Changes made to the Nevada Transition Plan in response to CMS letter dated July 9, 2015.

The first section noted by CMS is captioned **Public Notice**. Following are the changes and additions made in response:
There is a table titled "Summary of Public Comments" beginning on page 21 of the Transition Plan. This table contains the aggregate comments and questions from each of the Public Workshops held by the Division of Health Care Financing and Policy's (DHCFP). Additionally, the table has been updated with new URLs for the DHCFP website and the State of Nevada's public notice webpage. Additionally, copies of the Public Notices placed on the Division's website, the State's Public Notice webpage as well as posted in the DHCFP office, the State Library and Archives and the county libraries throughout the State were added to the State Transition Plan as Appendix M. Pages 21 through 23 contain summaries of comments made at the various Public Workshops. If testimony was read at the hearing or submitted through other venues, the written testimony has been placed as an appendix. (Appendices F, G, J and K). A new section titled, "State of Nevada's Summary of Responses to Public Comment," has been inserted between the "Summary of Public Comments" and the "Transition Plan for Compliance."

The next section is headed **Remedial Actions** and has several sub headings. The first sub-heading is **Milestones**. To address this, various changes were made to the section titled "Transition Plan for Compliance," pages 27 to 32:

- The 3rd Action Item, formerly titled Recipient Education and Notification, was renamed Recipient Self Assessment. The information regarding notification and education was deleted from the Description and the Proposed Start and End Dates, Documents and Phase were changed to indicate a survey was sent out during Phase I.
- The 4th Action Item, Onsite Assessment, has been renamed to Onsite Assessment of Current Providers and updated to include the completion rates of the in person site reviews completed by ADSD staff. The overall completion rate is over 50%. DHCFP will conduct a second review of providers that case managers flag as potentially not meeting settings requirements by December 2015.
- A new Action Item has been added for Heightened Scrutiny. There are several steps listed and the creation and use of a tool will begin in January 2016 and the heightened review of current providers will be completed by December 2016.
- The 6th Action Item, Provider Education, has been renamed to Provider Education and Enrollment. The Start Date has been changed to January 2015 from August 2015.
- A new Action Item has been added titled New Enrollment detailing the requirement for on-site assessment of entities that wish to become HCBS Providers effective March 2019.
- The 8th Action Item, Medicaid Service Manual Revisions, has been updated to reflect a Start Date of July 2015 rather than June 2017 and End Date, June 2016 rather than June 2018. Additionally, the Description indicates the policy has been updated and is in the State's extensive review and approval process. The sample policy has been added as Appendix N.
- A new Action Item has been added for Recipient Notification indicating letters and web announcements will be used from January 2016 through March 2019 to inform and educate recipients about any changes to programs and the process the State and providers are undergoing.
- The 10th Action Item, Provider Compliance Reviews, has been updated to explicitly state it is a continuation of the onsite assessment milestone and that a tool will be developed to track changes required to come into compliance for those providers who will meet settings requirements with modifications. The Proposed Start Date has been changed from June 2017 to January 2016.
- The 11th Action Item, Monitoring, has been updated to indicate the Data Gathering Tools, Corrective Action Plans and Provider Education Tools will be developed for use with the providers the State believes will be able to come into compliance with the New Rule with modifications.

The second sub-heading is **Setting Assessment**. This topic is addressed in the Action Items titled Heightened Scrutiny and Provider Compliance Reviews. As stated above, the State will begin work on a Heightened Scrutiny Tool in January 2016 and submit all questionable settings to CMS by December 2016. The final sub-heading, titled **Heightened Scrutiny**, is addressed in the new Action Item of the same name.

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 dhcfp.nv.gov/hcbs.htm.

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. 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 as identified above.
  - **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: HCBW for Individuals with Intellectual Disabilities and Related Conditions:

Service	Service Description
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.	
Behavioral Consultation Training and Intervention	This 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.
Career Planning	This 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.
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.
Counseling Services	This service provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes.
Non-Medical Transportation	Service 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.
Nutrition Counseling	This 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.
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 according to the Individual Service Plan established with the individual.

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 those that are thought to fully comply with changes to current policy and regulation. The State will provide a list of needed changes and a timeline for compliance.	
Day Habilitation	Day habilitation services 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.
Supported Employment	This 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. These services are provided in a non-residential setting.
Prevocational Services	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. These services are provided in a non-residential setting.

II: HCBW for the Frail Elderly

Service	**Service Description**
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.	
Case Management	This 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.
Respite Services	Short-term relief for full time non-paid caregivers.
Homemaker Services	This service provides additional time for IADL's, over and above what is offered under the Medicaid State Plan.
Personal Emergency Response Systems	This allows for a recipient to call for help in an emergency by pushing a button.
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 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	This service provides activities of daily living and instrumental activities of daily living in a group care setting which is located within the community. The State does not have any group care providers who are on the campus, or associated with, nursing facilities or hospitals.
Social Adult Day 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 as they are not associated with, or located on, a campus like setting, a nursing facility, or an impatient setting. 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 as identified above.

III. HCBW for Persons with Physical Disabilities

Service	Service Description
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.	
Case Management	This 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.
Respite Services	Short-term relief for full time non-paid caregivers.
Homemaker Services	This service provides additional time for IADL's, over and above what is offered under the Medicaid State Plan.
Personal Emergency Response Systems	This allows for a recipient to call for help in an emergency by pushing a button.
Attendant Care	This service provides additional time for ADL's, over and above what the Medicaid State Plan offers.
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.
Home Delivered Meals	Healthy meals that are delivered to a recipient's home.
Specialized Medical Equipment and Supplies	Equipment and supplies that are needed for an individual to live more independently, over and above what is offered under the Medicaid State Plan.
Environmental Modifications	Select areas of a home may be remodeled to help people live more independently.

These are 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.	
Assisted Living Service	This service provides activities of daily living and instrumental activities of daily living in a group care setting which is located within the community. The State does not have any group care providers who are on the campus, or associated with, nursing facilities or hospitals. This waiver utilizes disability specific apartments.

IV. Adult Day Health Care Services

Services that are thought to fully comply with changes to current policy and regulation. The State will provide a list of needed changes and a timeline for compliance.	
Adult Day Health Care Services	These settings are not residential, but are services provided during the day for individuals who are elderly, intellectually or developmentally disabled, or physically disabled. The State believes that the current Adult Day Health Care facilities are community based and allow for access to the greater community as they are not associated with, or located on, a campus like setting, a nursing facility, or an impatient setting. 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 as identified above.

V. Home Based Habilitation Services

Services that are thought to fully comply with changes to current policy and regulation. The State will provide a list of needed changes and a timeline for compliance.	
Home Based Habilitation Services	With the exception of two providers, these services are outpatient, and individuals live in their own homes, and attend services either full day or half day. Some of these providers are located on campus like settings that include other medical providers, who provide an array of outpatient services.

VI. Partial Hospitalization

The State has not evaluated this program.	
Partial Hospitalization	This service will be removed from 1915 (i) once a transition plan has been submitted to CMS. A 1915(i) amendment will be submitted.

Definition of Institutional Setting:

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

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

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

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

Definition of a Home and Community Based Waiver Program:

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

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

Definition of Community:

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

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

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 homes 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. 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 as identified above.

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 is in the process of completing a non-residential assessment based on on-site visits to evaluate compliance with HCBS regulations. The assessment is being developed with guidance using CMS' home and community based services non-residential exploratory questions. The emphasis of the assessment is ensuring services support 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. This needs to be addressed further.

There are two residential homes for individuals with traumatic brain injury under Home Based Habilitation Services. These individuals have been through rehabilitation and are ready to live in the community, but 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:

- o Verify service viability
- o Identify potentially isolating locations and congregate member living
- o 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.

Provider Assessment Results for 1915 (c) Wavier Services

Provider Self-Assessment Survey #1:

The State sent out 300 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 300 surveys sent, 147 were returned, or 49%.

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

- Fifty percent of respondents stated that the individuals were not employed in the larger community.
- Seventy-one percent of respondents stated that choice of roommate was not-applicable.
- 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.
- Thirty-two percent of respondents stated that bedroom doors cannot be locked.
- 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:

- 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.
- Some individuals in supported living arrangements have their own rooms.
- 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.
- The main reason individuals cannot come and go as they please is due to safety concerns; these are documented in the plan of care.
- 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.
- 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. Provider advocates will encourage the provider community to complete the 2nd survey.

Provider Assessment Results for 1915 (i) State Plan Services

Adult Day Health Care Services

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.

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 service. 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 (continued)
<u>Partial Hospitalization</u> 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 all home and community based settings which include choice of providers, choice of roommates, and choice of activities. However, recipients do not 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, but these are expensive to maintain.
- 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.
- 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 bedrooms and bathrooms because recipients require 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.
- Statewide training for case managers and service coordination regarding the New Rule was conducted during the week of December 15, 2014. The goal of the training was to ensure the case managers can discuss settings requirements with recipients and clearly articulate the choices available.
- Some settings are provider owned which means that lease agreements must be in place and must comply with state regulations. The State will educate the provider community on this during the transition period.

Copies of the Provider Self-Assessment Surveys and Results are Appendices A through E.

Recipient Assessment Results

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

- 1080 surveys were returned completed – a 21% response rate
- 500 surveys returned to sender – a 9% return rate. These can be attributed to several factors, including the recipients lack of timely notification of address changes and delays in system processing.

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.

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.

Copies of the Recipient Self-Assessment Surveys and Results are Appendices H and I.

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:

Specific Requirement	Regulation	Outcome
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.	N/A	This degree of integration is not prohibited by NRS or NAC.
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.	N/A	Setting selection is not prohibited by NRS or NAC.
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	This is supported by regulation.
Facilitates individual choice regarding services and supports, and who provides them.	N/A	Choice regarding who provides services and supports is not prohibited.
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 dis-charged 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.

Specific Requirement	Regulation	Outcome
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	A visitor, at any time, is supported.
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:

Specific Requirement	Regulation	Outcome
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.
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:	N/A	Based on results of annual reviews, self assessment and in person visits: Facilities are open to the public and visitors can come and go; choice is indicated in the POC, and facilities have room for walkers and wheelchairs, including bathroom facilities.

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.

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.

Specific Requirement	Regulation	Outcome
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)	Developmental Services Standards of Service Provision (DSSSP), Section F.2, F.10 and F.11 detail these expectations.
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.	N/A	Setting selection is not prohibited by NRS or NAC.
Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	DS-QA-01(ii)(1.21.14)	This is supported, DSSSP F.2.
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)	This is supported, DSSSP F.2, F.10 and F.11.
Facilitates individual choice regarding services and supports, and who provides them.	DS-QA-01(ii)(1.21.14)	This is supported, DSSP F.13.
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.	N/A	Addressed through Developmental Services Standards of Service Provisions
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.

Supported Living Services (continued)

Specific Requirement	Regulation	Outcome
Individuals sharing units have a choice of roommates in that setting.	DS-QA-01(ii)(1.21.14)	Having a choice of roommates is not prohibited; however DSSP F. specifies that the organization involves individuals served in decision-making processes.
Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	N/A	Not directly addressed.
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)	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.	N/A	Not directly addressed but encouraged.
The setting is physically accessible to the individual.	DS-QA-01(ii)(1.21.14)	Physical accessibility is supported.

Medical Conditions in Residential Settings for Groups

Regulation	Analysis/Changes
NAC 449.2722 Residents having unmanageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder incontinence.	It is allowable to admit or retain a resident with an unmanageable condition of bowel or bladder.
NAC 449.2732 Residents requiring protective supervision.	It is allowable to admit/retain a resident who requires protective supervision.
NAC 449.2714 Residents requiring use of intermittent positive pressure breathing equipment.	It is proposed to add language specific to training on the use of intermittent positive pressure breathing equipment to the Medicaid Service Manual (MSM).
NAC 449.2712 Residents requiring use of oxygen.	It is proposed to add language specific to training on the use of oxygen to the MSM. Otherwise, this condition is generally allowable in the group care setting.
NAC 449.2716 Residents having colostomy or ileostomy.	It is proposed to add language for training specific to caring for a colostomy or ileostomy to the MSM.
NAC 449.2718 Residents requiring manual removal of fecal impactions or use of enemas or suppositories.	It is proposed to add language to the MSM regarding using a waiver to allow this medical condition in a group care setting.
NAC 449.2728 Residents requiring regular intramuscular, subcutaneous or intradermal injections.	Current regulation states that shots must be given by a medical professional not employed by the facility. It is possible that existing regulation governing skilled services provided by a "unskilled" person may allow this shots to be given. The regulatory committee will review. This will require an outside agency/individual to provide the service.
NAC 449.271 Residents requiring gastrostomy care or suffering from staphylococcus infection or other serious infection or medical condition. Except as otherwise provided in, a person must not be admitted to a residential facility or permitted to remain as a resident of a residential facility if he or she: 1. Requires gastrostomy care; 2. Suffers from a staphylococcus infection or other serious infection; or 3. Suffers from any other serious medical condition that is not described in NAC 449.2712 to 449.2734, inclusive.	Changes may need to be made the NAC to permit residents' aging in place.

Medical Conditions in Residential Settings for Groups (cont'd.)

Regulation	Analysis/Changes
NAC 449.272 Residents requiring use of indwelling catheter.	It is allowable to admit or retain residents requiring the use of an indwelling catheter with assistance from a trained caregiver for emptying the catheter bag. The resident must have medical oversight for insertion, removal or any complications associated.
NAC 449.2724 Residents having contractures.	Under Review by a Medical Professional.
NAC 449.2734 Residents having tracheotomy or open wound requiring treatment by medical professional; residents have pressure or stasis ulcers.	This condition may be allowable in an AGC with the appropriate medical waiver information. The procedure to exempt certain residents from restrictions is found in NAC 449.2736.
NAC 449.2726 Residents having diabetes.	Due to federal regulations, providers must have a Clinical Laboratory Improvement Amendment (CLIA) license in order to perform blood glucose checks. Given the current requirements to obtain a CLIA license; this makes it virtually impossible for providers.

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". Currently, the State has regulations regarding medical conditions that may be in conflict with this requirement due to language that prohibits the admission or retention of residents exhibiting these medical conditions. 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 Bureau of Health Care Quality and Compliance (HCQC). A technical bulletin from HCQC will be published soon detailing a new policy to eliminate this barrier. The bulletin and accompanying forms will be added to the Transition Plan as an attachment.

- Certain medical conditions have been identified as being problematic for continued residence. These may require some minor changes to regulation, in addition to providing information within waiver amendments and policy manuals.

Summary of Public Comments

Notices of Public Workshops were posted on the DHCFP website in the section for Public Notices: http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/ as well as on the page devoted to the HCBS New Rule: http://dhcfp.nv.gov/Home/WhatsNew/HCBS/
The notices were also posted physically at the DCHFP Central Office in Carson City and the Las Vegas District Office as well as the Nevada State Library and in the public libraries throughout the state.
Copies of these public notices are available as Appendix M.

Following is a summary of the comments made during each of the Public Workshops held by DHCFP and copies of written notices received are available as Appendices F, G, J and K.

Public Workshop – June 6, 2014

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

Public Workshop August 19, 2014

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

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 F
- Mark Olson of LTO Ventures provided written comments, Appendix G

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 J

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. At the first workshop, it was requested the State create 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.

Many of the comments, especially at the earlier workshops, were questions about the intent of the New Rule and requests for clarifications of the requirements. For example, several providers at the August 19, 2014 workshop expressed concern that they would have to hire a cook 24 hours a day to ensure residents had access to meals if they did not want to eat at established meal times. The DHCFP responded that the intent was to ensure recipients receiving services under home and community based care are not treated as though they lived in an institution, and that with person-centered planning focused on the individual's needs and limitations, alternate plans could be made that would not be onerous for the provider. Additionally, several providers expressed concern about how to offer choice to residents with Alzheimer's or other dementia diagnoses. The State again emphasized the importance of person centered planning and the involvement of family and or guardians to assist in choosing the best options in care for the individual. Some providers were unclear about the extent the State of Nevada could waive some of the requirements. The DHCFP assured all providers that the new rule was applicable to all home and community based service providers and that the State, along with the provider community, recipients and advocates must work together to meet these new requirements.

Some of the questions raised were logistical in nature regarding the Public Workshops themselves. Some providers requested more efforts be made to include the rural providers in the workshops; the DCHFP added some rural site videoconferencing as well as made teleconferencing available for those providers unable to attend in person. Nevada has a large rural area and providers face different challenges in these rural areas than in the densely populated urban areas of Clark and Washoe Counties. The DHCFP responded that the resources available in an urban setting were not going to be expected of a rural setting. However, this will be an area in which the use of the Heightened Scrutiny Tool to be developed by the State will be required.

Providers expressed concern related to the costs that they would incur with implementation of some provisions, and asked if the State was going to assist them to pay for things such as new locks. The State is unable to reimburse providers for regulation changes, but will continue to explore ways in which rate increases can be requested through the State Legislature.

Some advocates requested DHCFP to survey recipients about their current services and their level of satisfaction with their current providers. That survey was sent to 5,100 recipients. The DCHFP received responses from approximately 20% of the recipients surveyed. The response was overwhelmingly positive. The survey and the responses are available as Appendices H and I.

The final version of the Nevada Transition Plan that was submitted to CMS on March 18, 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 re-survey those sites deemed to need assistance in meeting settings requirements has been set for December 2015. This deadline corresponds with the addition of a Heightened Scrutiny Tool creation and submission to CMS that will occur in Phase III of the Transition Plan.

In addition, the State has created more detailed remedial milestones found in the section titled "Transition Plan for Compliance" that begins on page 26 and continues through page 31.

List of Public Meetings	
Date	**Meeting Type**
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 7, 2014	HCBS Committee Meeting (State Staff)
April 8, 2014	Tribal Consultation
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
June 6, 2014	Public Workshop #1
June 9, 2014	HCBS Committee Meeting
June 12, 2014	Southern Nevada Association of Providers Presentation
June 24, 2014	HCBS Steering Committee Meeting
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, 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	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 4, 2014	NV Governor's Council on Developmental Disabilities
January 16, 2015	Public Workshop #4
January 20, 2015	Assisted Living Advisory Council
February 9, 2015	Committee on Senior Citizens, Veterans and Adults with Special Needs
February 10, 2015	Home for Individual Residential Care Advisory Council

Posting of Transition Plan for Public Comment	Time Frame
Letter to Provider	April 2014
Provider Self Assessment Survey	April 2014
Draft #1 of Transition Plan	July 1, 2014 (July 1, 2014 – August 19, 2014 Public Comment Period)
Letter to Recipients	December 2014
Draft #2 of Transition Plan	December 1, 2014 (December 1, 2014 – January 16, 2015 Public Comment Period)
Transition Plan to CMS	March 18, 2015

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 – June 2015) This phase includes in person surveys' by state staff to verify provider self assessment survey's and to visit sites of providers that did not respond. This also includes the initial identification of changes needed to bring industry practices into compliance.

Phase III (July 2015 – June 2017) includes provider education and training on compliance issues, ongoing monitoring of provider compliance, and provider self monitoring. This phase includes changes needed to State regulations.

Phase IV (July 2017 – March 2019) includes the continuation of provider training and education, ongoing monitoring of provider compliance, provider self monitoring, transition plans for recipients who may need to move, provider actions for providers who do not come into compliance, and internal policy changes and updates. Tools will be created to bring about the required changes so settings requirements will be met. Training will be provided to State staff, providers and recipients.

Phase V (March 2019 – ongoing) Procedural changes incorporated to ensure compliance with HCBS settings requirements.

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Results Report 1st 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. The survey has been completed and the State is working to identify the level of compliance and beginning work on steps to assist providers to become 100% compliant.	Completed	Completed	Survey Report	I
2nd Provider Survey and Results Report	The Steering Committee decided to resend the Self Assessment Survey, with explanations for each question. The main goal of this second survey was to increase the percentage of respondents from the provider community. The second survey has been completed. The State is working to identify the level of compliance and beginning work on steps to assist providers to become 100% compliant.	Completed	Completed	2nd Survey Report	I
Recipient Self Assessment	Recipients are welcome to attend public workshops or be involved in sub committees. Recipients are crucial in providing information on the services they receive, so a random sample of recipients was selected to complete a survey on how they view their services and choices. Recipients assessed the same questions as providers.	Completed	Completed	Recipient Survey	I

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Onsite Assessment of Current Providers	The State will incorporate the provider self assessment reviews of settings during in person site reviews. The State will identify providers with sites of service that have the characteristics of HCBS or the qualities of an institution. The State will rely on the operating agency, Aging and Disability Services Division to complete on-site reviews. Prior to this review, participating reviewers or case managers will be trained in order to ensure consistency with on site reviews. It is the State's intent to visit at least 50% of all providers by June of 2015. Current status as of 07/24/2015: • 50% of residential settings under the FE waiver have been reviewed. • 50% of Jobs and Day Training under the ID waiver have been reviewed. • 50% of supported living providers under the ID waiver have been reviewed. • 50% of Adult Day Health Care providers under 1915 (i) have been reviewed. • 75% of Habilitation providers under 1915 (i) have been reviewed. These reviews are continuing. Phase II of the onsite reviews: Supervisory/management teams will conduct a second review of providers that case managers flagged as potentially not meeting settings requirements. This will begin in October 2015 to be completed by December 2015.	January 2015 In process	December 2015	Modification to the Self Assessment Survey	II & III

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Heightened Scrutiny	The State has identified some providers that may not meet settings requirements based on the location, singular diagnosis or access issues. The State will develop a tool for submission to CMS. The State will complete an assessment using this tool for each setting that is questionable and requires review by CMS. The State will submit all questionable settings to CMS at one time, after all initial and follow up reviews are completed. The State will compile data from site reviews and create the tool in January, 2016.	January 2016	December 2016	Heightened Scrutiny Tool CMS certification	III
Provider Education and Enrollment	When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to sign and submit certification that they have received, understand, and comply with these setting requirements. This will be incorporated into the provider enrollment checklist and verified initially and every three years during re-enrollment. The Fiscal Agent is responsible for all enrollment activities and provider trainings on prior authorization and billing guidelines. The State will provide education and training to the Fiscal Agent's provider enrollment staff on new checklists and enrollment requirements. Enrollment checklists may coincide with state regulations meaning that checklists cannot be updated until regulations are updated.	January 2015	June 2017	Provider enrollment checklists Certification statement Provider Trainings	II and III

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
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	New Site Assessment Form	V
Medicaid Service Manual Revisions	The State will revise HCBS provider manuals, Medicaid Services Manuals, to incorporate regulatory requirements for HCBS and qualities of an HCBS setting. The Medicaid Services Manual (MSM) is owned by the State Medicaid Agency and there is a chapter for each Medicaid program covered within the State. The MSM is where the State outlines program requirements, provider qualifications, etc. The identified MSMs will be updated to reflect residential and non-residential settings requirements. The State has drafted a sample policy section to be incorporated in all 1915 (c) and 1915 (i) policy manuals. The same language will be used in all manuals. (Appendix N) New language additions must go through an intensive internal review process and be presented publicly before changes are incorporated.	July 2015	June 2016	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	March 2019	Web Announce-ments Educational Letters	III and IV

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Provider Compliance Reviews	The State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule. The State will develop an inventory and description of all HCBS settings (residential and non-residential) and summarize which settings meet requirements and which settings do not. This is a continuation of the "onsite assessment" milestone. The State will develop a tool to track changes made by providers to be in compliance with the new rule. This area is specifically for those providers who will meet setting requirements with some modifications.	January 2016	March 2019	Review Tools	III and IV
Monitoring	The State will continuously collect and analyze data from provider compliance reviews and work with providers to come into compliance either through education or corrective action plans. The State will target those providers who do not meet residential or non-residential providers to assist them in either becoming compliant or being terminated as a provider of HCBS because they are unable to become compliant. The State will develop a tool to track changes made by those providers who must make some modifications to be in compliance with the New Rule's setting requirements.	June 2017	March 2019	Data Gathering Tools Corrective Action Plans Provider Education Tools	III, and IV

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Provider Actions	If providers do not come into compliance within required time frames, they will be terminated as Medicaid providers. Providers will be given the opportunity to propose changes to come into compliance. However, if they do not accept this opportunity, or are unable to make the required changes, they will be terminated. The State will create a letter detailing the process so the providers know why they are being terminated. Providers that do not meet setting requirements will not be initially enrolled or re-enrolled.	June 2018	N/A	Provider letters	IV
Provider Self-Monitoring Tool	Providers are willing to monitor their own progress during this period through a self monitoring process. The State will work to create a tool for providers.	June 2018	March 2019	Self Monitoring Tool	IV
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. Proper notice and due process will be given to each individual affected. Individuals will be offered a choice of alternative settings through a person centered planning process. The State will ensure that there will be no break in services due to a potential transition.	June 2015	March 2019	Various case management documents Provider letters Individual letters Hearing rights	IV

Appendix A
Provider Self Assessment Survey #1

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

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

Appendix B
1st 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? ☐ 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? ☐ 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

Appendix C
Provider Self Assessment Survey #2

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

	Characteristics expected to be present in all HCBS:	
9.	Can the client choose what, when, where and with whom to eat? *<u>Explanation</u>: If meal times are scheduled, can the client choose not to eat at those scheduled times, but eat at a different time. Can the client eat in his or her room if they choose? If they don't want to sit at the table with the other residents, can they sit somewhere else?*	☐Yes ☐No
10.	Does the client have access to food whenever s/he wants? *<u>Explanation</u>: Does the Provider allow the client to prepare his or her own meals, or have an outside support person come in to do so? Are clients allowed to choose with whom they sit to eat?* ***This section assumes that the Person Centered Plan outlines restrictions imposed on the client due to medical or behavioral issues.***	☐Yes ☐No
11.	Are the client's preferences incorporated into the services and supports provided? *<u>Explanation</u>: The client is the one in charge of his or her services. His or her input is required and should be obtained. Some individuals have guardians or representatives and they may be the decision makers if the client is unable to participate.*	☐Yes ☐No
12.	Can the client choose the provider of services and supports? *<u>Explanation</u>: This is about choice. For residential providers, the choice is the choice of living situation. Does the client have the ability to choose the provider of services, meaning the SLA or Group?*	☐Yes ☐No
13.	Does the client have access to make private telephone calls/texts/email at his or her convenience? *<u>Explanation</u>: Most community based settings have more than one resident, so do residents have the ability to make private phone calls, can they have a cell phone if they want? The provider should provide a land line; but is not obligated to provide a cell phone or computer. If the clients have those things, can they use them in private if they want?*	☐Yes ☐No
14.	Is the client free from coercion? *<u>Explanation</u>: The provider cannot talk the client into doing something they don't want to do. If they refuse a service that day, then indicate "refused" on the log. Providers are well within their scope to cue, provide reminders, or re-direct. This is different than coercion.*	☐Yes ☐No
15.	If the client has concerns, is s/he comfortable discussing them? *<u>Explanation</u>: The provider must have a policy in place to address client concerns. Clients must have a private place to discuss concerns and clients must know they can discuss concerns.*	☐Yes ☐No
16.	Does the client or authorized representative have an active role in the development and updating of the client's person-centered plan? *<u>Explanation</u>: This is referred to as the Individual Support Plan (ISP) or Plan of Care (POC). The client drives his or her own services and should be integral in planning and directing services, as well as decisions and changes.*	☐Yes ☐No
17.	Does the setting facilitate integration of clients within the broader community? (Ex. Banking, medical visits, beautician, church/spiritual affiliations, civic groups, volunteerism, gyms, classes, recreational events, etc.? *<u>Explanation</u>: This does not mean the setting must transport the client to any and all events or activities. It DOES mean that the Provider will work with the client and his or her family/support group to schedule transportation etc. (This is not referring to medical appointments or jobs and day training – this is social in nature).*	☐Yes ☐No

	Characteristics expected to be present in all HCBS:	
18.	Is the client able to receive visitors when and where s/he wants? *<u>Explanation</u>; Are there restricted visiting hours? If, yes, please explain why on a separate sheet.*	☐Yes ☐No
20.	Does the setting support the client's comfort, independence and preferences? *<u>Explanation</u>: Can clients have their own furniture, paint their room, and make their living situation their own?*	☐Yes ☐No
21.	Is the setting physically accessible? *<u>Explanation</u>: Thinking about clients who use wheelchairs or walkers, is the home accessible to them?*	☐Yes ☐No
22.	Are supports or adaptations available for the clients who need them? *<u>Explanation</u>: If the client needs a ramp or grab bars, can they be installed and available for their use?*	☐Yes ☐No
23.	Are clients able to come and go at will? *<u>Explanation</u>: For those clients whose health and safety would be at risk, is the restriction placed on their movement documented in the Care Plan?*	☐Yes ☐No
24.	Do clients have access to public transportation? *<u>Explanation</u>: 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?*	☐Yes ☐No
25.	If public transportation is limited, are other resources provided to clients? *<u>Explanation</u>: 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.?*	☐Yes ☐No
26.	Is the client's PHI and other personal information kept private? *<u>Explanation</u>: 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.*	☐Yes ☐No
27.	Are clients who need assistance to dress given choices and respect? *<u>Explanation</u>: This is about choice. If the clients are able, do they help pick out their own clothes?*	☐Yes ☐No
28.	Does staff communicate with clients in a respectful and dignified manner? *<u>Explanation</u>: 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.*	☐Yes ☐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? *<u>Explanation</u>: 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.*	☐Yes ☐No
30.	Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications? *<u>Explanation</u>: 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.*	☐Yes ☐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? ☐N/A Explanation: *In Residential Facilities for Groups, restrictive intervention is against state law. In a Supported Living Arrangement, restrictive intervention must be justified and reviewed.*	☐Yes ☐No
32.	Do clients have privacy in their living and sleeping spaces and toileting facilities? 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.*	☐Yes ☐No
33.	Is furniture arranged as the clients prefer? 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?*	☐Yes ☐No
34.	Can bedroom and bathroom doors be locked? 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?*	☐Yes ☐No
35.	Do staff or other residents knock before entering? 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?*	☐Yes ☐No
36.	Do staff use a key to enter a living space only under limited circumstances previously agreed upon with the client? Explanation: *This is a continuation of question 34. Staff may have keys, but are staff trained in the circumstances to use those keys?*	☐Yes ☐No
37.	Is resident free from video monitoring/continuous monitoring? 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.*	☐Yes ☐No
38.	Are clients able to furnish and decorate their sleeping and/or living units as they desire? 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.*	☐Yes ☐No
39.	Is the residence owned by someone other than the Provider or Provider's affiliate(s)? 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?*	☐Yes ☐No
40.	Is there a lease or written residency agreement? If No to 39, please answer, if Yes to 39, please skip. ☐N/A Explanation: *For those Settings in which the Provider or Provider's affiliate owns the residence, is there a lease or written residency agreement?*	☐Yes ☐No
41.	Does the client know his or her rights regarding housing and when s/he could be required to relocate? 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?*	☐Yes ☐No

	Characteristics expected to be present in all HCBS:	
42.	Do clients know how to relocate and request new housing? <u>Explanation</u>: *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 long term or month to month agreements.*	☐Yes ☐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? <u>Explanation</u>: *Both the landlord and the client must be protected in the rental agreement. The agreement must outline eviction processes and appeals.*	☐Yes ☐No
44.	Does the facility have adequate staff to accommodate specific, spontaneous requests from residents? <u>Explanation</u>: *If a client wants to spontaneously go somewhere, or has an immediate, unscheduled, need, can the staff assist? This does not mean the staff has to take the person, but can they assist in facilitating these requests?*	☐Yes ☐No

Appendix D
2nd 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? ☐ 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? ☐ 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

Appendix E

In Person Provider Assessment

Characteristics expected to be present in all Non-Residential Settings			
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. 42 CFR 441.301(c)(4)(i) /441.710(a)(1)(i)/441.530 (a)(1)(i)			**Approved Modification?**
1.	Does the setting provide opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual?	☐Yes ☐No	
Example:			
2.	Does the setting afford opportunities for individual schedules that focus on the needs and desires of an individual and an opportunity for individual growth?	☐Yes ☐No	
Example:			
3.	Does the setting allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting? For example, do individuals receive HCBS in an area of the setting that is fully integrated with individuals not receiving Medicaid HCBS?	☐Yes ☐No	
Example:			
4.	Is the setting in the community/building located among other residential buildings, private businesses, retail businesses, restaurants, doctor's offices, etc. that facilitates integration with the greater community?	☐Yes ☐No	
Example:			
5.	Do employment settings provide individuals with the opportunity to participate in negotiating his/her work schedule, break/lunch times and leave and medical benefits with his/her employer to the same extent as individuals not receiving Medicaid funded HCBS?	☐Yes ☐No	
Example:			
6.	Does the setting provide individuals with contact information access to and training on the use of public transportation, such as buses, taxis, etc., and are the public transportation schedules and telephone numbers available in a convenient location?	☐Yes ☐No	
Example:			
7.	Does the setting assure that tasks and activities are comparable to tasks and activities for people of similar ages who do not receive HCB services?	☐Yes ☐No	
Example:			
The setting is selected by the individual from among setting options including non-disability specific settings… The settings options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, …42 CFR 441.301(c)(4) (ii)/441.710(a)(1)(ii)/441.530(a)(1)(ii)			
1.	Does the setting reflect individual needs and preferences and do its policies ensure the informed choice of the individual? (Update or change their preferences)	☐Yes ☐No	
Example:			
2.	Do the setting options offered include non-disability-specific settings, such as competitive employment in an integrated public setting, volunteering in the community, or engaging in general non-disabled community activities such as those available at a YMCA?	☐Yes ☐No	
Example:			
3.	Do the setting options include the opportunity for the individual to choose to combine more than one service delivery setting or type of HCBS in any given day/week (e.g. combine competitive employment with community habilitation)?	☐Yes ☐No	

Example:			
The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. 42 CFR 441.301(c)(4)(iii)/441,710(a)(1)(iii)/441.530(a)(1)(iii)			
1.	Does the setting assure that staff interacts and communicate with individuals respectfully and in a manner in which the person would like to be addressed, while providing assistance during the regular course of daily activities?	☐Yes ☐No	
Example:			
2.	Do setting requirements assure that staff do not talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present?	☐Yes ☐No	
Example:			
3.	Does the setting policy require that the individual and/or representative grant informed consent prior to the use of restraints and/or restrictive interventions and document these interventions in the person- centered plan?	☐Yes ☐No	
Example:			
4.	Does the setting policy ensure that each individual's supports and plans to address behavioral needs are specific to the individual and not the same as everyone else in the setting and/or restrictive to the rights of every individual receiving support within the setting?	☐Yes ☐No	
Example:			
5.	Does the setting offer a secure place for the individual to store personal belongings?	☐Yes ☐No	
Example:			
The setting 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. 42 CFR 441.301(c)(4)(iv)/441.710(a)(1)(iv)/441.530(a)(1)(iv)			
1.	Are there gates, Velcro strips, locked doors, fences or other barriers preventing individuals' entrance to or exit from certain areas of the setting?	☐Yes ☐No	
Example:			
2.	Does the setting afford a variety of meaningful non-work activities that are responsive to goals, interests and match to skills and needs of individuals? Does the physical environment support a variety of individual goals and needs (for example, does the setting provide indoor and outdoor gathering spaces; does the setting provide for larger group activities as well as solitary activities; does the setting provide for stimulating as well as calming activities)?	☐Yes ☐No	
Example:			
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?	☐Yes ☐No	
Example:			
4.	Does the setting afford the opportunity for tasks and activities matched to individuals' skills, abilities and desires? Is setting staff knowledgeable about the capabilities, interests, preferences and needs of individuals?	☐Yes ☐No	
Example:			
The setting facilitates individual choice regarding services and supports, and who provides them. 42 CFR 441.301(c)(4)(v)/441.710(a)(1)(v)/441.530(a)(1)(v)			
1.	Was the individual provided a choice regarding the services, provider and settings and the opportunity to visit/understand the options?	☐Yes ☐No	
Example:			

Appendix F

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.

Appendix G

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 <u>not</u> include was specific settings types that would not be allowed. What it <u>did</u> 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 <u>take no action</u> 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.

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

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

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

Appendix I
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

Appendix J

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 January 16, 2015] tomorrow's public workshop until around 1:00 PM today and will be unable to attend. May I give some written comments? [In response to the Transition Plan posted on the DHCFP's through the Public Workshop on January 16, 2015.]

- 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.

Appendix K

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 Case Norte, a 9-bedroom home now licensed as a Residential Facility for Groups located on the Northwest side of the Las Vegas Valley. There are currently seven (7) private rooms and one (1) shared room housing nine (9) residents with brain injuries - but we are seeking funding to create nine (9) private rooms by the end of 2015.

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

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

ASI encourages residents to exercise meaningful choice in their lives. While some choice may be limited due to regulatory requirements, or if the individual is not their own legal guardian, residents regularly exercise choice in their daily activities. Examples of personal choice include the ability to furnish and decorate their living spaces to their personal tastes, choose meals and meal times, have visitors and private phone calls, have access to personal funds, and the ability to maintain privacy. All bedrooms have doors for privacy (and

will have locks in the near future) and staff request permission before entering the units. There is no video monitoring within the house.

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

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

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

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

Residents have access to their personal funds and determine how their funds are managed. Some individuals maintain their money on their person while others choose to have their funds safely locked up with access as desired. Some individuals have designated ASI to be their Representative Payee.
The licensure for Casa Norte requires that schedules and menus for meals and snacks are posted in advance. However, residents have the option to eat at the time of their choosing and may choose the prepared menu, an alternative menu or their own personal food items. Healthy menus are planned with consideration towards resident recommendations.

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

responsible party capable of providing appropriate supervision and support.

Residents may have visitors and private phone calls. There is a phone line established specifically for the residents' use and there are no restrictions regarding resident communication. Individuals can take calls in the community space or privately in their rooms. Several of the residents have their own personal cellular devices for personal communication but it is not required.

ASI is committed to providing quality housing and service to the residents at Casa Norte. ASI fully supports community integration for all individuals with disabilities and encourages each individual to reach their highest level of independence possible. ASI is committed to accommodating any and all requirements established by the Centers for Medicare and Medicaid (CMS) final rule for Home and Community-Based Service (HCBS) settings.

Appendix L
Clarifications from CMS

Clarification required from CMS:

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

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

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

4. Nevada does not have a Traumatic Brain Injury (TBI) Waiver, nor does it have adequate resources for individuals with TBI. There is one provider in Nevada who provides out-patient habilitation services for individuals with TBI who reside in their own homes. However, some individuals with TBI are unable to live in the community without 24-hour supervision, assistance with basic needs, and management of medications. These individuals require a group setting which provides these services. Nevada currently has one setting that houses nine individuals with TBI. All of these individuals are male, and the home in 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?

Appendix M
Public Notices

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

BRIAN SANDOVAL
Governor

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: (DHCFP)
The Division of Health Care Financing and Policy
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

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

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

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

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

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

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

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 (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 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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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); 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@dhcfp.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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Appendix N
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.
2. 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:
    - A clear description of the recipient's condition that is directly proportionate to the specific assessed need;
    - An established time limit for periodic review to determine if the care plan is appropriate or needs modification:
    - Informed consent of the individual; and
    - 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.