

Research

Expanding Stakeholder Knowledge of the Home and Community Based Services (HCBS) Settings Rule



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Abstract

The Home and Community Based Settings (HCBS) settings rule (CMS 2249-F/2296-F) strictly enforces meaningful community-based settings for those receiving Medicaid HCBS funding. Stakeholders have the opportunity to impact states' setting rule plans and hold states accountable to ensure rules are truly community based. Yet, the complex rule can be inaccessible for the very people it will impact most. This exploratory study evaluates the HCBS Advocates Creating Transformation (ACT) program's ability to educate 86 stakeholders about the rule. Our findings suggest that the HCBS ACT program pilot was a useful intervention that can be replicated for education and outreach programs. Doing so can actively engage people with disabilities, their families, and their support staff in the policy process.

Keywords: Medicaid; Home and Community Based Services (HCBS) final settings rule; community living; public policy

Expanding Stakeholder Knowledge of the Home and Community Based Services (HCBS) Settings Rule

Over time disability services in the United States have shifted from an institutional model, where people with disabilities were granted few rights and opportunities, to a community model, where the aim is for people with disabilities to live in the most integrated settings possible with person centered planning – services and supports prioritized by the person with disabilities. The institutionalization of people with intellectual and developmental disabilities has been on a downward trend since 1967 due to a number of factors including advocacy from people with disabilities and their families and state and federal initiatives resulting in the downsizing of institutions and expansion of community alternatives (Braddock, 2007; Braddock et al., 2015; Trent, 1994). The landmark 1972 *Wyatt v. Stickney* (2009) ruling also required sweeping changes to Alabama’s institutions, and standardized care for people with disabilities across the nation. While some changes to Medicaid, such as the ability to receive federal matching funds for Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) resulted in decreases in the institutional censuses, others including the Home and Community Based Services (HCBS) 1915(c) waiver program, allowed states to emphasize care in the community rather than institutions.

Today in the United States Medicaid provides the majority of federal funding for people with intellectual and developmental disabilities (Braddock et al., 2015). Of that funding, approximately two-thirds is provided by Medicaid HCBS 1915(c) waivers. Medicaid HCBS waivers, the largest funders of long-term services and supports (LTSS) for people with intellectual and developmental disabilities (Braddock et al., 2015), were developed in 1981 as an alternative to institutional care. HCBS waivers allow states to ‘waive’ the three main provisions

of the Social Security Act (i.e., state-wideness, comparability, and income and resource rules) in order to tailor services for particular underserved populations that would otherwise require institutional based care (U.S. Department of Health and Human Services, 2000). These customized programs give states the flexibility to determine target groups (e.g., people with intellectual and developmental disabilities, people with HIV/AIDs, people with physical disabilities), services, participant direction options, provider qualifications, health and welfare strategies, and cost-effective delivery systems at the state level (Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, & Department of Health and Human Services, 2015). Because of the benefits of community living, its cost effectiveness, and the preferences of people with intellectual and developmental disabilities, HCBS waiver funding has far surpassed institutional funding for people with intellectual and developmental disabilities (Braddock et al., 2015).

The Americans with Disabilities Act (ADA) (1990) and the *Olmstead v L. C.* (1999) decision have also played key roles in the community inclusion of people with disabilities. The ADA, the main disability civil rights law in the United States, prohibits discrimination against people with disabilities. The four main goals set forth by the ADA are “equal opportunity, full participation, independent living, and economic self-sufficiency for people with disabilities” (U.S. Department of Justice, 2015, n.p.). These rights were reinforced by the *Olmstead v. L. C.* (1999) decision which ruled institutions are a form of discrimination because they segregate people with disabilities. In the decision

the Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based

services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity. (U.S. Department of Justice Civil Rights Division, n.d., n.p.)

However, actual implementation of the landmark *Olmstead v L. C.* (1999) ruling has been slow, often requiring class-action lawsuits and federal initiatives for significant progress to occur.

In 2009 a Community Living Initiative from the Department of Health and Human Services resulted in a new HCBS regulation, the HCBS Settings Rule. As part of the Affordable Care Act, the HCBS settings rule (CMS 2249-F/2296-F) aimed to “develop and implement innovative strategies to increase opportunities for Americans with disabilities and older adults to enjoy meaningful community living” (Medicaid Program, 2014, n.p.). The HCBS settings rule, which was implemented in 2014, shifts “away from defining home and community-based settings by ‘what they are not,’ and toward defining them by the nature and quality of participants’ experiences” (Centers for Medicare and Medicaid, 2014, p. 2). As a result, the HCBS settings rule “establish[ed] a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting’s location, geography, or physical characteristics” (Centers for Medicare and Medicaid, 2014, p. 2).

The HCBS settings rule includes a number of regulatory changes that states must implement before 2019 in order to continue to receive Medicaid funding. One of the main focuses of the HCBS settings rule is meaningful inclusion; the HCBS settings rule has strict requirements enforcing community-based settings. States are not only required to provide community opportunities but those opportunities must be *meaningful*, that is people with disabilities must have the same access to community as nondisabled people (Medicaid Program,

2014; State of Tennessee, n.d.). In addition to being able to choose where people with disabilities live, these changes mean people with disabilities must have access to things such as keys to their homes, and their own money. People with disabilities also are required to have choice about factors such as when they have visitors, where they work, and what services they receive. As such, the HCBS settings rule is centered around person centered planning; LTSS must be directed by the individuals' preferences and goals (Medicaid Program, 2014). Particular attention is drawn to person centered planning to promote community participation, employment, education, and healthcare, all of which could require shifts in how states provide services (Centers for Medicare and Medicaid, 2014; Medicaid Program, 2014).

Although these requirements may seem fairly simple, ensuring successful *and* meaningful community inclusion of people with disabilities requires complex changes in a system where “people with [intellectual and developmental disabilities] have merely become physically relocated into the community and not meaningfully integrated in and engaged with the community” (Friedman & Spassiani, in press, p. 5). True social inclusion requires a multidimensional combination of equitable access and quality, wherein success is measured through self-determination and empowerment (Gidley, Hampson, Wheeler, Bereded-Samuel, 2010). Gidley et al. (2010) explains, according to social inclusion theory, “the narrowest interpretation [of social inclusion] pertains to the neoliberal notion of social inclusion as access” (p. 7). Access in this instance is about social capital, not necessarily about quality. “A broader interpretation regards the social justice idea of social inclusion as participation or engagement,” (Gidley et al., 2010, p. 7) particularly human rights, opportunity, and fairness. Finally, the widest interpretation [of social inclusion] involves the human potential lens of social inclusion as success through empowerment; ... social inclusion asserts and

goes beyond both economic equity/access, and social justice notions of equal rights for all, to maximise the potential of each human being thus supporting broader cultural transformation. Employing models of possibility instead of models of deficiency, human potential approaches take a further step beyond access and participation to encourage the interpretation of social inclusion as empowerment (Gidley et al., 2010, p. 7).

The HCBS settings rule grants people with disabilities choice making opportunities aimed at empowering people with disabilities. Yet, because of the HCBS settings rule's complexity it can be largely inaccessible to key stakeholders, including people with intellectual and developmental disabilities, their families, and their support staff. The aim of the *Home and Community Based Services - Advocates Creating Transformation* (HCBS ACT) program was to increase stakeholders' knowledge of the HCBS settings rule and its implications.

The HCBS ACT program lead trainings around the state of Illinois about the HCBS settings rule for people with intellectual and developmental disabilities, family members of people with intellectual and developmental disabilities, and professionals, such as support staff. The approximately two-hour training described all aspects of the HCBS settings rule, especially focusing on the aspects of the rule that directly impact the quality of services and supports people with disabilities receive. The purpose of this exploratory study was to evaluate the effectiveness of the HCBS ACT program to educate key stakeholders about the HCBS settings rule. To do so, matched pre- and post-test scores from participants in the program were compared to determine significant knowledge growth. Doing so is necessary to establish if it would be effective to attempt to replicate similar programs as outreach efforts to actively engage people with

intellectual and developmental disabilities, their families, and their support staff in the policy process.

Methods

Recruitment

After approval from our university's institutional review board (IRB), people with intellectual and developmental disabilities, family members of people with intellectual and developmental disabilities, and professionals working with people with intellectual and developmental disabilities (e.g., direct support professionals, individual service coordinators, case managers) were recruited through Independent Service Coordination (ISC) centers in both rural and urban areas of Illinois. Funded by the Illinois Department of Human Services Division of Developmental Disabilities, ISCs provide:

an array of activities on behalf of individuals with developmental disabilities and their families/guardians to help them access generic and specialized services and supports. The program's mission is to ensure such services and supports are responsive to the unique needs and desires of each individual and to effectively promote independence, community inclusion, and self-determination.

(Champaign County Regional Planning Commission, 2009).

Examples of ISC activities include providing information, service eligibility, waiting list enrollment, referrals, and advocacy. Eighty-six people participated in the HCBS ACT training. The majority of participants were white, women, and from big cities (larger than 2,500 people). The average age of participants was 52 years. Forty participants were family members, 23 were professionals, and 15 were people with disabilities. Less than half of participants were involved

in disability advocacy, and only a small portion reported receiving HCBS waiver services themselves. See Table 1.

Measure

The survey instrument was developed based on examination of the content of the HCBS settings rule. The survey was then reviewed by the president of a non-profit disability organization, a leader from the state's developmental disabilities council, a well-respected self-advocate, and two academic researchers, and revised in response to their comments. In addition to answering questions about their demographics, participants were asked to self-report their knowledge of the HCBS settings rule (i.e., never heard of it; heard of it but do not know much about it; know a little about it; know a lot about it) on the pretest. Participants were asked on both the pretest and the posttest to complete the following questions to determine their knowledge of the HCBS settings rule (correct answers are underlined):

- Does the HCBS settings rule say people with disabilities should have full access to the community? (yes, no, not sure)
- Does the HCBS settings rule say services must be person-centered (i.e., must be what the person with disabilities really wants)? (yes, no, not sure)
- Does the HCBS settings rule say people with disabilities must be allowed to control their own lives? (yes, no, not sure)
- Does the HCBS settings rule apply only to group homes who serve at least 10 people? (yes, no, not sure)
- Does the HCBS settings rule say people with disabilities are allowed to have keys to their own homes? (yes, no, not sure)

- Does the HCBS settings rule say people with disabilities can only have visitors at certain times? (yes, no, not sure)
- Does the HCBS settings rule say people with disabilities are not allowed to manage their money? (yes, no, not sure)
- Are ICFs/DD (Intermediate Care Facilities for Developmental Disabilities) considered community-based settings? (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to choose where to live. (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to choose who to live with. (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to choose what to do during the day and at night. (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to choose where to work. (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to make a choice for somebody else. (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to choose what services they receive. (yes, no, not sure)
- According to the HCBS settings rule people with disabilities are allowed to choose who provides their services. (yes, no, not sure)

Procedure

Upon arrival at an HCBS ACT training participants were first given the pretest that included demographic questions, as well as the above questions about knowledge of the HCBS

settings rule. Participants were also asked to create an identifier code using their initials and birth year (e.g., CC1974), which would link the pre- and post-tests together but still allowed the data to be de-identified to the researcher.

Participants then attended an approximately two-hour training designed for people with intellectual and developmental disabilities, their families, and professionals. The training was co-facilitated by people who had extensive leadership experience (ranging from five to over thirty-five years) working with people with intellectual and developmental disabilities and policy. The co-facilitators included: people with intellectual and developmental disabilities; disability non-profit employees; advocacy specialists; policy experts; and, academic researchers. The first section of the training thoroughly described what home and community based services are, and what settings fall under the umbrella of home and community based settings. The section started with a short history of HCBS services, and institutionalized care. The trainers then discussed community integrated living arrangements versus ICFs/DD. Trainers then went on to describe that rules are changing in order to promote choice, control, and self-determination, as well as to describe the Centers for Medicare and Medicaid Services (CMS) authority to make the rules. After this introductory material was presented, the program described the main contributions of the HCBS settings rule in-depth including:

- community inclusion and supports for full access to community;
- options for non-disability specific settings;
- individual rights, including privacy, dignity, respect, and freedom from coercion and restraint;
- encouraging individual autonomy and choice;
- choice about services and supports, including who provides them.

The next section of the training focused on what the rules mean for providers, and settings owned or controlled by providers. Trainers began with an in-depth discussion of the features that make settings institutions as well as a description of heightened scrutiny for community-based settings that may appear institutional. The program went on to describe new CMS rules for providers including people's rights to: leases; privacy; keys; a choice of living arrangements/roommates; furnish and decorate within limits of the lease; have control over schedules and activities, including access to food at any time; visitors at any time; and, a home that meets physical accessibility needs.

The training then moved on to discuss what the HCBS settings rule means for person-centered planning, and employment and day services. Finally, the program described when states must come into compliance with these new regulations (2019). After again emphasizing the HCBS settings rule's emphasis on choice, trainers took questions from the audience. (The complete HCBS ACT training PowerPoint as well as a pre-recorded webinar are available from the Council on Quality and Leadership (2017).)

Following the training participants completed the posttest that measured their knowledge of the HCBS settings rule that included the same questions that were on the pretest they took approximately two hours prior. They were then thanked for their participation.

Analysis

Each of the participants' answers on the pre- and post-tests were dichotomously coded for correct (1) and incorrect (0). Participants' scores on the 15 questions were summed for both the pretest and the posttest; these scores comprised their pre- and post-test total knowledge scores. Descriptive statistics were then run.

A paired-samples *t*-test was conducted to determine the effectiveness of the HCBS ACT training, that is if participants' knowledge about the HCBS settings rule significantly increased after participating in the training. To determine if and how knowledge increased in specific areas in particular, McNemar tests were also utilized. Pre- and post-test scores from each of the 15 knowledge questions were individually analyzed using a McNemar test to determine if participants' knowledge increased on that subject area after participating in the training. Finally, analyses of variance were utilized to determine if there were differences in post-test knowledge depending on stakeholder group.

Results

Descriptive Statistics

Prior to participating in the study participants were asked to self-report their knowledge about the HCBS settings rule. The majority of participants (40.0%, $n = 28$) reported they had never heard of it, 28.6% ($n = 20$) reported they had heard about it but did not know much about it, 20.0% ($n = 14$) knew a little about it, and 11.4% ($n = 8$) knew a lot about it.

Participants were asked to complete 15 questions testing their knowledge about the HCBS settings rule both before and after completing the ACT training. The mean knowledge score on the pretest was 8.59 ($SD = 5.39$). On the posttest the mean knowledge score was 12.96 ($SD = 3.34$). Table 2 details the number of correct answers for individual questions on the pre- and post-tests.

Overall Knowledge Growth

A paired-samples *t*-test was conducted to evaluate whether participants had more knowledge about the HCBS settings rule after completing the training. The results indicated that the mean knowledge after the training ($M = 12.96$, $SD = 3.34$) was significantly greater than the

knowledge before the training ($M = 8.59$, $SD = 5.39$), $t(45) = -6.06$, $p < .01$. The standardized effect size, Cohen's d , was large (.89). The 95% confidence interval for the mean difference between the two knowledge scores was -5.82 to -2.92.

Knowledge Growth on Particular Subjects

McNemar tests of dependent proportions were run for each of the HCBS settings rule knowledge questions to determine in particular which questions participants' knowledge significantly increased. All of the McNemar tests indicated significant differences in terms of knowledge between the pretest and the posttest (see Table 2).

Knowledge Growth by Stakeholder Group

An one-way analysis of variance (ANOVA) was utilized to determine if there was a difference in post-test knowledge across the three groups of stakeholders (i.e., people with intellectual and developmental disabilities, family members, professionals); there was not a significant difference between post-test scores by group ($F(2, 48) = 2.54$, $p = 0.09$). Moreover, according to an analysis of covariance (ANCOVA), there also was not a significant difference between the three groups' post-test scores when their initial pre-test knowledge was controlled ($F(2, 46) = 2.43$, $p = 0.10$). These findings suggest there was not a significant difference in post-test knowledge across three stakeholder groups.

Discussion

The HCBS settings rule reinforces people with disabilities' rights to be in and be part of the community. With even brief education about the HCBS setting rule key stakeholders, including people with disabilities and their family members, were able to improve their knowledge about the HCBS settings rule. The findings of this exploratory study suggest training programs, such as the HCBS ACT education program, can be an effective means to increase the

knowledge of key stakeholders, including people with intellectual and developmental disabilities, family members of people with intellectual and developmental disabilities, and professionals, about the rights of people with disabilities under the HCBS settings rule. Not only did the HCBS ACT program significantly increase participants' overall knowledge of the HCBS settings rule, participants' knowledge of different aspects of the HCBS settings rule grew across the board as well. For example, after attending the HCBS ACT training participants were better able to correctly identify that the HCBS settings rule requires people with disabilities be allowed to control their own lives, including where to live, who to live with, and what they do.

Although participants' knowledge significantly increased on each of the individual subjects, it appears more attention needs to be drawn to ICFs/DD and their relationship with community-based settings. Although participant knowledge on the item "are ICFs/DD considered community-based settings" grew significantly after participation in the HCBS ACT program, it saw one of the lowest correct proportions on the post-test (62.9%). Moreover, it was the question that was skipped the most on the posttest suggesting people were unsure of the answer. These findings suggest more education about the difference between ICFs/DD and community based settings is necessary. Another area with some confusion was that people with disabilities are allowed to access their own money. Again, there was a significant increase in knowledge but it was the least significant difference across all of the questions suggesting more education about access to money would be beneficial.

Limitations and Suggestions for Future Study

A number of limitations regarding our study should also be noted, particularly related to our sample. Our participants were volunteers so there is a chance of self-selection bias. As they were not incentivized a number of participants skipped survey items as well. The majority of our

participants were white women. Thus, our sample was not representative of the United States at large or the disability community. Moreover, this uneven distribution of participants may also have implications as past research has found women tend to have different relationships with people with disabilities than men (Hirschberger, Florian, & Mikulincer, 2005).

Our sample centered on people with intellectual and developmental disabilities and their allies; although HCBS waivers support people with intellectual and developmental disabilities more than other populations, people with other types of disabilities whose LTSS is provided by HCBS waivers are also effected by the HCBS settings rule. Future studies should aim for a more representative sample that parallels the larger community of people with disabilities and their allies to determine if HCBS settings rule trainings are effective for wider audiences. Finally, this study was exploratory in nature; while the findings suggest the HCBS ACT program can be a useful intervention for expanding stakeholders' knowledge of the settings rule, more research is necessary beyond this pilot program.

Implications for Policy and Practice

To document these complex new programs and compliance with the HCBS settings rule states must develop and submit transition plans to the Centers for Medicare and Medicaid (CMS). These transition plans must ensure all settings truly comply with home and community-based settings requirements (Medicaid Program, 2014). As of December 2016 only one state, Tennessee, has received approval (Centers for Medicare and Medicaid Services, n.d.). The remaining states have either not yet submitted their plans or had their plans rejected because they did not meet the HCBS settings rule standards (Centers for Medicare and Medicaid Services, n.d.).

Every time a state develops a transition plan or adjusts a plan in relation to CMS comments, they must open the plans up for public comment. Prior to resubmitting to CMS, states must address each of the public comments they receive. As a result, public comment periods allow stakeholders the opportunity to impact states plans regarding community inclusion. As such, advocates not only have the opportunity to impact states' HCBS setting rule plans, they also have the obligation to hold states accountable to the HCBS settings rule to ensure LTSS is truly community based as well as meaningful. Although professionals tend to have more knowledge about the HCBS settings rule than people with disabilities or their family members (Friedman, under review), programs like the HCBS ACT training can expand peoples' knowledge of the HCBS settings rule to participate in this advocacy. Knowledge of the landmark yet technical HCBS settings rule is necessary for people with disabilities and their allies to advocate for their rights.

Interventions supporting the education of people with intellectual and developmental disabilities are crucial to self-determination and empowerment. Nonnemacher and Bambara (2011) found self-advocates defined self-determination as speaking out and making themselves heard about what they want; knowing their rights was also an important part of self-determination. Other self-advocates in the study also mentioned self-determination meant being in charge of their daily decisions and reaching their goals (Nonnemacher & Bambara, 2011). Thus, supporting people with intellectual and developmental disabilities to learn about policy can help facilitate empowerment. Education about the HCBS settings rule in particular may be especially fruitful because the rule by its very nature includes expanded opportunities for choice making; its "interpretation of social inclusion [is] as empowerment" (Gidley et al., 2010, p. 7).

Moreover, families are often an important advocacy source for people with disabilities; although family involvement can be critical, advocating for their family member can be difficult because of inaccessibility (Burke et al., 2016). With policy concerns in particular, family may feel overwhelmed as they try to navigate a complex system with a lack of accessible information or they may feel disempowered when trying to share their concerns (Burke, 2015; Dixon et al., 2004; Fish, 2006). Education interventions for family have been linked to overall wellbeing, reduced stress, and increased coping mechanisms for those involved (Dixon et al., 2001; Dixon et al., 2001b; Dixon et al., 2011). In addition to increases in parent self-efficacy, even clinical outcomes can be improved when the family members receive information, guidance, and support (Dixon et al., 2001b; Robbins et al., 2008; Magana et al., 2014). Research indicates interventions inclusive of parents are more effective (Magana et al., 2014).

The HCBS settings rule aims to not only include people with disabilities in the community but to make inclusion *meaningful*. It does so by reinforcing that people with disabilities have the same rights as nondisabled people. These rights include both macro-system issues such as access to community living, and micro-system choices such as deciding what to eat for lunch. If implemented as intended, inclusion is the core of the HCBS settings rule. To promote the maximum inclusion of people with intellectual and developmental disabilities, people with intellectual and developmental disabilities, their families, and other key stakeholders must be supported to advocate to ensure these aims are met.

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Table 1
Demographics (n = 86)

	%	n	<i>M</i>	<i>SD</i>
Gender				
Man	21	18		
Woman	59	51		
Race				
White	78	67		
Black	1.2	1		
American Indian and/or Alaska Native	1.2	1		
Some other race	1.2	1		
Age			52.0	14.7
Participant group				
Person with disability	17	15		
Family member of someone with a disability	47	40		
Professional	27	23		
Education				
Some high school	4.7	4		
High school diploma or GED	17	15		
Trade/vocational school	1.2	1		
Some college	13	11		
College degree	19	16		
Some graduate school	8.1	7		
Graduate degree	17	15		
Hometown				
Big town or city (larger than 2,500)	61	52		
Very small town or in the country (less than 2,500 people)	21	18		
Receives waiver services	14	12		
Involved in disability advocacy	42	36		

Table 2
Individual Knowledge about the HCBS Settings Rule

Item	Pretest correct	Posttest correct	McNemar Tests		
			P _A	P _B	<i>p</i>
Rule says people with disabilities should have full access to the community	59.1%	84.1%	56.5%	82.6%	0.002**
Rule says services must be person-centered	61.2%	92.1%	63.0%	93.5%	<.001***
Rule says people with disabilities must be allowed to control their own lives	50.0%	93.7%	48.9%	95.6%	<.001***
Rule applies only to group homes who serve at least 10 people	53.0%	76.2%	57.8%	80.0%	0.013*
Rule says people with disabilities are allowed to have keys to their own homes	40.9%	88.9%	37.8%	88.9%	<.001***
Rule says people with disabilities can only have visitors at certain times	55.2%	81.0%	57.8%	86.7%	0.002**
Rule says people with disabilities are not allowed to manage their money	59.1%	75.8%	64.4%	80.0%	0.039*
ICFs/DD (Intermediate Care Facilities for Developmental Disabilities) considered community-based settings	30.3%	62.9%	33.3%	71.1%	<.001***
Rule says people can choose where to live	70.1%	93.5%	72.1%	100.0%	<.001***
Rule says people can choose who to live with	67.2%	98.3%	69.8%	100.0%	<.001***
Rule says people can choose what to do during the day and at night	67.2%	96.7%	69.8%	100.0%	<.001***
Rule says people can choose where to work	65.7%	93.3%	67.4%	95.3%	0.004**
Rule says people can make a choice for somebody else	51.5%	71.7%	53.5%	76.7%	0.006**
Rule says people can choose what services they receive	64.2%	96.7%	67.4%	100.0%	<.001***
Rule says people can choose who provides their services	62.7%	88.3%	62.8%	90.7%	0.002**

Note. **p* < .05. ***p* < .01. *** *p* < .001.