3. Providers must ensure health, safety, and welfare of all residents.
4. Providers must document positive interventions and supports used to redirect behavior as well as methods that did not work.
5. 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.

# I. 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 IICBS 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 individual receiving w<liver 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 within 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?