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

Background 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 three public workshops in which all members of the public were invited to learn about the new regulations and to provide comments. 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.

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, opportunity to seek employment, 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.

Service	Service Description
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 as the individual prefers, and needed, depending on the frequency and duration of approved services.
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. One concern the State has is the size of a group setting; that is located within the community and has access to the greater community. Setting sizes range from four to more than 100. Another concern is "aging in place". The State has regulations in place that prohibit individuals with certain "diagnosis" to live in group care because they need some skilled care.
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 recipients 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	

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. One concern is that some campuses do have acute care hospitals or rehabilitation clinics, which are inpatient. This needs to be addressed further. There are two residential homes for individuals with traumatic brain injury under Home Based Habilitation Services. These individuals have been through rehabilitation and are ready to live in the community, but the need a greater level of service, which includes 24 supervision, cuing, and medication management, in order to be successful in a community setting

VI. Partial Hospitalization

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. A group of people who have common interests, and the sharing, participation and fellowship of those interests. A group of people interacting with one another and with the environment in a specific region. Society as a whole.

State Specific Analysis:

Group Homes and Supported Living Arrangements:

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

The State has no group home settings, and minimal supported living arrangements that are located on a campus with an institution, or provide inpatient services.

The main concern is the size of the group setting. Group settings range from four to more than 100.

Another concern are 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. Finally, these settings include individuals with intellectual or development disabilities, and their caregivers.

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 during the day for individuals who choose to work within the community. This type of service can be compared to a sheltered workshop where individuals can enjoy independence while earning a paycheck. This is an excellent means of socialization for people with disabilities as many live very isolated lives due to their disability. In addition, family members may get some rest (respite) and the knowledge that their loved ones are in a safe environment.

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.

The emphasis of a sheltered workshop should be short term and emphasize job training so that individuals may learn a skill that they can use in the community and receive comparable pay to anyone with the same job.

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 settings 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.

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

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

Assessment Results for 1915 (c) Home and Community Based Waivers

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, for the Frail Elderly, and for Persons with Physical Disabilities and Related Conditions**.** Of the 300 surveys sent, 147 were completed and returned, which is 49%.

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

- Fifty percent of respondents stated that clients 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.
- Eighteen percent of respondents stated that someone other than the provider owned the home.
- 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.

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.
- 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 residential component is a small, 6 person, home which is fully integrated within the community.

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. These eligibility restrictions may be presumed not to meet the New Rule requirements.

Assessment Results for 1915 (i) State Plan Services

Partial Hospitalization

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

Analysis of Assessment Results:

- Provider facilities are located on campus settings, which are not home and community based; however, recipients receive services during the day only.

No identified problem areas.

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.
- 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, by 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.
- Training for case managers about the New Rule will begin the week of December 15, 2014. The goal of the training is 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 D.

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 discharged from the facility for a number of reasons, including being bedfast. There are no specific requirements for a lease agreement.
Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	NAC 449.220	Lockable doors are supported. Appropriate staff having keys is not prohibited.

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	Visitors, 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	
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 result 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

The Jobs and Day Training Settings operate under the Individuals with Intellectual Disabilities and Related Conditions Waiver and are regulated by NRS and NAC 435. These regulations do not specifically address the New Rule Requirements; however, they are addressed through the Disability Services Division Policies and Procedures Manuals. These Policies and Procedures have been revised and are currently under review by the Legislature and the Public.

Supported Living Services

The Supported Living Services Settings operate under the Individuals with Intellectual Disabilities and Related Conditions Waiver and are regulated by NRS and NAC 435. These regulations do not specifically address the New Rule Requirements; however, they are addressed through the Disability Services Division Policies and Procedures Manuals.

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.		
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.

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.		
The setting is physically accessible to the individual.	DS-QA-01(ii)(1.21.14)	Physical accessibility is supported.

Medical Conditions in any Setting

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.	Shots must be given by a medical professional not employed by the facility. 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.	#1: Under review by a Medical Professional. #2 and #3: These will need to be managed by a medical professional outside the agency.

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 tracheostomy 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 state regulations, NRS 652, it is not allowable to have caregivers or medical professionals take blood glucose levels.

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.

The State held three public workshops at the same time that the Settings Self Assessment and the Regulatory Reviews were being conducted. Overall, the turnout was excellent and comprised of a mix of providers, recipients, regulators, advocates, and state staff. The summary of comments is provided below.

Summary of Public Comments

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 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.
- 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?

Summary of Public Comments

Public Workshop August 19, 2014 (continued)

- 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.
- 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

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

The State appreciated the thoughtfulness and genuineness of the comments provided at the three public workshops. Many of the comments were directly related to the cost that providers will incur with implementation of some provisions. The State is unable to reimburse providers for regulation changes, but the State will look into the following to address the comments of providers:

- Rate increases (must be approved by the State Legislature); and
- Reimbursement mechanisms for providers to attend team meetings.
- Lease Agreements

List of Committee Meetings, Tribal Consultation, Public Workshops and Staff Presentations	
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
November 10, 2014	Public Workshop #3
November 12, 2014	Adult Day Health Care Advisory Council
December 4, 2014	NV Governor's Council on Developmental Disabilities

Transition Plan for Compliance

Nevada's transition plan includes multiple phases.

Phase I (March 2014 – December 2014) 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.

Phase II (December 2014 – June 2015) includes recipient notification and in person evaluations of residential settings. This phase includes the 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.

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. Upon the completion of the survey and data analysis, the State will identify the level of compliance and begin work on steps to assist providers to become 100% compliant.	July 2014	October 2014	Survey Report	I

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
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 is to increase the percentage of respondents from the provider community. Upon the completion of the survey, the State will verify the number of new respondents and calculate the data. The goal is 100% compliance for all providers.	October 2014	December 2015	2nd Survey Report	I
Recipient Education and Notification	Recipients are welcome to attend public workshops or be involved in sub committees. In addition, the State will provide notification and education letters to recipients at various intervals during the identification and implementation stages. Recipients are crucial in providing information on the services they receive, so a random sample of recipients will be selected to complete a survey on how they view their services and choices. Recipients will be asked to assess the same questions as providers.	December 2014	March 2019	Recipient Letters Recipient Survey	II
Onsite Assessment	The State will incorporate review of settings into the review tools used by the HCBS reviewers. 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. This will include a comprehensive review of non-residential settings. The self assessment survey only captured a portion of non-residential settings, and the remaining must be visited in person. Prior to this review, participating reviewers or case managers will be trained in order to ensure consistency with reviews. It is the State's intent to visit at least 50% of all providers by June of 2015.	December 2014	June 2015	Modification to the Self Assessment Survey	II

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
Provider Education	When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements. This can be incorporated into the provider enrollment checklist and verified initially and every three years. 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.	August 2015	June 2018	Provider enrollment checklists Certification statement Provider Trainings	II and III
Nevada Administrative Code (NAC)	The State will revise NAC to reflect new regulations for HCBS settings. These new regulations will prohibit providers from being licensed; therefore, being enrolled as Medicaid providers. Rules will clarify expectations of member control of their environment and access to community.	January 2016	December 2018	NAC 449	III
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.	January 2015	June 2018	For six (6) programs affected	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.	June 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.	June 2015	March 2019	Data gather tools Corrective Actions Plans Provider Education tools	II, III, and IV
Provider Actions	If providers do not come into compliance by required time frames, they will be terminated as Medicaid providers. Providers that do not meet setting requirements will not be initially enrolled or re-enrolled.	June 2015	N/A	Provider letters	II, III, and 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 2015	March 2019	Self Monitoring Tool	II, III, and IV

Action Item	Description	Proposed Start	Proposed End	Documents	Phase
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

1st Provider Self-Assessment Survey

	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	

	Characteristics expected to be present in all HCBS:		Approved Modification?
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	
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
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

	Question	Y	N	N/A	Blank
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
2nd Provider Self-Assessment Survey

	Characteristics expected to be present in all HCBS:	
1.	Was the client given a choice regarding where to live/receive services? *Explanation: 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? *Explanation: The recipient should be able to make choices about the activities that they want to participate in, whether the activity is within the residence or outside of the residence. This does not mean the setting must transport the client to any and all events or activities. It DOES mean that the Provider will work with the client and his or her family/support group to schedule transportation etc.*	☐Yes ☐No
3.	Is the client employed in the larger community? *Explanation: 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? *Explanation: If there are single rooms available, can the client choose to have one? Medicaid funds are not paid for room and board. This is between the recipient and the provider. If the recipient wants his or her own room, this is an agreement between the recipient and provider. If the provider cannot offer a private room, maybe another provider can. This is again about choice. If the recipient chooses a specific provider and wants that provider, but they don't have a private room available, then the recipient made that choice.*	☐Yes ☐No
5.	If the client shares a room, was s/he given a choice of roommates? *Explanation: The same explanation as above. This is about choice. Does the Provider have a system in place for residents to approve – or not – the individual who will share a room?*	☐Yes ☐No
6.	Do married couples share or not share a room by choice? ☐N/A *Explanation: 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? *Explanation: Refer to question number 2. Are all individuals living in a setting on the same schedule or do they have the right to do as they please? Note: due to cognitive or safety concerns, staff monitors so they don't wander. This question refers to what they do within the residence.*	☐Yes ☐No
8.	Does the client have control over and access to his or her personal resources? *Explanation: Think about a group setting, who has control over the client's money? It could be an authorized representative, or even the provider, with written permission. If someone else controls it, does the client have access to an allowance or money to spend on personal items.*	☐Yes ☐No
9.	Can the client choose what, when, where and with whom to eat? *Explanation: If meal times are scheduled, can the client choose not to eat at those scheduled times, but eat at a different time. Can the client eat in his or her room if they choose? If they don't want to sit at the table with the other residents, can they sit somewhere else?*	☐Yes ☐No

	Characteristics expected to be present in all HCBS:	
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 chose 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
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

	Characteristics expected to be present in all HCBS:	
22.	Are supports or adaptations available for the clients who need them? *Explanation: 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? *Explanation: 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? *Explanation: Providers should think about rural and urban. If urban, do clients have access to public transportation? If rural, is the client given assistance to find alternate transportation?*	☐Yes ☐No
25.	If public transportation is limited, are other resources provided to clients? *Explanation: Nevada is a rural state meaning that areas outside of the urban areas do not have public transportation. If there isn't public transportation, are there other options for clients such as friends, family, civic organizations, etc.?*	☐Yes ☐No
26.	Is the client's PHI and other personal information kept private? *Explanation: Nevada's policy is that all recipients have a file and that file is located in a locked area. This is verification that the provider keeps the client's information locked.*	☐Yes ☐No
27.	Are clients who need assistance to dress given choices and respect? *Explanation: 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? *Explanation: Clients must be treated with respect and dignity. Providers should offer and provide training to caregivers in how to treat clients in this manner. In addition, there should internal policies in place for this.*	☐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? *Explanation: Landlords or home owners have the right to say no to a modification that is needed. If a recipient needs a modification, the landlord or owner must know that it is medically necessary and justified. This is found in the ISP or POC. If the landlord does say no, the client should be given the option to select another provider. This is all about the provider and the client working together to deal with supports that the client may need.*	☐Yes ☐No
30.	Is there documentation of positive, less intrusive, interventions and supports used prior to any plan modifications? *Explanation: As stated above, landlords and owners have the right to say no, and also have the right to request other interventions, such as cuing, redirecting, or actual hands on assistance, prior to making a modification. Physical modifications would be made after these have been attempted and are unsuccessful. This would be documented in the ISP or POC. This is all about the provider and the client working together to deal with supports that the client may need.*	☐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 *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

	Characteristics expected to be present in all HCBS:	
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
42.	Do clients know how to relocate and request new housing? *Explanation: The client may choose at any time to change providers. The lease agreement must be explained to the client. The client must have the choice to sign a long term or month to month agreements.*	☐Yes ☐No

	Characteristics expected to be present in all HCBS:	
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

Please explain any "No" answers below. Continue onto another sheet if necessary.

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?	74	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
22.	Are supports or adaptations available for the clients who need them?	72	1	0	2
23.	Are clients able to come and go at will?	68	5	1	1
24.	Do clients have access to public transportation?	72	3	0	0

	Question	Y	N	N/A	Blank
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

AARP Real Possibilities in Nevada

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 F

DHCFP Workshop – November 10, 2014

Thank you for the opportunity to provide public comment on the HCBS Transition Plan for the State of Nevada. My name is Mark Olson.

I am here today in several capacities:

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

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

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

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

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

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

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

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

Non-compliance with US Administrative Procedures Act

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

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

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

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

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

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

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

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

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

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

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

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

Must Emphasize the Central Role of Person-Centered Planning

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

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

Moreover, DHCFP must make it a priority to:

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

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

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

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

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

We know that the setting is not the issue. It is the design and management of those settings that is the key. Individual experiences and outcomes can be just as successful in large, well-designed settings as they can in individual homes and apartments, and conversely we know that outcomes and experiences

can be just as undesirable in individual homes and apartments as in larger settings. In fact, this is supported by data from research documented in the National Core Indicators that indicates that individuals in congregate settings report feeling lonely less than those in other settings.

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