FINAL PROPOSED RULE # 22-P23

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Disability Services-Developmental Services

/S/ Todd W. Dalod , on 12/9/22
(signature) (date)

Printed Name and Title:
Todd Daloz, Deputy Secretary
Agency of Human Services

RECEIVED BY: ________

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

1. TITLE OF RULE FILING:
   Disability Services-Developmental Services
2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   22P023
3. ADOPTING AGENCY:
   Agency of Human Services (AHS); Department of Disabilities, Aging, and Independent Living (DAIL)
4. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Clare McFadden

   Agency: Department of Disabilities, Aging and Independent Living/Developmental Disabilities Services Division (DAIL/DDSD)

   Mailing Address: 280 State Drive, Waterbury, VT 05671-2030

   Telephone: (802)585-5396 Fax: (802)241-0410

   E-Mail: clare.mcfadden@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*: www.dail.vermont.gov
5. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Stuart Schurr, General Counsel

   Agency: Department of Disabilities, Aging, and Independent Living

   Mailing Address: 280 State Drive, HC2 South, Waterbury, VT 05671-2020

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6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) Yes

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   1 V.S.A. § 317 (c)(1): Records that by law are designated confidential or by a similar term are exempt from public inspection and copying.

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

18 V.S.A. § 8728 affords every person with a developmental disability and every family who receives services the right to privacy and confidentiality.

7. LEGAL AUTHORITY / ENABLING LEGISLATION:
(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

   18 V.S.A. § 8726

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
   18 V.S.A. § 8726 requires DAIL to adopt rules necessary to carry out the requirements of the Developmental Disabilities Act of 1996 (DD Act), 18 V.S.A. Chapter 204A.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

   The purpose of this rule is to fulfill the requirements of the Developmental Disabilities Act (DD Act), to include specific details for its implementation. The effective date of the last adopted rule was October 1, 2017. Since then, 2022 Acts and Resolves No. 186 eliminated the requirement in 18 V.S.A. § 8725 that certain categories of the Developmental Services System of Care Plan be adopted by rule. Further, the federal rules relating to Medicaid grievances and appeals have been amended. Finally, the Vermont Supreme Court's decision in In re: R.R., 2019 VT 31, requires that the Standard Error of Measurement (SEM) for IQ tests, including IQ scores of 75 or below, be considered when determining eligibility for services. The proposed language includes IQ scores of 75 or below when accounting for the SEM. Other amendments to the rule include formatting, as well as updates to align with current practice in the administration of the Developmental Services program.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

The rule is necessary to comply with the requirements in 18 V.S.A. § 8726.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The proposed language adheres to the requirements set forth in 18 V.S.A. § 8726 and Health Care Administrative Rule 8.100 and codifies the Vermont Supreme Court's decision in In re: R.R., 2019 VT 31. The decision to include such language would make sense to a reasonable person.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Individuals with developmental disabilities, their family members and guardians; Vermont Legal Aid-Disability Law Project; Green Mountain Self-Advocates; advocates representing the interests of people with autism; providers, including Vermont Care Partners, designated agencies, and specialized service agencies; the VT Developmental Disabilities Council; the Developmental Disabilities Services (DDS) State Program Standing Committee; Vermont Family Network; Federation for Children and Families; University of Vermont Center for Disability and Community Inclusion; AHS; and DAIL

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

The proposed changes to the eligibility criteria for people ages six and up have the potential for increasing the number of people who are eligible for DDS, placing increased pressure on the DAIL/DDSD budget to serve additional people. In response to In re: R.R., 2019 VT 31, DDSD has adjusted its threshold for eligibility from an IQ score of 70 to 75 when accounting for the SEM. Since then, an average of one additional person per month has received Home and Community-Based Services (HCBS) based upon this change, for an average annual cost of $472,727 as of February

2022. This increase has already been factored into the budgeting process for DAIL. The Office of Public Guardian (OPG), within DDSD, may experience increased referrals for people in need of guardianship, which, over time, could require additional OPG staff. Finally, access to services may have a positive financial impact on some family caregivers by enabling them to enter the workforce or increase their work hours.

19. A HEARING WAS HELD.

20. HEARING INFORMATION
(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 10/11/2022
Time: 10:00 AM
Street Address: virtual: see attached
Zip Code:

Date: 10/19/2022
Time: 04:00 PM
Street Address: virtual: see attached
Zip Code:

Date:
Time: AM
Street Address:
Zip Code:

Date:
Time: AM
Street Address:
Zip Code:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
10/28/2022

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

system of care plan

developmental disabilities

developmental services

eligibility

Department of Disabilities, Aging, and Independent Living

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Commissioner's Office
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TO: Legislative Committee on Administrative Rules (LCAR)

FROM: Stuart G. Schurr, Esq., General Counsel SGS
Department of Disabilities, Aging & Independent Living (DAIL)

DATE: December 11, 2022

SUBJECT: 22P-023; Final Proposed Rule; *Disability Services-Developmental Services*

The Agency of Human Services (AHS) and DAIL propose numerous amendments to the existing Health Care Administrative Rule (HCAR) 7.100: *Disability Services-Developmental Services.*

A. Background

The purpose of this rule is to fulfill the requirements of the Developmental Disabilities Act (DD Act), to include specific details for its implementation. The effective date of the last adopted rule was October 1, 2017. Since then, 2022 Acts and Resolves No. 186 eliminated the requirement in 18 V.S.A. § 8725 that certain categories of the Developmental Services System of Care Plan be adopted by rule. Further, the federal rules relating to Medicaid grievances and appeals have been amended. Finally, the Vermont Supreme Court's decision in *In re: R.R.*, 2019 VT 31, requires that the Standard Error of Measurement (SEM) for IQ tests, including IQ scores of 75 or below, be considered when determining eligibility for services. The proposed language includes IQ scores of 75 or below when accounting for the SEM. Other amendments to the rule include formatting, as well as updates to align with current practice in the administration of the Developmental Services program.

Specific Changes

The following chart reflects all changes made to the proposed rule since its filing with the Secretary of State.

Section of proposed Rule, as submitted to Secretary of State	Description of Change
7.100.2(ff)(1)	Section 7.100.2(ff)(1) was revised to read: "A person placed in an out of state institution, as defined by Health Benefits Eligibility and Enrollment (HBEE) 3.00, by a department of the State of Vermont, or"
7.100.3(i)(5)	The following sentence was struck from 7.100.3(i)(5): "For evaluations of children from birth to age six, a developmental-behavioral or neurodevelopmental disabilities pediatrician or pediatric neurologist must perform the assessment or be part of the assessment team."
7.100.3(j)(1)	The following section 7.100.3(o) was added: "(o) Missing information to document developmental disability There may be circumstances in which considerable effort is made to obtain all the required history and documentation to determine whether a person has a developmental disability, but the required information cannot be obtained. This may include situations in which there are no available informants to document a person's functioning prior to age 18, previous records cannot be obtained, or do not exist. In these circumstances, the determination of whether the person meets the criteria for having a developmental disability should be based upon the current assessment and all available information, including other life factors that occurred after age 18 that could potentially impact cognitive, adaptive, or other functioning."
7.100.5(d)(1)(B)	Section 7.100.5(d)(1)(B) was revised to read: "Notifying the applicant of the rights of recipients in plain language, including the procedures for filing a grievance or appeal and their rights as outlined in the federal CMS HCBS rules;"
7.100.5(i)(2)(D)	7.100.5(i)(2)(D) was amended as follows: "If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based Services funding, the notice must state that the DA will continue to offer information and referral services and will place the person's name on a waiting list (Section 7.100.5(q))."

Section of proposed Rule, as submitted to Secretary of State	Description of Change
7.100.5(l)(3)	Revised 7.100.5(l)(3) as follows: "As part of the periodic review, the agency or Supportive ISO must ask each recipient about his or her satisfaction with services, and provide each recipient and individual's authorized representative with an explanation of the rights of recipients, including those outlined in the federal CMS HCBS rules, and how to initiate a grievance or appeal (See 7.100.9 and 8.100)."
7.100.5(q)	Revised 7.100.5(q) as follows: "A person with a developmental disability whose application for Home and Community-Based Services, Flexible Family Funding or Family Managed Respite is denied must be added to a waiting list maintained by the Designated Agency. The Designated Agency must notify an applicant that his or her name has been added to the waiting list and explain the rules for periodic review of the needs of people on the waiting list. (1) The Division will provide instructions to the Designated Agencies for reporting waiting list information to the Division. (2) Each Designated Agency must notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list must occur: (A) When there are changes in the funding priorities or funds available; or (B) When notified of significant changes in the individual's life situation. (3) Waiting list information will be included the DDS Annual Report and will be reviewed annually by the DDS State Program Standing Committee.
7.100.6	The final sentence in the first paragraph of 7.100.6 was amended as follows: "An individual or a family member may manage up to 12 hours a day of In-home Family Supports or Supervised Living, but may not self/family manage Staffed Living, Group Living or Shared Living."

Section of proposed Rule, as submitted to Secretary of State	Description of Change
7.100.6(d)(3)(G)	Revised 7.100.6(d)(3)(G) as follows: "Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996 and the rights outlined in the federal CMS HCBS rules; and"
7.100.10(d)	The second sentence in 7.100.10(d) was amended to include "contractor" in the list of employers of record: "The employer of record, whether recipient, family, shared living provider, contractor or agency, is responsible for providing or arranging for this training for their workers."
7.100.10(d)(4)(A)	Revised 7.100.10(d)(4)(A) as follows: "Individual rights, as specified in 18 V.S.A. §8728 and as outlined in the federal CMS HCBS rules:"
7.100.10(d)(4)(F)	Section 7.100.10(d)(4)(F) was added. "(F) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand."
7.100.10(e)(1)	The third sentence in 7.100.10(e)(1) was amended to include "contractor" in the list of employers of record: "The employer of record, whether recipient, family, shared living provider, contractor or agency, is responsible for providing or arranging for this training for their workers."
7.100.10(e)(1)(B)	The first sentence in 7.100.10(e)(1)(B) was amended to read: "The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support methods of communication used by the recipient, and supporting decision making)."
7.100.11(b)(1)(C)	Revised 7.100.11(b)(1)(C) as follows: "Provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728) and the rights outlined in the federal CMS HCBS rules."

Rulemaking Process – Public Input

On March 10, 2022, the DAIL Commissioner distributed to the members of the State Program Standing Committee (SPSC), the advisory board established in 18 V.S.A. § 8733, an initial draft of the proposed rule, for advice and recommendations. As requested by the advisory board in February 2022, a plain language document explaining the proposed changes was developed and shared with the board on March 10, 2022. During the SPSC meeting on March 17, 2022, DAIL staff and the SPSC members reviewed and discussed the draft. The SPSC members offered comments and suggested some changes. The SPSC was given an additional 30 days to provide any additional advice or recommendations in writing to DAIL. On April 18, 2022, Vermont Legal Aid (VLA), which is represented on the SPSC, submitted to DAIL its recommended changes to the proposed draft. No other written comments were received from the SPSC. The recommendations from VLA and the SPSC were reviewed by DAIL staff, and several were adopted and incorporated into the proposed rule.

Prior to drafting the proposed rule changes, DAIL consulted with two licensed psychologists with expertise in the diagnosis of intellectual disability. DAIL also met with Agency of Education staff involved with early education programs for children under age 6. The purpose was to align eligibility criteria to the extent feasible to streamline processes for families across state programs. DAIL also met with staff from provider agencies to get feedback on a draft of the proposed changes.

Following ICAR review, the proposed rule was filed with the Secretary of State, at which time DAIL sent information regarding the proposed rule and public comment period to the following organizations: Vermont Care Partners, Developmental Disabilities Services Agency Directors, Designated Agency Executive Directors, the DDS State Program Standing Committee, Vermont Family Network, Green Mountain Self-Advocates, the DAIL Advisory Board, Vermont Coalition of Disability Rights, Vermont Legal Aid, Vermont Developmental Disabilities Council, and Vermont Center for Independent Living. The proposed rule was posted on the DAIL website, and two (2) virtual public hearings were held. In addition, DAIL invited the public to submit written comments on the rule during the public comment period.

Both during and after the public hearings, DAIL received public comments from several of the above stakeholders, among others. DAIL has considered the comments received and has incorporated suggested changes, as appropriate.

Below is a summary of the comments received and DAIL's responses to those comments.

B. Public Comments and DAIL's Responses

#	Public Comment Received	Department Response
	General Comments	
1.	The Vermont Developmental Disabilities Council applauds the Developmental Disabilities Services Division (the Division) for providing robust opportunities for public engagement as part of the rule-making process. The Division provided the State Program Standing Committee (SPSC), the advisory board established in 18 V.S.A. §8733, with an initial draft of the proposed rule, seeking advice and recommendations in March 2022. A plain language document explaining the proposed	The Department appreciates the positive feedback.

#	**Public Comment Received**	**Department Response**
	changes was developed and shared with the board. DAIL staff and the SPSC members reviewed and discussed the draft. The SPSC members offered comments and suggested some changes to the proposed draft.	
2.	A family member indicated that the rules should be amended to allow the use of cannabis for medicinal purposes for people receiving services in residential settings. People who are using cannabis medicine should have access to both residential programs and their cannabis medicine.	The requested content is beyond the scope of this *Rule*, as required by 18 V.S.A. 8726(a) & (b). Further, while the use of marijuana for medicinal purposes is permitted under Vermont law, it remains unlawful under federal law. As Medicaid funds are used to provide the services described in these rules, the Department declines to include language that could be construed to authorize the violation of federal law, which, in turn, could jeopardize the availability of federal funding. No change to the *Rules* will be made in response to this comment.
3.	A family, including a person with a developmental disability, commented that "Federal law allows up to five adults with ID/DD (intellectual disability/developmental disability) to live together under the same roof. We would like the Vermont policy that no more than two adults with developmental disabilities can reside together in the same home under the Shared Living arrangement be changed to align more with Federal law. Also, would like to see that housing could be created for more than 3 individuals residing together without requiring licensure and have DAIL/DDSD work with licensure to change this requirement. Perhaps licensure shouldn't be based on # of people being served within a residence, but on level of need of the clients residing together." The Developmental Disabilities Housing Initiative, a group of approximately 80 parents advocating for the expansion of housing options in DDS, also recommends changing the policy to allow up to five individuals to be supported in a shared living arrangement to align with what is allowable under Federal law.	Shared Living is not defined in this *Rule*. The definition, referenced in Developmental Disabilities Services (DDS) System of Care Plan, indicates that it is for 1-2 individuals being supported by a caregiver in a home. Federal IRS law does allow for the exclusion of payments for full time home care of for up to five adults with a disability being cared for by a Shared Living provider (also called "adult foster care"). However, Vermont defines adult foster care as "provision of 24-hour home care services for 1-2 adult persons with a disability in the residence of the person providing home care services" (33 V.S.A. §502(1). This rule was added in 2007 to clarify that payments to adult foster care providers could be excluded

#	Public Comment Received	Department Response
		from homeowners' incomes when calculating VT property taxes. In addition, as noted in the comment, the licensing rules, which are overseen by the Department's Division of Licensing and Protection, are separate from this rule. They currently require homes providing care for 3 or more unrelated persons to be licensed. While DDSD is open to exploring the possibility of expanding the number of persons who could be supported in Shared Living, the other rules noted above would need to be changed first. Consideration to a change in DDSD policy would be through the DDS System of Care Plan where the definition of Shared Living currently exists. The Department will not make any change to the *Rule* at this time in response to this comment.
4	A parent recommended that the DDSD implement significant changes, now, in the Regulations and the SOCP so that Vermonters have meaningful choice in their living arrangements. This parent endorsed the specific recommendations for changes made by another commenter.	The Department will respond to the specific recommendations in the comments below where they are referenced.
5	The Vermont Developmental Disabilities Council (VTDDC) "recommends embedding the core elements of CMS' HCBS (Home and Community-Based Services) Settings into Vermont's DS Regulations." VTDDC provided considerable detail reiterating the requirements of the federal HCBS setting rules which include services being integrated into the community, providing full access to community life, choice and control of services and daily life, lease or lease-like agreements between providers and individuals in provider-controlled home settings, etc.	The *Rules* currently reference the requirement to follow the Federal Centers for Medicare and Medicaid Services (CMS) HCBS setting rules in the provision of HCBS (7.100.2(u)), Community Supports (7.100.2(j)) and in Home Supports (7.100.2(v)). The Department agrees to embed additional language regarding compliance with the

#	**Public Comment Received**	**Department Response**
	They also recommend that the State provide a model agreement for Shared Living arrangements in lease-like protections to ensure consistency across providers.	HCBS rules. See the response to comment # 25 for details. The Department does not believe it is necessary or appropriate to repeat the detailed requirements of the federal HCBS rule in this *Rule* for the following reasons. DAIL is currently obligated to follow the HCBS settings rule as part of its agreement with CMS in its operation of HCBS (VT-GCH-Extension-STCs-Technical-Corrections-10-12-2022.pdf (vermont.gov)). The agreement also specifies quality measures and reporting requirements to ensure compliance with the federal rules. Additionally, the State has approval of its plan to comply with the setting rules in its Comprehensive Quality Strategy and Statewide Transition Plan. The Department intends to develop a model of a lease-like agreement for Shared Living providers and a policy related to individuals having lockable doors for their private space as part of the Statewide Transition Plan.
6	A family, including a person with DD, would like to see the Regulations encourage the expansion of housing and residential service options for adults with developmental disabilities, and any barriers/obstacles to new and creative housing options should be removed from the Regulations.	The Department is committed to expanding housing support options for people with developmental disabilities. The Department has initiated efforts to comply with the recently passed Act 186 that includes a focus on expanding housing options. Act 186 requires the Division to explore and pilot new housing support models. This work has just begun, and it is not yet known what models will be

#	Public Comment Received	Department Response
		recommended for development and what current rules would be barriers to their creation. Greater stakeholder input will be needed regarding changing some rules to allow for the expansion of housing support options in order to avoid unintended consequences for recipients. The Division is open to changing the rules as the work progresses.
	The Regulations should align with the HCBS Settings Criteria and provide meaningful choices for residential living situations for individuals requiring 24-hour supports	See response to comment # 5.
7	The Developmental Disabilities Housing Initiative, which is a group of approximately 80 parents advocating for and supporting the development of stable, service-supported housing communities for their adult daughters and sons, many of whom have significant support needs and would benefit from the option of living with peers, would like to see the regulations change to at least lay the groundwork by removing barriers so that new housing models can emerge.	As noted above in response to comment #6, the Department is committed to working with stakeholders on expanding housing options. It is not yet known what those options will be.
	The commenter provided recommendations for changes to specific sections of the *Rules* that are seen as barriers to additional housing support options. Those recommendations are included below in the specific sections of the *Rule*.	The Department responds to the recommendations related to specific sections of the *Rule* below.
8	VTDDC recommends that the Person-Centered Planning Rule Plan of Correction should be incorporated in the R*ules* by reference. Vermont lacks person-centered planning processes that are free from undue conflicts of interest. VTDDC notes that the Vermont Agency of Human Services submitted a proposed plan of correction to CMS to address the lack of conflict-of-interest free case management in Vermont. When the Plan of Correction is approved by CMS it will be added to the Global Commitment to Healthcare waiver as Attachment Q. The Plan of Correction should be incorporated in the new *Rule* by reference.	The Department disagrees with this recommendation. The *Rules* lay out the current requirements for the provision of HCBS. Vermont has submitted its Plan of Correction and it has not yet been approved by CMS. When Vermont receives approval and then implements the Plan of Correction, it is likely that considerable changes to these *Rules* will be required. It is not yet known what the changes will be, so they cannot be incorporated in this *Rule* at this time.

#	Public Comment Received	Department Response
		No change will be made in response to this comment.
9	Vermont Developmental Disabilities Council recommends that the Department "embed an Independent Ombudsman in the *Rules*: Vermonters with disabilities who are receiving home and community-based services for a developmental disability need an outside independent entity to address complaints and conduct independent investigations. These beneficiaries should have access to a service that has been embedded in Choices for Care since its inception".	The list of available services and supports is no longer required to be adopted by rule according to Act 186 which was approved in the 2022 legislative session. The Department agrees that the development of an ombuds program for DDS should be a special initiative (See 7.100.5(h)). Special initiatives are proposed in the DDS System of Care Plan. The draft System of Care Plan is currently out for public comment. The development of an ombuds program is listed as one of those initiatives in the Draft Plan. The Department does not agree with including reference to a service that does not currently exist in the *Rule*. No change to the *Rule* based on this comment will be made at this time.
	7.100.1 Developmental Disabilities Services (DDS) Purpose and Scope	
10	**7.100.1 (a)** A parent who has worked closely with a group of other parents on advocating for an expansion of housing options for people with DD commented that "the purpose of the Regulations is to implement the DD Act (18 V.S.A., Chapter 204A), and not be a barrier to implementing the Act. DAIL and DDSD need to acknowledge that the State had fallen short of meeting one of the key principles of service in the Vermont Developmental Disabilities Act of 1996 – specifically the State has not met its obligation to provide meaningful choices when it comes to providing residential living situations for individuals requiring 24-hour supports. The DD act indicates that "People with developmental disabilities and their families cannot make good decisions without meaningful choices about how they live and the kinds of services they	The Department acknowledges that there is currently limited choice for most people who need 24- hour Home Support. The 2021 DDS Annual Report indicates that 90% of the 1526 people receiving 24- hour Home Support live in Shared Living arrangements, 5% live in Staffed Living and 5% live in group homes. Staffed Living and Group Living options generally serve people with more significant behavioral and/or medical issues. There are a variety of reasons that Shared Living has become

#	Public Comment Received	Department Response
	receive. Effective services shall be flexible so they can be individualized to support and accommodate personalized choices, values, and needs and assure that each recipient is directly involved in decisions that affect that person's life." In reality, the majority of individuals who need 24-hour support have only one choice, which is to live with a shared living provider. The Department needs to make changes to its rules to foster choice and not create barriers to meeting the Principles of Service outlined in the DD Act. The commenter provided recommendations for changes to specific sections of the *Rules,* which are included below. Another parent endorsed these recommendations.	the predominant option, but two major factors are the lack of availability of affordable housing and relative cost-effectiveness of Shared Living compared to other arrangements requiring staffing. As noted above, the Department is committed to expanding housing support options for people with developmental disabilities. The Department has initiated efforts to comply with the recently passed Act 186 that includes a focus on expanding housing options. The Department responds to the recommendations related to specific sections of the *Rule* below.
	7.100.2 Definitions - General Comment	
	No general comments were received.	
	7.100.2 Definitions – comments by section	
11	**7.100.2(j)** Vermont Developmental Disabilities Council commends the Department for including language in the definition of Community Supports to clarify that transportation is included in this service.	This language was added to clarify that both workers employed by agencies and those who are independent direct support workers can be reimbursed for mileage for transporting people when they are receiving Community or Employment Supports.
12	**7.100.2(v)** The definition of Home Supports Includes "compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community." A parent commented that currently, for the majority of people, there really is no choice for Home Supports other than Shared Living if an individual requires 24-hour supports. Another parent endorsed this comment.	See response to comment #10.
13	**7.100.2(ff)**	HCAR 7.100.2(ff) aligns with

#	Public Comment Received	Department Response
	A parent commented that "in subsection (ff)(1) a "facility" is not defined, but the Regulations should clearly permit individuals to reside in an out of state residential community (e.g., Visions in New Hampshire) in an adjoining state just as the Regulations allow for a person to remain a Vermont resident if the person lives with a Shared Living Provider in an adjoining state." Another parent endorsed this comment.	the requirements of Health Benefits Eligibility and Enrollment (HBEE) Rule 21.01, which states that health benefits will be provided to an eligible Vermont resident, and HBEE Rule 21.03, which provides that, to be a Vermont resident, one must meet the conditions in §§ 21.04 through 21.08 of the Rule. More specifically, HBEE Rule 21.04 currently provides that an individual is a Vermont resident *if a state agency arranges for* the individual to be placed in an out-of-state "institution." HBEE Rule 3.00 defines "institution" as "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor." For clarity and consistency with the HBEE Rule, the Department agrees to strike from 7.100.2(ff)(1), "school, facility, correctional center, or hospital" and replace it with, "institution, as defined in Health Benefits Eligibility and Enrollment (HBEE) 3.00," No additional changes will be made at this time. The *Rules* as written do allow for a person to reside in an out of state setting if the setting meets the criteria outlined in the *Rule* as well as the requirements in the DDS System of Care Plan. A person could reside in an out of state residential community in an adjoining state if the person was placed there by the State or by a provider who agrees to sub-contract with an out of state provider. Before placing an individual in

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		an out-of-state institution, the Department or Designated Agency considers numerous factors, which include, but are not limited to, the following: -Ability of the provider to comply with all State and Federal Medicaid rules, policies and guidelines - Guardianship – court jurisdiction - Access to Crisis services - Nursing delegation of nursing tasks to non-nurse caregivers - Adult Protective Services jurisdiction for reporting and investigating abuse and neglect - State-specific laws (e.g., administration of psychotropic drugs) - DA/SSA oversight – especially when person lives a long distance from the VT border.
14	**7.100.2(ff)** A parent commented "The state should allow for HCBS funding to be used for out-of-state authorized services, including housing, if there are no options to meet the client's needs within the state." Another parent endorsed this comment.	See response to comment #13. As a point of clarification, while HCBS funding can pay for supportive services in homes, it cannot be used to pay for "housing" costs such as room and board. Room and board are covered by a person's SSI or other sources. So, the department would not include the term "housing" in this section. Also, the Department disagrees with adding language to allow for out of state placements when "there are no options to meet the client's needs within the state." The State or designated provider already has the authority to place a person in an out of state setting when needed to meet a person's needs. They have the authority to consider available

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		options. Recipients or their guardians also have the right to appeal the decisions of the State or provider.
	7.100.3 Criteria for Determining Developmental Disability – general comments	
15	A family, including a person with DD, commented: "Expand the definition of individuals that qualify for the HCBS Waiver to include those individuals that fall on the Fetal Alcohol Spectrum like the Federal government defines today. This is a developmental disability, and many students leave high school with no supports and services which are greatly needed. Fetal Alcohol in utero is organic damage to the brain and often these clients plateau and will never achieve independence."	Individuals who have Fetal Alcohol Spectrum who also meet the definition of Developmental Disability as outline in the proposed *Rule* would be eligible. The Developmental Disabilities Act, in 18 V.S.A. §8722 defines who is to be served in the DDS program to include people with an intellectual disability, or autism. The purpose of these *Rules* is to provide specific details for the implementation of the DD Act. Adding new qualifying diagnoses would require amending the Act. The Department will not make any changes in response to this comment.
16	A director of a provider agency indicated that the changes to the language related to eligibility of young children is clearer.	The Department appreciates the positive feedback.
17	The Vermont Developmental Disabilities Council commends the Department for the amendments to the eligibility criteria to align with the 2019 VT Supreme Court ruling in *R.R.*	The Department appreciates the positive feedback.
	7.100.3 Criteria for Determining Developmental Disability – comments by section	
18	**7.100.3(d)(1)** Vermont Legal Aid indicated appreciation of the inclusion of the revised language clarifying the use of the standard error of measurement in testing for determining eligibility based on diagnosis of intellectual disability.	The Department appreciates the positive feedback.
19	**7.100.3(d)(1)** A staff person from a provider agency indicated that description of eligibility is clear and helpful. In terms of IQ and VT Supreme Court decision, her agency has had a number of applicants that now qualify for services due to that change. So, the change mattered.	The Department has been following the Supreme Court ruling in its eligibility determinations since the decision was made in 2019. The changes in the *Rule* were made to codify the current practice in eligibility determinations.
20	**7.100.3(d)(1) and 7.100.3(k)** A parent said the	The Department appreciates the

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	allowing for consideration of the standard error of measurement in IQ testing and adaptive behavior assessment was helpful.	positive feedback.
21	**7.100.3(d)(1)** A service provider noted that the increase of IQ standard expands who is eligible and is concern that this will lead to a resource crunch.	The proposed change to the *Rule* does expand who could be eligible for services and increase pressure on the available program budget. The Department shares this concern but is required to follow the Supreme Court ruling. To date, as noted in the filing of the proposed *Rule,* the Department has not experienced a significant increase in applicants who are eligible based upon the change and the financial impact has not been significant to date. No change will be made based on this comment.
22	**7.100.3(i)(5)** requires that evaluations for children under 6, a "developmental-behavioral or neurodevelopmental disabilities pediatrician or pediatric neurologist shall perform the assessment or be part of the assessment team". A licensed psychologist commented that this is not currently practical due to lack of clinicians with those qualifications in VT. He believes that licensed psychologists or psychiatrists are appropriate to make diagnoses of autism spectrum disorders for young children.	The Department agrees with this recommendation and that the remaining qualifications of evaluators listed in **7.100.3(i)** are adequate to ensure that evaluators have the appropriate qualifications to render autism spectrum diagnoses for young children. The department will strike the following sentence from **7.100.3(i)(5)**: "For evaluations of children from birth to age six, a developmental-behavioral or neurodevelopmental disabilities pediatrician or pediatric neurologist must perform the assessment or be part of the assessment team."
23	**7.100.3(j)(1)** indicates that evaluations to determine whether a person has an autism spectrum disorder should be based on a "comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history." A licensed psychologist suggested that language be added to	The Department agrees with this recommendation and will add **7.100.3(o):** "(o) Missing information to document developmental disability

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	address when the historical information cannot be found, even after repeated requests to acquire it.	There may be circumstances in which considerable effort is made to obtain all the required history and documentation to determine whether a person has a developmental disability, but the required information cannot be obtained. This may include situations in which there are no available informants to document a person's functioning prior to age 18, previous records cannot be obtained, or do not exist. In these circumstances, the determination of whether the person meets the criteria for having a developmental disability should be based upon the current assessment and all available information, including other life factors that occurred after age 18 that could potentially impact cognitive, adaptive, or other functioning."
	7.100.4 Recipient Criteria – general comments	
	No general comments were received.	
	7.100.4 Recipient Criteria – comments by section	
24	**7.100.4 (b)** A parent commented that "Subsection (b) cross-references 7.100.2(ff)(1). Again, if an individual is considered to maintain Vermont residency when the individual resides in an adjoining state, that individual should have that same consideration for a residential community in an adjoining state." Another parent endorsed this comment.	See response to comment #13.
	7.100.5 Application, Assessment, Funding Authorization, Programs and Funding sources, Notification, Support Planning and Periodic Review – general comments	
	There were no general comments.	
	7.100.5 Application, Assessment, Funding Authorization, Programs and Funding sources, Notification, Support Planning and Periodic Review – comments by section	
25	**7.100.5(d)(1)(B)** The Vermont Developmental Disabilities Council recommends: "The State must provide a Notice of Rights for HCBS recipients – in plain language – detailing the rights enumerated in the settings and person-	The Department agrees that applicants and recipients must be notified of their rights outlined in the CMS HCBS rules. We agree to add to

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	centered-planning rules and include it in the Rules."	**7.100.5(d)(1)(B)**, which relates to initial screening, as follows: "Notifying the applicant of the rights of recipients in plain language, including the procedures for filing a grievance or appeal and their rights as outlined in the federal CMS HCBS rules;" and add to **7.100.5(l)(3)** which relates to the annual review process with the recipient, as follows: "As part of the periodic review, the agency or Supportive ISO must ask each recipient about his or her satisfaction with services, and provide each recipient and individual's authorized representative with an explanation of the rights of recipients, including those outlined in the federal CMS HCBS rules, and how to initiate a grievance or appeal (See 7.100.9 and 8.100)." And add to **7.100.6(d)(3)(G)**, which relates to tasks of a QDDP for people who self or family manage as follows: "Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996 and the rights outlined in the federal CMS HCBS rules; and" and add to **7.100.10(d)(4)(A)**, which relates to pre-service training of workers as follows: (A) Individual rights, as specified in 18 V.S.A. §8728 and as outlined in the federal CMS HCBS rules:"

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		and add to **7.100.11(b)(1)(C)**, which relates to the certification of providers, as follows: "Provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728) and the rights outlined in the federal CMS HCBS rules."
26	**7.100.5(f)** This section indicates that when authorizing services, the authorization must be based on the most cost-effective method of meeting a person's needs. A family, including a person with DD, commented "Provide services including housing options that are based on a client's needs and not just on the lowest cost option of providing a specific service."	As indicated in **7.100.5(e)**, a person's plan of services must be based upon an assessment of need. **7.100.5(f)** does indicate that the authorization of funding must be based on the most cost-effective method of meeting the person's needs. The last sentence in this section indicates "When determining cost effectiveness, consideration will be given to circumstances in which less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful." Cost-effectiveness considers both the cost and the anticipated effectiveness of services. So, the lowest cost option is not always the one that is most cost-effective. The Department has the responsibility to ensure that it manages the DDS program within its legislatively appropriated budget. Removing the language in this section related to cost-effectiveness would impact the Department's ability to manage within available funding. Additional funding would be needed to remove the language related to cost-effectiveness.

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		That being said, the Department is committed to expanding supported housing options and exploring the necessary resources to expand options. Additional work will be needed regarding how to balance offering meaningful choices for service options and managing within available funds. No change to the *Rules* will be made at this time.
27	**4.7 of current Regulations.** Vermont Legal Aid objects to the removal of section 4.7 of the current regulations that describes the programs and services available within DDS. Although Act 186 no longer requires the eligibility and access criteria to be established in rule, *nor does it prohibit* leaving this section in place as it is. Given that the System of Care Plan and these regulations operate in tandem, there is no burden to leaving them in place in the regulations and including them in the System of Care Plan. This improves access to understanding the available programs, to have them exist in both documents. Even beneficiaries and family members who are long-time users of the programs are often unaware of the System of Care Plan. Limiting their placement to only one of these two documents that govern these programs is, in our view, less transparent. The notice and comment process, and the oversight of LCAR regarding these criteria, is to the benefit of our system, and we request that the Department choose to leave Section 4.7 in place.	The Department disagrees with this recommendation. Act 186 removed the requirement to adopt certain categories of the System of Care Plan through the rulemaking process. The intention of the change was to allow the Department to make changes in those categories without going through the lengthy rulemaking process. The DD Act requires the Department to submit proposed changes to the System of Care Plan to the DDS State Program Standing Committee for recommendations. The Department also seeks robust stakeholder input prior to developing the draft Plan, publishes the draft Plan, holds public hearings and solicits written comment during a public comment period. The Department believes this is a sufficient public input process. The Department believes that the *Rules*, with this proposed change, are sufficiently transparent regarding the available programs and funding sources. Section **7.100.5(g)** specifies that the available programs and details related to

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		eligibility for these programs are described in the DDS System of Care Plan. Both the *Rules* and the System of Care Plan can be located on the Division website. No change will be made based on this comment.
28	**7.100.5(i)(2)(D)** An internal DDSD staff and the DS Directors recommend that this section be amended as follows: "If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based Services funding, the notice shall state that the DA shall continue to offer information and referral services and shall place the person's name on a waiting list."	The Department agrees with this recommendation. This is clearer, as meeting funding priorities relates only to Home and Community-Based Services. **7.100.5(i)(2)(D)** will be amended as follows: "If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based Services funding, the notice must state that the DA will continue to offer information and referral services and will place the person's name on a waiting list (Section 7.100.5(q))."
29	**7.100.5(j)(1)(E)** says "A recipient or family may request that an agency sub-contract with a non-agency provider to provide some or all of the authorized services; however, the decision to do so is at the discretion of the agency." This language is currently in Subsection 4.10(a)(5) of the 2017 Regulations. This subsection should include language that makes it clear that an agency's consent to a family's request to have services provided through a subcontract with a non-agency provider must not be unreasonably withheld. The Regulations should be clear that if an individual or family wants services provided through a non-agency provider, then the presumption should be that the agency will enter such a subcontract, and the agency's discretion not to subcontract should only be exercised in the event that there is a reasonable basis to conclude that the sub-contractor is unable to comply with the	The denial of a beneficiary's request to obtain services from a non-agency provider outside the network, **when made by the Medicaid Program,** *is* an adverse benefit determination, to which appeal rights attach. Here, however, a DA/SSA, in refusing to subcontract with an out of network provider, is acting as a service provider, not as the Medicaid Program. In order to provide services, providers are required to be certified as specified in **7.100.11**. Any entity wanting to provide DD services can submit a request to become certified. Certification allows the Department to verify that providers meet certain standards

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	applicable programmatic requirements. Additionally, there should be clear language that if an agency refuses to enter into a contract with a non-agency provider, then the individual or Authorized Representative (e.g., parent/guardian), may appeal the refusal to subcontract to the DDSD Director. Another parent endorsed this comment.	in the provision of services. Certified providers can sub-contract with other providers, but sub-contracting is arrangement between a certified provider and the sub-contractor. The *Rules* requires that certified providers retain responsibility for their sub-contractors in following all requirements of the program. However, the Department cannot require a provider to enter into a sub-contract with another entity. No change will be made based on this comment.
30	**7.100.5(j)** A family, including a person with DD, and the Developmental Disabilities Housing Initiative commented "Eliminate the provision that a DA/SSA can refuse to subcontract with a family or recipient who desires that their authorized services be provided by a non-agency." "Currently, granting such a request is "at the discretion of the agency (DA/SSA)."	See response #29.
31	**7.100.5(j)(2)** Developmental Disabilities Housing Initiative recommends: Include and/or clarify that HCBS funding can be used for out-of-state authorized services, including housing, if the recipient's "needs are so specialized" that no provider within the recipient's geographic area can accommodate the recipient's needs.	If all other state and federal requirements are met, services may be provided by a provider outside the geographic region, but the availability of home supports is subject to Medicaid residency requirements, as outlined in HBEE Rule 21.00, et seq. See response to comments # 13 and #14. The Department recommends no changes to this subsection.
32	**7.100.5(j)(3)(A)** A parent recommends a change to the language in this section so that if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider shall submit a budget to the DA and the DA shall determine its costs to serve the individual, **and the individual will have the choice of which of the services they would prefer not based completely or only, on the lowest possible cost.**	See response to comment #26 related to funding of the most cost-effective option. The State maintains a Designated Agency system for the provision of DDS. The purpose of this system is to ensure that there is at least one provider of DDS in a geographic

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	The parent further notes: a. The previous rule wording does not support the individual having choices in housing because the lowest possible housing cost is the SLP, and the cost is so low that it does not provide adequate financial support for any other housing choices. b. This is particularly true for any individual needing 24/7 service and supports. c. One reason that 90% of adults receiving Home Supports are in Shared Living is because it is the least expensive to the DAs and the State. The Adult Foster Care payments to Shared Living Providers are exempt from income taxation under Section 131. Additionally, the "operations and maintenance" costs of the real estate is not the responsibility of the DAs. d. Creating new, sustainable, housing options has to recognize that the current lack of choice is directly tied to inadequate funding for DD services for decades. e. The fact that Group Living and Staffed Living are more expensive ignores the fact that they are more expensive because the people served in those models have the highest needs. They are also more expensive because both of those models operate entirely on shift-staff.	region who is required to serve eligible individuals. It was set up this way due to VT being a small rural state with a limited number of available providers. Expectations and reimbursement for those services are outlined in Provider Agreements between the State and the Designated Agencies. The Department authorizes funding for individuals based upon their assessed needs and costs associated with the Designated Agency to meet those needs. The Department is obligated to manage within the funds allocated by the legislature. Allowing a recipient to choose a higher cost service when the Designated Provider can provide it at a lower rate would not allow the Department to manage its available funds. One of the future goals of the Department, through the DDS Payment Reform project is to create uniform rates for services so that the state pays the same amount to all providers for a particular service. It is anticipated that this will allow for leveling the playing field across providers and make it easier for recipients to choose another provider outside their Designated Agency. It is acknowledged that the current structure of the system has led to Shared Living as the only home support option offered for most people who require 24 hour supports. As noted previously, the Department is committed to expanding home support options

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		as required by Act 186. No change will be made in response to this comment.
33	**7.100.5(q)** An internal DDSD staff and the DS Directors recommend that the first sentence in the introductory paragraph of this section be amended to apply only to Home and Community-based Services when the person's whole requested plan is denied because the person's needs do not meet a funding priority. The designated agency would be responsible for maintaining that waiting list.	The stated intent of the proposed changes to the **7.100.5(q)** was to streamline the information collected on the waiting list to that which is meaningful and useful. The Department agrees that the current level of detail in this section is not helpful in identifying people's unmet needs. The Department will amend this section as follows: "A person with a developmental disability whose application for Home and Community-Based Services, Flexible Family Funding or Family Managed Respite is denied must be added to a waiting list maintained by the Designated Agency. The Designated Agency must notify an applicant that his or her name has been added to the waiting list and explain the rules for periodic review of the needs of people on the waiting list. (1) The Division will provide instructions to the Designated Agencies for reporting waiting list information to the Division. (2) Each Designated Agency must notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list must occur: (A) When there are changes in the funding priorities or funds available; or (B) When notified of

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		significant changes in the individual's life situation (3) Waiting list information will be included the DDS Annual Report and will be reviewed annually by the DDS State Program Standing Committee.
34	**7.100.5(q)(1)(A)** An internal DDSD staff and the DS Directors recommend not including those already receiving services from being added to the waiting list when their request for additional HCBS is denied, either in whole or in part. The rational provided in follow up to the feedback was that the annual periodic review process for people currently receiving services provides an opportunity for determining if the person's circumstances have changed or of the funding priorities have changed that would then warrant approval of additional services.	The Department agrees that there is a process for following up with individuals who are current recipients to determine if their needs have changed or whether a change in funding priorities would warrant additional funding. This process is the annual periodic review of people's needs that is required. However, it is not known whether all stakeholders would agree that the information about current recipients being denied additional funding should not be collected. That is the rationale for the annual review by the DDS State Program Standing Committee, as noted in the response to comment #33. The Department agrees to strike this section and amend section **7.100.5(q)** as noted in the response to comment #33.
35	**7.100.5(q)(1)(C)** An internal DDSD staff and the DS Directors recommend not requiring that a waiting list be maintained for people eligible for Targeted Case Management who are denied due to insufficient funds.	The Department agrees with the recommendation to not maintain a waiting list for people requesting Targeted Case Management. There have been no people on this waiting list for many years. There have been sufficient funds to meet the needs of people needing this service and there is a mechanism for providers to request additional funding if needed. The Department agrees to strike this section as noted in response to comment #33.

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36	**7.100.5(q)(1)(E)** An internal DDSD staff and the DS Directors recommend not requiring that a waiting list be maintained for people eligible for the Post-Secondary Education Initiative who are denied due to insufficient funds or lack of capacity for additional students.	The Department agrees with the recommendation to not maintain a waiting list for people requesting Post-Secondary Education Initiative services. There have been no people on this waiting list for many years. There have been sufficient funds to meet the needs of people requesting this service and there is a mechanism for providers to request additional funding if needed. The Department agrees to strike this section as noted in response to comment #33.
37	**7.100.5(q)(2)(A)** An internal DDSD staff and the DS Directors recommend not requiring individuals on the waiting list be reviewed annually, but instead only when there are changes in funding priorities or funds available or when notified a significant change in a person's circumstances.	The Department agrees that an annual review of the waiting list is not needed as the only time a different decision could be made would be if the other two criteria listed in **7.100.5(q)(2)(B) & (C)** are met. The Department agrees to strike this section and re-label **7.100.5(q)(2)(B) & (C)** to **7.100.5(q)(2)(A) & (B)** as noted in response to comment #33.
	7.100.6 Self/Family-Managed Services -general comments	
38	**7.100.6** A number of parents recommended that the prohibition on Self/Family Management of 24-hour home supports should be eliminated. One parent noted "That 8-hour limitation is an arbitrarily imposed barrier to creating alternative, sustainable housing options for individuals and families. Whatever the "problematic" situations were that led to the 8-hour limitation being imposed by a memo in 2005, and then jammed into the 2011 DD Regulations over the unanimous objection of all public commenters, are not a legitimate basis to prohibit all individuals or families from managing 24-hour Home Supports. The fact that there was a recent horrible situation of abuse and neglect in the Shared Living Provider Program does not mean the DDSD is going to ban	The Department does not agree with the recommendation to eliminate the 8 hour a day limitation on home supports for those who are self or family managing their services. However, the Department agrees to raise the limit to 12 hours of day of Home Supports in the categories of In-Home Family Supports and Supervised Living. Home Supports include the following areas: • In-home Family Supports • Supervised Living • Staffed Living • Group Living

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	all Shared Living Providers. It is the DDSD's job, and the Supportive ISO's job, to administer the Self/Family Management Program. There is a process to terminate individuals or families from the management of services. If the individuals or families are not up to the task, then those individuals or families can have their ability to manage services taken away. It should be no different when it comes to management of 24-hour services. Another parent reiterated this point indicating "The DD Regulations are currently clear: "In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in Section 7.100.6(b)." Because the 8-hour Home Support limitation should finally be eliminated, and the ability to manage 24-hour Home Supports should be restored as it existed before March of 2005, then the requirement in the current 2017 Regulations, Section **5.2(m)** should be reinstated ("Follow the requirements of the Housing Safety and Accessibility Review Process to ensure that the individual is living in a safe and accessible home."). Another parent endorsed this comment.	• Shared Living • Remote Supports • Home Modifications Remote Supports and Home Modifications are not hourly services, so the rule does not apply to these services. Staffed Living and Group Living are defined as services staffed by providers (see 7.100.2(bb) for definition of "provider"). As such, they cannot be self or family managed. Shared Living providers/foster families are contracted home providers and are generally compensated through a "Difficulty of Care" foster care payment. According to IRS rules (26 U.S Code §131), difficulty of care payments may be excluded from the Shared Living providers income when the person with the disability is placed in the home of the provider by a "Qualified Foster Care Placement Agency." These agencies are defined as entities that are licensed or certified by a State or political subdivision thereof, or an entity designated by a State or political subdivision thereof, for the foster care program of such State or political subdivision to make foster care payments to providers of foster care." Transition II, the Supportive ISO for individuals and families who are self/family managing, is not a designated as a Qualified Foster Care Placement Agency. Their responsibilities as a Supportive ISO does not include screening and monitoring of

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		Shared Living providers. They are not certified to provide direct services as are the DA/SSAs. The Department also believes that for the purposes of ensuring health and safety and compliance with all rules and guidelines applicable to Shared Living arrangements, placements must be made by certified providers. It is acknowledged that abuse and neglect have happened in Shared Living arrangements that are overseen by certified providers. This oversight does not prevent all incidents from occurring but provides the structure for monitoring health and safety and quality of supports. In a self/family management arrangement, there would not be an entity to provide oversight outside the family. The Department is not willing to allow for self/family management of Shared Living at this time. The Department agrees to change the rules to allow for up to 12 hours a day of In-Home Family Support and Supervised Living to be self or family managed. It should also be noted that depending on the assessed needs of the individual, other categories of service may be authorized and can be self/family managed, such as Community Supports, Employment Supports and Respite which can provide additional hours of support per day. The final sentence in the first

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		paragraph of **7.100.6** will be amended as follows: "An individual or a family member may manage up to 12 hours a day of In-home Family Supports or Supervised Living, but may not self/family manage Staffed Living, Group Living or Shared Living."
39	A family, including a person with DD, and the Developmental Disabilities Housing Initiative commented: "Self and family management only allows for 8 hours/day of paid in-home supports and we believe the state should allow for family management of 24/7 paid in-home supports."	See response to comment #38.
	7.100.6 Self/Family-Managed Services – comments by section	
	No comments by section were received.	
	7.100.7 Recipient financial Requirements	
	No comments were received.	
	7.100.8 Special Care Procedures – General comments	
	No general comments were received.	
	7.100.8 Special Care Procedures - comments by section	
	No comments by section were received.	
	7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings - general comments	
40	Vermont Legal Aid has grave concerns about the failure to describe the process for Grievance, Internal Appeals and Fair Hearings. The HCAR regulations at 8.100 have their own difficulties in not stating a clear path for DD applicants and recipients. The HCAR rule defines how to grieve and appeal from a decision of a "Medicaid Program." A "Medicaid Program" can be DVHA, DAIL, a Designated Agency, a Specialized Agency, or a subcontractor. HCAR 8.100.2(g). The first level of appeal is the Internal Appeal. HCAR 8.100.4. In the DD context, an internal appeal may, depending on the circumstances, be an appeal to the Designated or Specialized Services Agency, to ARIS or Transitions II, or it may be a Commissioner's Review with the DAIL Commissioner or her designee. However, these terms are entirely absent from the HCAR rule, and it only refers to the Internal Appeal from the "Medicaid Program". As the HCAR rule is	The proposed language complies with the requirements of 18 V.S.A.§ 8726(a)(5), which directs the Department to adopt rules that include "[c]omplaints and appeals, including notice as required in section 8727 of this title." More specifically, the content of HCAR 8.100 fully and strictly complies with the requirements of 42 CFR Part 438, subpart F. Nothing contained therein requires, in rule, the level of specificity requested by this commenter; rather, what is required is a notice that includes an explanation of the right to request an appeal and the identification of the entity to which the request should be

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	currently written, it is often unclear to whom, among these various entities, an internal appeal must be directed. It is also unclear who are the "parties" representing the adverse decision in the internal appeal and the Fair Hearing. HCAR 8.100.4(j); 8.100.5(i). Is DAIL or the Designated Agency the one representing the position to deny, reduce or terminate? For families and individuals who self-, family- or shared-manage the appeals process becomes even cloudier. We appreciate that the Division will develop a plain language guide to grievances, internal appeals, and fair hearings. However, a plain language document can only be written after the Division has identified the process through regulations. In multiple conversations with stakeholders, agencies, and division staff, stakeholders who use these processes do not agree on how and when each of the processes should work, and that is because DAIL has not spelled it out.	directed. Notices provide the applicant or recipient instructions as to how to contact the entity responsible for hearing the internal appeal. Notices of determination issued by the entity hearing the internal appeal include, among other things, information as to how the applicant or recipient may request a fair hearing with the Human Services Board. The Department appreciates this request for the inclusion of such detail, and, as such, has offered to prepare and make available the referenced "plain language document." The Department's approach of simply incorporating (by reference) HCAR 8.100, however, will avoid the need to amend HCAR 7.100 if there are changes to 42 C.F.R. Part 438, subpart F (and, in turn, HCAR 8.100). No change to the *Rule* is being made in response to this comment.
41	A parent indicated that she did not know what the appeal information means and that it is confusing. She recommended that plain language information regarding filing grievances and appeals is important and needed for individuals and families. She noted that there is a lag time with providers disseminating information and that even the agencies do not fully understand the rules.	The Department is currently in the process of developing a plain language guide for filing grievances and appeals. The proposed *Rules* would require this information to be provided to applicants, recipients and their authorized representatives in plain language at initial intake, whenever decisions are made regarding services, and at least annually. See also response to comment #41.
	7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings – comments by section	
	No comments by section were received.	
	7.100.10 Training – general comments	
42	Vermont Developmental Disabilities Council	The proposed *Rule* includes

#	Public Comment Received	Department Response
	recommends that "the training section can be amended so that .....employees and contractors receive training on formal and informal methods of supported decision making and serving as supporters in a more formal supported decision-making agreement if they so choose."	reference to supported decision making in pre-service (**7.100.10(d)(4)(E)**) and in-service (**7.100.10(e)(1)(B)**) training. The other training areas listed in **7.100.10** reference broad areas and do not provide details regarding the content of that training. The Department does not believe this level of detail is appropriate in *Rule*. This allows for training on a subject to evolve with changing best practice without the necessity of changing the *Rule*. No further changes will be made based on this comment.
43	VT Developmental Disabilities Council recommends that knowledge of Person-centered planning and settings rules requirements be added to training requirements.	The Department agrees with this recommendation and as noted in comment #25, agrees to add to **7.100.10(d)(4)(A)**, which relates to pre-service training of workers as follows: "Individual rights, as specified in 18 V.S.A. §8728 and as outlined in the federal CMS HCBS rules:" The CMS HCBS rules include requirements regarding services settings and person-centered planning.
	7.100.10. Training – comments by section	
44	**7.100.10(e)(1)(B)** Vermont Legal Aid appreciates the inclusion of language for in-service training in supporting communication and decision-making.	The Department appreciates the positive feedback.
45	**7.100.10(d)(3)(D)** Vermont Communication Task Force recommended that this section be amended as follows: "Methods of communication used by the individual including tools, technology, and effective partner support strategies"	This feedback had been provided prior to filing the current draft and had previously been incorporated into the current proposed *Rule*.
46	**7.100.10(d)(4)** Vermont Communication Task Force recommended adding the following to the list of values for pre-service training of workers "Presumption of Competence: a strength-based	The Department agrees with this recommendation. **7.100.10(d)(4)(F)** will be added as follows:

#	Public Comment Received	Department Response
	approach that assumes all people have abilities to learn, think, and understand."	"(F) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand."
47	**7.100.10(e)(1)** Vermont Communication Task Force recommended that "contractor" be added to the list of employers of record who are responsible for providing or arranging for in-service training.	The Department agrees with this addition. The third sentence in **7.100.10(e)(1)** and the second sentence in **7.100.10(d)** will be amended to include "contractor" in the list of employers of record: "The employer of record, whether recipient, family, shared living provider, contractor or agency, is responsible for providing or arranging for this training for their workers."
48	**7.100.10(e)(1)(B)** Vermont Communication Task Force recommended the first sentence of this section be amended as follows: The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support methods of communication used by the recipient).	The Department agrees with this recommendation. The first sentence in **7.100.10(e)(1)(B)** will be amended to read: "The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support methods of communication used by the recipient, and supporting decision making)."
	7.100.11 Certification of Providers – general comments	
	No general comments were received.	
	7.100.11 Certification of Providers –comments by section	
49	**7.100.11(e)(2)** Vermont Developmental Disabilities Council recommends "The certification section can be amended so that the guidelines for quality review incorporate adoption of supported decision-making approaches, and providers report on how supported decision making is incorporated into ISAs, and how many beneficiaries served are using some form of supported decision making, just as ISAs reflect supervision needs and communication	The Department disagrees with this recommendation. The proposed rule in this section has been amended to include receiving "support in decision making, when needed." The details regarding how providers are meeting the quality standards are included in the

#	Public Comment Received	Department Response
	support.	*Guidelines for the Quality Review Process of Developmental Disabilities Services.* These guidelines, rather than the *Rule,* would be the place to incorporate those details. What providers are required to report to the Department is outlined in the Provider Agreements between the Departments and Providers. As what is meaningful and useful data evolves over time, it is not included in *Rules.* The Department agrees with the recommendation that ISAs include a section related to support around decision making, however, this should be included in an update of the *Individual Support Agreement Guidelines* rather than in this *Rule*. The Department will consider how to incorporate supporting decision making in the next revision of the ISA Guidelines. No changes to the *Rules* are being made based on this comment.
50	**7.100.11(e)(2).** Vermont Legal Aid is glad to see that certification quality standards include that individuals receiving services will "receive support in decision-making when needed".	The Department appreciates the positive feedback.
51	**7.100.11(e)(2).** The Committee on Guardianship and Supported Decision Making recommended that the principles of supported decision making be incorporated into the Quality Standards for Services for certified providers.	Department has added language to **7.100.11(e)(2)** to include supported decision making in the proposed *Rule*. The Department does not believe that the details regarding the principles of supported decision making should be delineated in this section of the *Rule.* As noted in the response to comment #49, these details are more appropriate for the

#	Public Comment Received	Department Response
		Guidelines for the Quality Review Process of Developmental Disabilities Services rather than the *Rule.* In addition, supported decision making is included in the proposed *Rule* in the required pre-service training of workers **(7.100.10(d)(4)(e))** and in-service training **(7.100.10(e)(1)(B).** The principles would appropriately be incorporated into these trainings on supported decision making. No further changes to the rule are being made in response to this comment.
52	**7.100.11(f)(1)** A parent said to see his comment related to 7.100.5(j) (#29 above). He noted that **7.100.11(f)(1)** should mirror his recommendation regarding subsection **7.100.5(j)** and be made clear that there is a presumption that the agency will enter a subcontract with a non-designated organization, and the discretion not to subcontract with a non-designated organization will only be exercised if there is a reasonable basis to conclude that the subcontractor is unable to comply with the applicable programmatic requirements. Another parent endorsed this comment.	See response to comment #29. No change will be made in response to this comment.
	7.100.12 Evaluation and Assessment of the Success of Programs – general comments	
53	The Vermont Developmental Disabilities Council recommends "Quality reviews and monitoring of compliance with HCBS rules should be increased to significantly more than a 15% review every 2 years and set out in the Rules."	The Department disagrees with this recommendation. Section 7.100.12(a) specifies that providers will be reviewed according to the *Guidelines for Quality Review Process for Developmental Disabilities Services*. That document spells out the frequency and percentage of people to be reviewed. The frequency and percentage are based upon what can be reasonably done with the existing staffing resources in the Division. While the Department

#	Public Comment Received	Department Response
		recognizes the benefit of expanding the frequency and percentage of those reviewed, doing so would require additional resources which is legislative budget issue. The Department cannot commit in the *Rule* to activities for which we do not have identified resources. Act 186, which was passed in most recent legislative session requires the Department to provide a report to the legislature regarding resources needed to expand the frequency of quality reviews of providers. This issue will be considered in the Legislature. If additional resources become available, the Department will modify the frequency and percentages identified in the *Guidelines for Quality Review Process for Developmental Disabilities Services.* No change in the *Rule* will be made in response to this recommendation.
	7.100.12 Evaluation and Assessment of the Success of Programs – comments by section	
	No comments by section were received.	

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

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1. TITLE OF RULE FILING:
   Disability Services-Developmental Services
2. ADOPTING AGENCY:
   Agency of Human Services (AHS); Department of Disabilities, Aging, and Independent Living (DAIL)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE .**

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):
   SOS Log#: 17-052, Regulations Implementing the Developmental Disabilities Act of 1996, October 1, 2017.

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Kristin L. Clouser, Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: August 8, 2022, virtually via Microsoft Teams
Members Present: Chair Douglas Farnham, Brendan Atwood, Diane Bothfeld, Jennifer Mojo, John Kessler, Diane Sherman, and Michael Obuchowski
Members Absent: Donna Russo-Savage and Jared Adler
Minutes By: Melissa Mazza-Paquette

- 2:02 p.m. meeting called to order, welcome and introductions.
- Review and approval of minutes from the July 11, 2022 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- Public comment:
  - Robb Kidd, Sierra Club, emailed letter to ICAR members on 08/03/22 pertaining to the Vermont Low and Zero Emission Vehicle Regulations proposed rule.
- Presentation of Proposed Rules on pages 2-5 to follow.
  1. Vermont Low and Zero Emission Vehicle Regulations, Agency of Natural Resources, pages 2-3
  2. Rules Governing the Licensing of Educators and the Preparation of Education Professionals, Vermont Standards Board for Professional Educators, page 4
  3. Disability Services-Developmental Services, Dept. of Disabilities, Aging and Independent Living, page 5
- No other business
- Next scheduled meeting is Monday, September 12, 2022 at 2:00 p.m.
- 4:05 p.m. meeting adjourned.

Proposed Rule: Disability Services-Developmental Services, Dept. of Disabilities, Aging and Independent Living

Presented By: Stuart Schurr

Motion made to accept the rule by Diane Sherman, seconded by Diane Bothfeld, and passed unanimously except for Brendan Atwood who abstained, with the following recommendations:

1. Proposed Filing – Coversheet, #5: Include language for (c) (1).
2. Proposed Filing – Coversheet, #8: Indicate what the term DD Act means. Clarify eligibility.
3. Proposed Filing – Coversheet, #12: Include positive economic impacts to families.
4. Proposed Filing – Coversheet, #14 and 15: Complete once identified.
5. Economic Impact Analysis, #6: Clarify.
6. Public Input, #4: Include Vermont Legal Aid.
7. Proposed Rule, 7.100.1: Cite authority to include the specific statutory provision.
8. Proposed Rule, 7.100.2: Define 'school aged child'.
9. Proposed Rule, 7.100.3 (d)(1): Include additional details for clarity.
10. Proposed Rule, 7.100.3 (f)(4): Include language referencing up to 75 or define up above as 5% of the IQ score.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

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1. TITLE OF RULE FILING:

   Disability Services-Developmental Services

2. ADOPTING AGENCY:

   Agency of Human Services (AHS); Department of Disabilities, Aging, and Independent Living (DAIL)

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   On March 10, 2022, the Commissioner of DAIL distributed to the members of the State Program Standing Committee (SPSC), the advisory board established in 18 V.S.A. § 8733, an initial draft of the proposed rule, for advice and recommendations. As requested by the advisory board in February, 2022, a plain language document explaining the proposed changes was developed and shared with the board on March 10, 2022. During the SPSC meeting on March 17, 2022, DAIL staff and the SPSC members reviewed and discussed the draft. The SPSC members offered comments and suggested some changes. The SPSC was given an additional 30 days to provide any additional advice or recommendations in writing to DAIL. On April 18, 2022, Vermont Legal Aid (VLA), which is represented on the SPSC, submitted to DAIL a number of recommended changes to the proposed draft. No other written comments were received from the SPSC. The recommendations from VLA and the SPSC were reviewed by

DAIL staff, and a number of them were adopted and incorporated into the proposed rule.

Following ICAR review, the proposed rule was filed with the Secretary of State's Office, at which time DAIL sent information regarding the proposed rule and public comment period to the following organizations: Vermont Care Partners, Developmental Disabilities Services Agency Directors, Designated Agency Executive Directors, the DDS State Program Standing Committee, Vermont Family Network, Green Mountain Self-Advocates, the DAIL Advisory Board, Vermont Coalition of Disability Rights, Vermont Legal Aid, Vermont Developmental Disabilities Council, and Vermont Center for Independent Living. The proposed rule was posted on the DAIL website, and two (2) virtual public hearings were held. In addition, DAIL invited the public to submit written comments on the rule during the public comment period.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Prior to drafting the proposed rule changes, DAIL consulted with two licensed psychologists with expertise in the diagnosis of intellectual disability. DAIL also met with Agency of Education staff involved with early education programs for children under age 6. The purpose was to align eligibility criteria to the extent feasible to streamline processes for families across state programs. DAIL also met with staff from provider agencies to get feedback on a draft of the proposed changes.

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

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1. TITLE OF RULE FILING:

   Disability Services-Developmental Services

2. ADOPTING AGENCY:

   Agency of Human Services (AHS); Department of Disabilities, Aging, and Independent Living (DAIL)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Those potentially affected by the adoption of this rule include:

   Individuals with developmental disabilities and their families, who may benefit from the expansion of the eligibility criteria for accessing services. DAIL has already made the change in eligibility criteria, which has resulted in an average of one (1) additional person per month receiving Home and Community-Based Services, at an annual benefit of $39,393 per person. There are several other smaller programs in DDSD, for which 18 additional people have become eligible since 2019. The costs for these services are negligible and have been absorbed into the existing programs.

Developmental Disabilities Services providers (i.e., Designated and Specialized Services Agencies), which are paid to provide these services. While additional revenue is generally viewed positively by providers, they are currently experiencing unprecedented staff shortages, making the delivery of these additional services a challenge. It is unclear if and when these staffing issues will be resolved.

The proposed changes to the eligibility criteria for people ages six and up have the potential for increasing the number of people who are eligible for DDS, which would place increased pressure on the DDSD budget to serve additional people. In response to In re: R.R., 2019 VT 31, DAIL has adjusted its threshold for eligibility from an IQ score of 70 to 75 when accounting for the SEM. DAIL has been monitoring the economic impact of this change in practice since then. An average of one (1) additional person per month has received Home- and Community-Based Services based upon this change, for an average annual cost of $472,727 as of February, 2022. This increase is has already been factored into the budgeting process for DDSD. DDSD has not tracked the costs to serve additional people in some of its smaller programs. The dollar amounts are negligible, and the additional people were served within existing budgets. It is difficult to predict with certainty whether there will be a significant increase in applications for services based upon the change in eligibility criteria, but the data currently available to DAIL indicate that the impact will not be significant. For context, the average annual increase of $474,727 is .19% of the $253 million DDSD FY22 budget. The Office of Public Guardian (OPG), within DDSD, may experience increased referrals for people in need of guardianship. Over time, additional OPG staff may be needed to support an increased caseload. Finally, access to services may have a positive financial impact on some family caregivers by enabling them to enter the workforce or increase their work hours.

4. IMPACT ON SCHOOLS:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact on schools or taxpayers as a result of the change to this rule is anticipated.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

Not applicable, as no impact on local school districts from the changes to the regulations is anticipated.

6. IMPACT ON SMALL BUSINESSES:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

To the extent that Designated Agencies and Specialized Services Agencies may be considered small businesses, the changes in eligibility criteria could, in light of unprecedented staffing shortages, make the delivery of additional services a challenge. No other impact on small businesses is anticipated.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

Designated Agencies are required to serve all eligible consumers in their geographic area and, as such, cannot reduce the burden of compliance. No other impact on small businesses is anticipated.

8. COMPARISON:
COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:

There are no alternatives to the adoption of the rule. Having no rule would violate the DD Act requirement, as set forth in 18 V.S.A. § 8726, to adopt rules for the administration of the Developmental Disabilities Services system.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*

DDSD utilized internal data collection to track the impact of expanding the eligibility criteria. Data were collected in collaboration with provider agencies. Beyond that impact, as noted more fully above, the rule neither increases nor reduces an economic burden on any other person or entity.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

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1. TITLE OF RULE FILING:

   Disability Services-Developmental Services

2. ADOPTING AGENCY:

   Agency of Human Services (AHS); Department of Disabilities, Aging, and Independent Living (DAIL)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact is anticipated.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact is anticipated.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact is anticipated.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   No impact is anticipated.
7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact is anticipated.
8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact is anticipated.
9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   The proposed expansion of eligibility for the provision of community-based care to individuals with disabilities is not anticipated to have an environmental impact.

Finally, SDM takes a collaborative approach to problem-solving, which echoes the partnerships with families, communities, and providers envisioned by DAIL in its principles.[2]

While we are here focused on the Developmental Services System of Care Plan, the need to incorporate SDM as an approach to case management, direct support, and other services, should be incorporated across programs that assist Vermonters with disabilities, including disabilities associated with aging. Beneficiaries of Choices for Care, the TBI program, and CRT also need the opportunity to use supported decision making to retain their right to fully exercise their legal capacity.

Background

Supported Decision-Making is a practice that helps to ensure that a person with a disability can direct their life choices. An individual using SDM identifies a group of people who can assist them with important decisions. The individual decides what types of decisions (financial, vocational, medical, etc.) he or she wants assistance with, and which supporters will help with each type of decision. SDM may be formalized by using a written agreement and/or scheduling periodic meetings; or it may be established more informally as a verbal agreement. Many states now recognize the legal standing of SDM Agreements in statute.

SDM has grown in popularity since the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (entered into force in 2008), which the United States has signed, but not ratified. The CRPD provides for the concept of Equal Recognition in that "State Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." Further, it requires that state parties "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity." [CRPD Article 12]. The Convention also addresses the way individuals with disabilities have been deprived of their legal right to act on their own behalf, simply because of their disability. The purpose of the Equal Recognition provision is to transform a persistent cultural and legal bias that if a person has a disability they should not be allowed to exercise their own capacity. Instead, the Convention presumes in favor of the person with a disability as their own decisionmaker: "Even when an individual with a disability requires total support, the support person(s) should enable the individual to exercise [their] legal capacity to the greatest extent possible, according ot the wishes of the individual."[3] [4]

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[2] See DAIL Mission Statement and Core Principles, https://dail.vermont.gov/DAIL-mission-and-principles

[3] "Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities," Ch. 6, available at http://www.ipu.org/PDF/publications/disabilities-e.pdf (last visited Aug. 2, 2022).

[4] Vermont's guardianship statutory scheme in Titles 14 and 18 of the Vermont Statutes does not empower courts to deprive a person with a disability of their rights to make their own decisions merely because of the existence of a disability. A court must find by the high evidentiary standard of clear and convincing evidence, that a person is

Studies of SDM specifically are limited. However, people with intellectual and developmental disabilities who exercise greater self-determination—who are "causal agents" with more control over their lives—have better life outcomes and a higher quality of life, including being more independent, more integrated into their communities, better problem-solvers, better employed, healthier, and better able to recognize and resist abuse.[5] By contrast, when denied self-determination, people can "feel helpless, hopeless, and self-critical,"[6] and experience "low self-esteem, passivity, and feelings of inadequacy and incompetency" and a "decrease in their ability to function."[7] Although not generalizable given limited number and size, professionally evaluated pilot programs have found that SDM led to positive outcomes for participants, including greater community inclusion, improved decision making skills, increased social and support networks, and increased self-confidence, happiness, and willingness to try new experiences.[8]

Despite this, there have been challenges in developing and implementing supported decision-making agreements here in Vermont. Some Designated and Special Service Agencies have been reluctant to, or have refused to, allow staff or contracted shared living providers to serve as supporters for beneficiaries of services, even when this is the stated preference of the individual. This practice runs contrary to the principles of DAIL and the DDS program.

<u>Recommendations</u>

To remedy the impact of overly broad guardianship arrangements, we propose revisions to the System of Care Plan and to the quality review mechanisms that explicitly incorporate Supported Decision Making in the following ways:

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unable to exercise the powers and duties of a guardian on their own behalf, in the specific areas of guardianship sought, prior to creating a guardianship. The statutory scheme also prohibits creation of a guardianship if a less restrictive alternative (such as supported decision making) would meet the needs of the individual.

[5] Yves Lachapelle, et al., "The Relationship Between Quality of Life and Self-Determination: An International Study," Journal of Intellectual Disability Research 49 (2005): 740–744, as quoted in National Council on Disability, "Beyond Guardianship: Toward Alternatives that Promote Greater Self-Determination" (March 2018), pg. 131.

[6] Shogren, et al., "Relationships Between Self-Determination and Postschool Outcomes for Youth with Disabilities," 256–267; Schwartz and Wehmeyer, "Self-determination and Positive Adult Outcomes," 245–255, as quoted in National Council on Disability, "Beyond Guardianship: Toward Alternatives that Promote Greater Self-Determination" (March 2018), pg. 131.

[7] B.J. Winick, "The Side-Effects of Incompetency Labeling and the Implications for Mental-Health Law," Psychology, Public Policy, and Law 1 (1995): 21, as quoted in National Council on Disability, "Beyond Guardianship: Toward Alternatives that Promote Greater Self-Determination" (March 2018), pg. 131.

[8] Office of the Public Advocate, Systems Advocacy, A Journey Towards Autonomy? Supported Decision-Making in Theory and in Practice, 1–32, February 2014, as quoted in National Council on Disability, "Beyond Guardianship: Toward Alternatives that Promote Greater Self-Determination" (March 2018), pg. 131.

(1) Add a required assurance that, when requested by a beneficiary, assigned staff and contractors, including Shared Living Providers, who are paid by a Designated or Specialized Services Agency (or through the supportive ISO for self- and family-managed individuals) have the discretion to agree to serve as supporters in formal or informal supported decision-making arrangements.

(2) Amend the Section 4(I) of the System of Care Plan to include a description of the philosophy of and mechanism for creating SDM arrangements. This information may be incorporated into the existing service descriptions or broken out as a free standing section in the list of services. In either case, it is important that SDM be presented as one means of assisting beneficiaries under existing billing codes. For example, if a case manager has agreed to be a supporter as part of an SDM arrangement, then the time spent assisting that individual with decisions is part of, and therefore billed as, case management services.

(3) Embed a quantitative and qualitative assessment of the implementation of SDM arrangements in existing quality reviews. Metrics should include the percentage of beneficiaries with SDM arrangements within and outside of guardianship, consumer satisfaction with the implementation of these arrangements, and an analysis of overall consumer satisfaction that compares individuals with and without SDM in terms of self-determination, personal and economic independence, and person-centeredness.

Thank you for considering these recommendations. If you have questions, please direct them to Rachel Seelig at the Disability Law Project and/or Kirsten Murphy at the Vermont Developmental Disabilities Council.

Yours Sincerely,

Kirsten Murphy
Vermont Developmental Disabilities Council
On behalf of the Committee

Rachel Seelig, Esq.
Disability Law Project, VT Legal Aid
On behalf of the Committee

cc. Commissioner Monica White

Enc. Committee Membership

Committee Regarding Guardianship and Supported Decision-Making

Association of Vermont Special Education Adm.	Darren McIntyre
Center for Public Representation	Cathy Costanzo, Esq.
	Morgan Whitlatch, Esq.
Developmental Disabilities Services Division	Jennifer Garabedian
	Jessica Nadeau
Disability Law Project, Vermont Legal Aid	Cammie Naylor, Esq.
	Rachel Seelig, Esq.
Disability Rights Vermont	Lindsay Owen, Esq.
Office of Public Guardian	Heather Allin
	Nathalie Lindgren
Green Mountain Self-Advocates	Max Barrows
	Isabella Carrera
	Lehana Guyette
	Hasan Ko
	Taylor Terry
	Karen Topper
Member at large, evaluator	Kim Allshouse
Vermont Agency of Education	John Spinney
Vermont Developmental Disabilities Council	Susan Aranoff
	Kirsten Murphy
Vermont Family Network	Jamie Rainville

From: j.e.townley1@gmail.com
To: AHS - DAIL DDSD SOCP & Regulations
Subject: SSOCP - Additional Input
Date: Friday, September 16, 2022 10:52:46 AM

Thank you for seeking stakeholder input. A change that I believe is critical to the SOCP and services is for DAIL/DDS to recognize the spectrum of Fetal Alcohol Disorders as a Developmental Disability (like the Federal government does) and services should be available to those that are impacted by this diagnosis. By not including this in the definition of Developmental Disabilities and not providing services / supports to assist, I am aware of many young adults that have transitioned out of high school that have gone off the cliff and are homeless, dealing with significant mental health issues/crises, self-medicating, unemployed, have the potential for committing crimes, and unable to function at a level capable of moving their lives forward in a positive direction. Scaffolding is still needed at 18 and for many years ahead. I strongly suspect that if more services / supports were available in a proactive manner (vs. reactive manner) to those on the fetal alcohol spectrum, there would be improved positive outcomes and a decrease in some of the social-economic issues being experienced today.

Thanks.
-Jenn

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JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Jim Condos, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: April 1, 2022

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Deputy Secretary of Human Services Todd W. Daloz as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedure Act, 3 V.S.A. § 801 et seq.

Cc: Todd W. Daloz

DD Act Regulations Hearing – 10/11/22
Notes taken by June
Participants – 3

- Elizabeth Barker – retired special ed director and a parent of an adult child – Section Eligibility for young child – condition about measurable delays – changed to adaptive self-help skills. Requested explanation as to why change was made.

- Delana Norton – DS Director – Changes to children's eligibility section – clearer than what was there before.

- E Barker – Change to IQ score is helpful.

DD Act Regulations Hearing – 10/19/22
Notes taken by June
Participants – 6

Darlene Jenson – parent of 29-year-old with CP
Shelby Canterbury – HC
Allie Fitzsimmons – HC
Chuck Medick – HC
Barb Prine – DLP
Ann Schumacher – HC

- Shocking not to see the programs listed in the regulations. Unsettling. This detail is what is of the most interest. Concern about ICF no longer an option but that's not for discussion regarding the regs.

- Thank you for supreme court decision regarding IQ.

- Grievance and Appeal – fair hearing section. Referring people to the regular Medicaid regs – which is an internal appeal. It's not clear where and when an internal appeal goes to the various entities. DDSD needs to tell a person which decisions go where (eligibility, equity, ability to self/family manage). Just to say it will be put into plain language, it's an impossible task if the state does say what is meant by internal appeals.

- As parent, I don't know what the appeal information means. It's confusing. Plain language is important. It needs more information as Barb pointed out. There's a lag in when information gets out to everyone. Even the agencies don't fully understand the rules.

- Clarity of eligibility is clear and helpful. In terms of IQ and supreme court decision, HC has had a number of applicants that now quality due to that change. So, the change mattered.

- Clearing up language and having things match is appreciated

- Increase of IQ standard and resource crunches is a concern.

DDSD Regulations Implementing the Developmental Disabilities Act of 1996

Public Comment/Public Input Session

Proposed Changes to the Regs

October 11, 2022

DDSD Attending: Jennifer, June, Hilary, Melanie, Clare, Judy

Attending:

Elizabeth Barker, retired SPED director and parent of adult child with DD

Jen Hayes,

Jessica Moore,

Jennifer McCabe,

Delaina Norton, Director Howard Center

1. Changes to eligibility requirements for young child--

   Elizabeth Barker—eligibility for young child says have to have various conditions. Changed to age 6. Preconditions changed from daily living skills to adaptive self-help skills, what is the reasoning for that?

   Clare--Essentially same types of functional error. Changed to be current with terms that are being used in early childhood ed and family services (?)

   Elizabeth—clarity is good

   Delaina—language is clearer than old regs

2. Change in IQ threshold

   Elizabeth—it's quite helpful because often we have kids who are fairly functional so allowing for raise in adaptive is helpful. My daughter skills can sometimes pop up above thresholds even though she is below 70.

3. Removing Service Descriptions and just having in SOCP

Clare—benefit from our perspective is that the SOCP is easier to update. Any changes to regs need more rigorous review than the SOCP. Allows us to make adjustments quicker than revising the regs.

No comments

4. Clarifying language around roles responsibilities for family management

No comment

5. Strengthening language around training for communication and SDM

No comment

General questions or input, comments.

No comments

Clare provided information for written comments -email and physical address.

Public Hearing re: Reg Implementing the DD Act

Darlene Jenson, Allie Fitzsimmons, Chuck Medick, Barb Prine, Shelby Canterbury, Ann Schumacher

Clare, June, Jennifer

Clare provided overview and major proposed changes to the Regulations

Barb Prine: It is really shocking to not see the programs described in the Regulations. Realize that it is what the law says. It is unsettling. Thanks for the work related to the eligibility. Concerns remain around grievance and appeals sections. Referring to regular Medicaid section doesn't tell people what to do. A plain language group won't tell people when it goes to DAIL, versus when it goes to the agency, versus a contractor.

Completely support crafting a plain language document, but the State hasn't provided a process and policy around where which kind of internal appeals should be targeted through the Regulations that a plain language document would provide assistance with.

Darlene Jensen: Thank you Barb. Realized as Clare was going through slides, didn't understand what everything meant. Really appreciated Barb pointing out that people need to know what tract an issue needs to follow. There is a lag in how information is disseminated to agencies (DAs and SSAs). Was on the committee for H. 720/housing options. Really appreciate that State is taking a closer look at things. Appreciate that there is a lot of hard work happening—really appreciate everything.

Barb: Think that part of the problem is that with the programs being out of the Regs, people are concerned with what the programs are and how they will work.

Clare: Draft of the System of Care is out and posted on the Division's website

Shelby Canterbury: Clarity around age 6/young children. Its simple. Don't do a lot of that, but helpful for FFF. The increased clarity is always helpful. As for the IQ changes, have had a fair amount of increased applications that this impacts.

Ann Schumaker: Clearing up language is always appreciated. Concern—IQ expansion and the resource crunches is always a concern.

Everything else is clear and appreciate the time.

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October 26, 2022

Sent via email only to: Jennifer.Garabedian@vermont.gov

Jennifer Garabedian, Division Director
Developmental Disabilities Services
Department of Disabilities, Aging and Independent Living

Re: Comments on Proposed Changes to Developmental Disability Services Regulations

Dear Jennifer:

Thank you for the opportunity to provide comment on the proposed changes to the Developmental Disability Services Regulations in the Health Care Administrative Rules.

To begin, we are heartened with several of the changes. We appreciate the inclusion of the revised language clarifying the use of standards errors of measurement for determining eligibility.

We also appreciate the inclusion of language for in-service training in supporting communication and decision-making. HCAR 7.100.10€(1)(B). We were glad to see that certification quality standards include that individuals receiving services will "receive support in decision-making when needed". HCAR 7.100.11(e)(2).

That said, we have two ongoing areas of concern.

First, as raised at the hearing on these rule changes, it is startling to see the absence of descriptions of available Developmental Services programs. In our pre-comments, we asked that the ICF/DD not be stricken from the regulations, because it remains a State Plan services that some individuals want to choose, even if it is not currently available within the bounds of the state, and the regulations should remain consistent in explained the state plan and waiver-based programs accessible through DDSD.

Although Act 186 no longer requires the eligibility and access criteria to be established in rule, *nor does it prohibit* leaving this section in place as it is. Given that the System of Care Plan and these regulations operate in tandem, there is no burden to leaving them in place in the regulations and including them in the System of Care Plan. This improves access to understanding the available programs, to have them exist in both documents. Even beneficiaries and family members who are long-time users of the programs are often unaware of the System of Care Plan. Limiting their placement to only one of these two documents that govern these programs is, in our view, less transparent. The notice and comment process, and the oversight of LCAR regarding these criteria, is to the benefit of our system, and we request that the Department choose to leave Section 4.7 in place.

Second, we continue to have grave concerns about the failure to describe the process for Grievance, Internal Appeals and Fair Hearings. The current DD Regulations on Grievance, Internal Appeal and Fair Hearings, at Part 8, are extremely difficult to understand due to the multiple references to the "Managed Care Entity" and the alphabet soup of acronyms. We agree they need to be stricken from the rules.

However, the HCAR regulations at 8.100 have their own difficulties in not stating a clear path for DD applicants and recipients. The HCAR rule defines how to grieve and appeal from a decision of a "Medicaid Program." A "Medicaid Program" can be DVHA, DAIL, a Designated Agency, a Specialized Agency, or a subcontractor. HCAR 8.100.2(g).

The first level of appeal is the Internal Appeal. HCAR 8.100.4. In the DD context, an internal appeal may, depending on the circumstances, be an appeal to the Designated or Specialized Services Agency, to ARIS or Transitions II, or it may be a Commissioner's Review with the DAIL Commissioner or her designee. However, these terms are entirely absent from the HCAR rule, and it only refers to the Internal Appeal from the "Medicaid Program". As the HCAR rule is currently written, it is often unclear to whom, among these various entities, an internal appeal must be directed. It is also unclear who are the "parties" representing the adverse decision in the internal appeal and the Fair Hearing . HCAR 8.100.4(j); 8.100.5(i). Is DAIL or the Designated Agency the one representing the position to deny, reduce or terminate?

For families and individuals who self-, family- or shared-manage the appeals process becomes even cloudier.

We appreciate that the Division will develop a plain language guide to grievances, internal appeals, and fair hearings. However, a plain language document can only be written after the Division has identified the process through regulations. In multiple conversations with stakeholders, agencies, and division staff, stakeholders who use these processes do not agree on how and when each of the processes should work, and that is because DAIL has not spelled it out.

Thank you for your consideration.

Sincerely,

/s/ *Rachel Seelig*
Rachel Seelig
Director
Disability Law Project

/s/ Barbara Prine
Barb Prine
Staff Attorney
Disability Law Project

From: Jim Caffry
To: McFadden, Clare; Garabedian, Jennifer
Cc: "Elizabeth Campbell"; "Barbara Lee"; "Connie"
Subject: RE: DDSD Workplan for 2022 - 2025; DD Regs, SOCP & Housing
Date: Thursday, October 20, 2022 4:00:42 PM
Attachments: Att. 2-DAIL.Memo re SFM 24-Hr Home Supports.3-9-05.pdf

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EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Clare and Jennifer:

Howdy. I am following up on the DD Standing Committee meeting this morning regarding the draft System of Care Plan, that I just started looking at, having been away last week. I have a couple of quick questions.

1. The version of the proposed 2022 DD Regulations that I found on the DDSD website look like they were made public last spring, prior to the passage of Act 186. Can one of you please send me a link to the current, proposed changes to the DD Regulations if there were any changes made to the proposed Regs following the Legislature's passage of Act 186?

2. Clare, you said today that, 24 hour Home Supports cannot qualify for the FICA tax exemption under IRC 131 (https://www.law.cornell.edu/uscode/text/26/131) if done under the Self & Family Management program. What legal authority are you relying on for that opinion?

Since any adult foster care provider (Shared Living Provider) must go through all of the same review and training processes, regardless of whether that foster care provider was chosen by a family under the SFM program or chosen by a DA/SSA, an argument could certainly be made that any SLP chosen by a family, that is vetted by Transition II, then that SLP was "place by" a "qualified foster care placement agency" under IRC 131. Presumably, every DA and SSA is covered by that, so why wouldn't Transition II? Do you have some definitive legal opinion from the Internal Revenue Service, or anyone for that matter, that a Shared Living Provider, hired by a Family Manager, under the oversight of Transition II for the SFM program, is not eligible for the income-tax free payment?

To my knowledge, when families were managing 24 hours from 1996 – 2005, those payments were income tax free just like any other SLP payment for any home provider found through a DA/SSA. Again, what is the legal authority that prohibits an SLP chosen by the family, and vetted through Transition II, from being paid tax-free under IRC 131.

I am pretty sure that if the DDSD wanted this to work for a tax-free stipend under IRC 131 for Family Management of 214 hour supports, the DDSD could make that work.

One of the main points of Act 186 was to encourage flexibility and creativity for living arrangements. If families are given the opportunity for that full engagement, then creative, sustainable, housing opportunities will more readily flow from there.

As Clare knows and she summarized today during the meeting, apparently, some things went awry before 2005 with 24-hour home support management being managed by families, so the moratorium was imposed by administrative fiat in 2005 (see attached). Then that 24-hour prohibition was adopted in the 2011 version of the DD Regulations. That rule change was made over the unanimous objections of every single rule commenter. I know that there was unanimous objection to the 24-hour prohibition because I filed a Freedom of Information Act request in the fall of 2010 when the DD Regulation changes were proposed, and I read every one of those public comments filed.

Without question, bad things can happen, particularly when there is a lack of governmental oversight.

Obviously, we all know that there have been "problematic" Shared Living Providers that were approved for 24-hour Shared Living by a DA or an SSA: https://vtdigger.org/2022/09/13/4-caregivers-for-vulnerable-adults-charged-with-abuse-and-neglect/. I would assume that the recent arrests of the these "problematic" Shared Living Providers in Milton and Swanton are not going to lead the DDSD to put a moratorium on the SLP program.

I do not have the figures in front of me, but my recollection is that there were about a dozen DDSD Quality Management Reviewers in the early 2000s when I first started paying attention to this. The most recent org chart I found for the VT DDSD is from 2017, and there are only 3 Quality Reviewers, 5 if you include the Team Leader and the Nurse Surveyor (https://ddsd.vermont.gov/sites/ddsd/files/documents/DDSD_OrgChart.pdf).

My last thought for the day, with all of the enthusiasm amongst parents for positive progress going forward following the passage of Act 186, it was rather deflating to see the draft 2023-2025 SOCP change in pretty insignificant ways. The barriers to housing alternatives, primarily in the laundry list of 20 "Limitations on Funding" in Section Five, Subsection IV.D from the prior SOCP remains unchanged, in particular, Subsections IV.D.13, 14 and 15. Additionally, there are minimal references to Act 186, and no substantive discussion of the current barriers to providing meaningful housing alternatives, many of which I spelled out in my email to the two of you in May (and included below).

I look forward to continuing the conversation.

Jim

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From: Jim Caffry <jim@caffrylaw.com>
Sent: Wednesday, May 4, 2022 12:54 PM
To: Clare.McFadden@vermont.gov; Jennifer.Garabedian@vermont.gov
Cc: 'Elizabeth Campbell' <eliz888@comcast.net>
Subject: DDSD Workplan for 2022 - 2025; DD Regs, SOCP & Housing

Clare and Jennifer:

Howdy. I must admit that I am relieved that Clare is not very good at being retired, as there is a whole lot on the plate of the DDSD right now. I am guessing that Jennifer is also glad that Clare is not very good at being retired.

I have quickly looked at the recent information put out by the DDSD about the various initiatives: https://ddsd.vermont.gov/programs/projects-initiatives/2022-update-regulations-and-system-care-plan/proposed-changes-vt-socp-dds.

I decided that I should send the two of you a few thoughts about some of these things while I am thinking of them, and before the various initiatives get too far down the tracks.

As you probably know, I have been part of the Developmental Disabilities Housing Initiative ("DDHI") efforts led by Elizabeth Campbell and others, so I have copied Elizabeth on this email. As you also know, in addition to my personal interest in these matters as a parent, I have worked with the only two existing residential models (to my knowledge) in Vermont that provide an alternative to the Shared Living Provider model (a/k/a adult foster care under Section 131 of the Internal Revenue Code).

I have publicly commented many times before that Shared Living is really the only option for adults who are eligible for 24/7 home supports, and that the statistic of 76% is misleading. It is my understanding that individuals only end up in the Staffed Living or Group Living (those "statewide resource" group homes that are owned and operated by Designated Agencies) if those individuals have previously tried, and failed, in multiple Shared Living homes – either due to high behavioral or medical needs. See: https://ddsd.vermont.gov/sites/ddsd/files/documents/Summary_of_Housing_Options_Issue.pdf. The 270 individuals that have Supervised Living Supports have the requisite skills and independence that they do not require 24/7 oversight and support.

The reality is that for individuals requiring 24/7 supports, that do not have high behavioral or medical needs that lands them in Staffed Living or Group Living, then Shared Living is the only choice for 100% of people receiving Home Supports without increased those high behavioral or medical challenges (excepting the small number of people living at Heartbeet or Yellow House).

The often-stated fact that Group Living and Staffed Living are more expensive ignores the fact that they are more expensive because the people served in those models have the highest needs. They are also more expensive because both of those models operate entirely on shift-staff.

Having gone through most of the materials on the DDSD website now, there are a few things that I think DDSD needs to be kept in mind as the Division moves forward in 2022:

1. **Shared Living can look different than it does now in Vermont under the federal IRC Section 131.**
    - Section 131 of the Internal Revenue Code allows for the income tax exemption for up to five adults under one roof.
    - While there is some sound reasoning behind the "not more than two" policy position, there are also sound public policy reasons to allow more than two. I recall finding out several years ago that Oregon and Minnesota allow adult foster homes for up to five developmentally disabled adults. I have not conducted an exhaustive search of what other states allow, and I recall that Oregon and Minnesota had more robust training and licensing requirements than Vermont for its Shared Living Providers.
    - As noted in some of the DDSD materials, under the current Shared Living operations, there are a few instances where a Home Provider moves into a home that is owned by an individual, or a family (or a Special Needs Trust). Therefore, when a Home Provider changes, the individual with ID/DD does not have to move out to some other home which could be anywhere within the DAs service territory.
    - If the payment model of Shared Living could be incorporated into a residential model where 3, or 4, or even 5, individuals with ID/DD live in the same house, ***that is their house***, then modifying the current Vermont Shared Living program could be a means to achieving "consistency of place" in a cost-efficient manner.
    - Perhaps one, or two, live-in support persons could be compensated as Shared Living Providers under IRC 131, and then there could be additional supports from shift-staff workers. This could result in some cost savings, in addition to addressing two of the DDHI's biggest concerns: (A) our adult children would not have to move every time a Shared Living Provider changes, and (B) the opportunity to live with some peers – for years on end.

2. **33 V.S.A. § 502(1) Needs to be Revisited.**
    - There is more statutory consideration that must happen outside of anything in the DD Act of 1996 (18 V.S.A., Chapter 204A).
    - Act 37 of 2007, introduced to the Legislature in February 2007, was the first time that Vermont put into statute the limitation on adult foster care payments to 2 people, codified at 33 V.S.A. § 502(1). It appears that the primary purpose of Act 37 was repeal the $6,500 cap on the exclusion of adult foster care payments for property tax calculation purposes that had previously be in 33 V.S.A. § 6061(5)(c). For a general discussion of the Shared Living Provider model and context on Act 37, please refer to the attached Report on Adult Disability Care Payments in Household Income (DAIL Commissioner Flood, Jan. 2007).
    - Prior to 2007, it had always been a policy-based decision to limit Shared

Living to 2 people, even though federal law allowed up to 5. That non-binding policy decision then became Vermont law with little fanfare or public debate because the focus was on the property tax exemption.

3. **Consider IRC Section 119.**
    - The other provision of the Internal Revenue Code that should be considered is IRC Section 119. Under IRC Section 119 and Treasury Regulation 1.119-1, if an employee is required to live in a particular residence and have meals on premises, then the value of the lodging and meals is not imputed taxable income to the employee. Nor is there imputed taxable income for the value of lodging or meals provided to the employee's spouse and children.
    - This is the tax code provision that is utilized by many of the Camphill Communities – Householders live in the community 24/7 and receive free room and board as part of the employment, and there is no "phantom income" that is subject to income taxation – in the same way that there is total cost savings under the adult foster care payments under IRC 131 with no FICA taxes to be paid by an employer or employee.

4. **33 V.S.A., Chapter 71 Needs to be Revisited.**
    - The licensing requirements for any residential care provider, whether a Residential Care Home or a Therapeutic Community Residence, kick in when there are 3 or more individuals being supported under one roof. I recall looking years ago, and the 19 Group Homes owned & operated by the DAs are split about equally in being licensed as either Res Care Homes or TCRs. Heartbeet and Yellow House are both licensed as TCRs.
    - Obviously, health and safety are paramount, but it needs to be considered whether the licensing requirements are a significant barrier to the creation of alternative housing models that will provide stable, long-term, residences (even if the care providers change).
    - In addition, or alternatively, consideration should be given to whether there should be a permanent position within the DDSD of a Residential Program Developer (which is currently contemplated as a 3-year limited service position under H.720), who could assist families and individuals, DAs, SSAs, and any independent service contractors that come along (in addition to Heartbeet and Yellow House) to provide stable, long-term, residential supports for adults with ID/DD in compliance with any licensing requirements.

5. **"No More Than Four" Is Not Law.**
    - This line has been stated as though it is legally binding by various people within the Vermont DS System for as long as I can remember. That is simply not true.
    - There is no prohibition on housing more than four individuals under one roof in the DD Act, 18 V.S.A., Chapter 204A, or under the licensing requirements of 33 V.S.A., Chapter 71.

- There is no legally binding prohibition under the Current (outdated) System of Care Plan, Chapter Four, Section IV.D.14.a (page 62): https://ddsd.vermont.gov/sites/ddsd/files/documents/Vermont_DS_State_System_of_Care_Plan.pdf

  14. Developmental disabilities HCBS services funding cannot be used to:
      a. Increase the availability of residential settings that provide supports to more than four adults (age 18 and over). Any exceptions to this limitation must be approved by the Division.

- Alas, the Division currently has the authority to allow more than 4 under the expire SOCP. Therefore, if there were 5 or 6 families, whose adult children had similar challenges and communication modes (e.g., communicating with American Sign Language), there is no legal prohibition under the Vermont DD Act, the DD Regulations, or even the non-binding, expired SOCP, that would prohibit those families from working together to create a stable, long-term living community that utilizes Medicaid HCBS money to support those individuals.
- It has been a while since I read them, but there is nothing in the 2014 CMS Regulations that would prohibit such a living community either.

6. **<u>Remove the Prohibition on Family Management of 24-Hour Home Supports</u>.**
    - When the Self & Family Management Program started, a family could manage 24/7 home supports. That ability was removed by a 2005 Policy Memo (see attached), and then that 24-hour Home Support management was inserted into the System of Care Plan in 2010 (I think) and then the 2011 DD Regulations over the universal objection of every public comment filed for those 2011 DD Regulation changes (I know that is true because I filed a Public Records Request for those public comments and DAIL ignored them all).
    - The fact that some families' 24-hour management was "problematic" is not a reason to prohibit every family from doing so.
    - See SOCP, Chapter Four, Section IV.D.14.a (page 62):

      13. Individuals who chooses to self/family-manage or share-manage cannot manage 24-hour home supports (i.e., shared living, staffed living, group living). Individuals may self/family-manage up to 8 hours per day of paid home supports. However, individuals who need 24-hour home supports may receive them from their local DA, or an SSA of their choice.

- See current DD Regulation, Part 5, and proposed renumbered Regulation 7.100.6. https://ddsd.vermont.gov/sites/ddsd/files/documents/DDAct_Regulations_Draft_Revisions_2022.pdf
- The DD Regulations are currently clear: "In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in Section 5.2" (*soon to be Section 7.100.6(b)*.

7. **<u>Remember Where DDSD Came From</u>.**

In my written testimony to the House Human Services Committee on February 15, 2022 (copy attached), I pointed out that in both the FY 2005-2007 and FY 2008-2010 System of Care Plans, there were 12 Funding Priorities for Developmental Services. In the 2018-2020 (extended to 2022) System of Care Plan, there are only 6 Funding Priorities.

- Conversely, trending in the opposite, but also wrong direction, the FY 2005-2007 System of Care Plan contained only 7 “Limitations for Funding”, and by the 2018-2020 (extended to 2022) System of Care Plan, the “Limitations for Funding” had exploded up to 20.
- It would appear to be a safe bet that funding priorities going south and funding limitations going north over the last 20 years is how Vermont arrived at the current “System of Crisis”.
- There is a Maya Angelou quote that says: “If you don’t know where you’ve come from, you don’t know where you’re going.” While the families involved in the DDHI are looking for a future in which the Vermont DD SOCP encourages and truly promotes “meaningful [residential] choices” for the first time, the DDSD should also be mindful of how the SOCP has changed (and not for the better) since its inception.

If you are still reading at this point, I will end this by saying that I, and other members of the DDHI, are looking forward to meaningful engagement in the various DDSD projects that will result in meaningful residential choices for our adult children.

Jim Caffry

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STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Aging and Independent Living

Division of Disability and Aging Services
103 South Main Street
Waterbury, VT 05671-1601

MEMORANDUM

TO: **Developmental Services Program Directors**

FROM: Theresa A. M. Wood, Deputy Commissioner, DAIL/DDAS

DATE: March 9, 2005

SUBJECT: Self- and Family-Managed Twenty-four Hour Home Supports

There are relatively few self- or family-managed twenty-four (24) hour home support arrangements across Vermont Although some of these arrangements have worked for people, a number of them have been problematic. These concerns have led us to question the advisability of self- and family-managing twenty-four (24) hour home supports.

Effective immediately, I am placing a moratorium on any new self- or family-managed twenty-four (24) hour home supports until, a number of issues can be addressed. It is our intent to have discussions regarding our concerns with a variety of sources, including the Developmental Services State Standing Committee.

At the current time, individuals and families may continue with any *existing* twenty-four (24) hour home support arrangements. Additionally, individuals and families may manage intermittent, hourly home supports which are less than twenty-four (24) hours.

The Division of Disability and Aging Services continues to be committed to providing the option to self- or family-manage services. We are also committed to Insuring the health, safety and rights of individuals. Please share this information with your staff and call if you have any questions.

All who now Self- or Family- Managed Twenty-four hour Home supports are now grandfathered into this new non-choice option.

/s
CC: DS Leadership Team
Community Alternatives Specialists
Maryann Wilson, ARIS

From: Annie Galloway
To: AHS - DAIL DDSD SOCP & Regulations
Subject: Cannabis medicine and Residential programs
Date: Friday, October 21, 2022 9:00:02 AM

Hello,

I'm writing as a family member and worker in the system of care. I'm writing as an advocate for healthy life choices for our families.

Now that we have legalized cannabis medicine in our state and we know many people who have disabilities or medical conditions that benefit from this medicine are using it daily to heal and restore their health.

We need to be at the forefront of creating change that allows our family members who are using cannabis medicine to have access to both residential programs and their cannabis medicine.

A woman in St Albans had to give up her life saving cannabis medicine in order to enter into a residential program. This is unethical.

As more and more people enter into this system this will become an issue. It already is an issue.

I hope you will be part of making a change so that we can move forward together in justice for all people.

Anne Galloway

Live by faith not by sight

From:	Jim Caffry
To:	McFadden, Clare; Garabedian, Jennifer
Cc:	"Elizabeth Campbell"; Karen Price; "Collins Reading Twing"; "Barbara Lee"; "Marla McOuiston"; "Lauren Arcuri"; "LAURIE MUMLEY"; "Jenn Townley"
Subject:	Comments on Proposed Changes to the Developmental Disabilities Services Regulations
Date:	Friday, October 28, 2022 2:33:08 PM

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Clare and Jennifer:

The following are written comments to the Developmental Disabilities Services Division ("DDSD"), within the Vermont Department of Disabilities Aging and Independent Living ("DAIL") regarding the proposed changes to the regulations, now to be referred to as the Developmental Disabilities Services Regulations.

I am filing these written comments individually. However, as you know, I have been part of the parent-led Developmental Disabilities Housing Initiative ("DDHI"), and my comments on the proposed Regulations are made with the goal of encouraging positive changes in the Vermont developmental services system, particularly in the area of providing stable, service-supported housing for Vermonters with developmental disabilities and high support needs.

Most of the changes needed to move forward will come through the development and adoption of new State System of Care Plan for Developmental Disabilities Services.

The comments in this communication are focused on the proposed Developmental Disabilities Services Regulations.

As a starting point, DAIL and DDSD need to acknowledge that the State had fallen short of meeting one of the key principles of service in the Vermont Developmental Disabilities Act of 1996 – specifically the State has not met its obligation to provide meaningful choices when it comes to providing residential living situations for individuals requiring 24-hour supports.

18 V.S.A. § 8724 (Principles of service) states:

> Services provided to people with developmental disabilities and their families shall foster and adhere to the following principles:
>
> ***
>
>> (6) Meaningful choices. People with developmental disabilities and their families cannot make good decisions without meaningful choices about how they live and the kinds of services they receive. Effective services shall be flexible so they can be individualized to support and accommodate personalized choices, values, and needs and assure that each recipient is directly involved in decisions that affect that person's life.

Additionally, the passage of Act 186 requires the DDSD to take affirmative steps to expand housing and residential services for individuals with developmental disabilities.

In some of the materials recently produced by DDSD regarding housing arrangements, the DDSD has stated that of the roughly 1,800 people receiving Home Supports, 76% percent live in Shared Living:

https://ddsd.vermont.gov/sites/ddsd/files/documents/Considerations_of_New_Housing_Options.pdf.

As has been expressed numerous times, that figure is very misleading. The 15% of people in Supervised Living have the independence skills that they do not require 24/7 supports. The 4% in Staffed Living and the 5% in Group Living generally have either significant medical needs or behavioral challenges that those 158 individuals have been unsuccessful in one or more Shared Living placements.

With some *very* limited exceptions, Shared Living is the *only* residential option for individuals who require 24/7 supports, but who do not have the medical or behavioral needs that result in Group or Staffed Living arrangements.

With those considerations in mind, turning to the proposed Developmental Disabilities Services Regulations, the DDSD is respectfully requested to consider the following:

1. **7.100.1 (Purpose and Scope)**
   See above. The purpose of the Regulations is to implement the DD Act (18 V.S.A., Chapter 204A), and not be a barrier to implementing the Act.

2. **7.100.2(v) (Definitions – Home Supports)**
   See above.
   "Home Supports" means services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. Home supports must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.
   Currently, there really is no choice for Home Supports if an individual requires 24-hour supports.

3. **7.100.2(ff) (Definitions – Resident)**
   In subsection (ff)(1) a "facility" is not defined, but the Regulations should clearly permit individuals to reside in an out of state residential community (e.g., Visions in New Hampshire) in an adjoining state just as the Regulations allow for a person to remain a Vermont resident if the person lives with a Shared Living Provider in an adjoining state.

4. **7.100.4 (Recipient Criteria)**
   Subsection (c) cross-references 7.100.2(ff)(1). Again, if an individual is considered to maintain Vermont residency when the individual resides in an adjoining state, that individual should have that same consideration for a residential community in an adjoining state.

5. **7.100.5(j) (Choice of Provider)**
   Subsection (j)(1)(E) states: A recipient or family may request that an agency sub-contract

with a non-agency provider to provide some or all of the authorized services; however, the decision to do so is at the discretion of the agency.

This language is currently in Subsection 4.10(a)(5) of the 2017 Regulations. This subsection should include language that makes it clear that an agency's consent to a family's request to have services provided through a subcontract with a non-agency provider must not be unreasonably withheld.

The Regulations should be clear that if an individual or family wants services provided through a non-agency provider, then the presumption should be that the agency will enter such a subcontract, and the agency's discretion not to subcontract should only be exercised in the event that there is a reasonable basis to conclude that the sub-contractor is unable to comply with the applicable programmatic requirements.

Additionally, there should be clear language that if an agency refuses to enter a contract with a non-agency provider, then the individual or Authorized Representative (e.g., parent/guardian), may appeal the refusal to subcontract to the DDSD Director.

6. **7.100.6 (Self/Family Management)**

As expressed in my October 20, 2022 email to the two of you, the prohibition on Self/Family Management of 24-hour home supports should be eliminated. That 8-hour limitation is an arbitrarily imposed barrier to creating alternative, sustainable housing options for individuals and families.

Whatever the "problematic" situations were that led to the 8-hour limitation being imposed by a memo in 2005, and then jammed into the 2011 DD Regulations over the unanimous objection of all public commenters, are not a legitimate basis to prohibit all individuals or families from managing 24-hour Home Supports.

The fact that there was a recent horrible situation of abuse and neglect in the Shared Living Provider Program (https://vtdigger.org/2022/09/13/4-caregivers-for-vulnerable-adults-charged-with-abuse-and-neglect/) does not mean the DDSD is going to ban all Shared Living Providers.

It is the DDSD's job, and the Supportive ISO's job, to administer the Self/Family Management Program. There is a process to terminate individuals or families from the management of services. If the individuals or families are not up to the task, then those individuals or families can have their ability to manage services taken away. It should be no different when it comes to management of 24-hour services.

Because the 8-hour Home Support limitation should finally be eliminated, and the ability to manage 24-hour Home Supports should be restored as it existed before March of 2005, then the requirement in the current 2017 Regulations, Section 5.2(m) should be reinstated ("Follow the requirements of the Housing Safety and Accessibility Review Process to ensure that the individual is living in a safe and accessible home.").

7. **7.100.11 (Certification of Providers)**

See Comment #5 above. The language of Subsection (f)(1) (Status of non-designated providers) should mirror Subsection 7.100.5(j) and be made clear that there is a presumption that the agency will enter a subcontract with a non-designated organization, and the discretion not to subcontract with a non-designated organization will only be exercised if there is a reasonable basis to conclude that the subcontractor is unable to comply with the applicable programmatic requirements.

In short, the Regulations should encourage the expansion of housing and residential service options for individuals with developmental disabilities, and any impediments to new and creative housing options should be removed from the Regulations. This is a requirement of both the DD Act of 1996 and of Act 186.

Thank you for your consideration of these comments.

Jim Caffry

118 Graves Farm Road
Waitsfield, VT 05673

From: j.e.townley1@gmail.com
To: McFadden, Clare; Garabedian, Jennifer
Subject: Comments on Proposed Changes to the DSD Regs
Date: Friday, October 28, 2022 3:59:06 PM

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Hi Jennifer & Clare,

After reviewing the Draft of the DSD Regulations, I would like to see the Regulations encourage the expansion of housing and residential service options for adults with developmental disabilities, and any barriers/obstacles to new and creative housing options should be removed from the Regulations. The Regulations should align with the HCBS Settings Criteria and provide meaningful choices for residential living situations for individuals requiring 24-hour supports. Although Act 186 is noted, changes could easily be incorporated as part of the current update of Regulations to support housing choice.

My family would like to see:

1. Federal law allows up to five adults with ID/DD to live together under the same roof. We would like the Vermont policy that no more than two adults with developmental disabilities can reside together in the same home under the Shared Living arrangement be changed to align more with Federal law. Also, would like to see that housing could be created for more than 3 individuals residing together without requiring licensure and have DAIL/DSD work with licensure to change this requirement. Perhaps licensure shouldn't be based on # of people being served within a residence, but on level of need of the clients residing together.

2. Self and family management only allows for 8 hours/day of paid in-home supports and we believe the state should allow for family management of 24/7 paid in-home supports.

3. Eliminate the provision that a DA/SSA can refuse to subcontract with a family or recipient who desires that their authorized services be provided by a non-agency.

4. The state should allow for HCBS funding to be used for out-of-state authorized services, including housing, if there are no options to meet the client's needs within the state.

5. Expand the definition of individuals that qualify for the HCBS Wavier to include those individuals that fall on the Fetal Alcohol Spectrum like the Federal government defines today. This is a developmental disability and many students leave high school with no supports and services which are greatly needed. Fetal Alcohol in utero is organic damage to the brain and often these clients plateau and will never achieve independence.

6. Provide services including housing options that are based on a client's needs and not

just on the lowest cost option of providing a specific service.

Thank you for your consideration.
-Jenn, Ed, Ben & Noah Townley

Vermont Developmental Disabilities Council

100 State Street, suite 342
Montpelier, Vermont 05633-0206

(802) 828-1310
vtddc@vermont.gov
www.ddc.vermont.gov

TO: Department of Disabilities, Aging, and Independent Living

RE: Proposed changes to Vermont's Developmental Disabilities Regulations

FROM: Vermont Developmental Disabilities Council
Susan Aranoff, Senior Policy Analyst and Planner

DATE: October 28, 2022

Thank you for the opportunity to comment on the proposed changes to Vermont's Developmental Disabilities Regulations. The Vermont Developmental Disabilities Council (hereafter "VTDDC") is a statewide board created by the federal Developmental Disabilities Assistance and Bill of Rights Act (hereafter "the DD Act"), first adopted by Congress in 1970. An estimated 86,000 Vermonters experience a developmental disability as defined by the DD Act, with approximately 5,100 receiving Medicaid-funded, home and community-based support (HCBS) through the Developmental Disabilities Services System of Care or in some cases, the Choices for Care Program.

VTDDC is charged under federal law with engaging at the state level in "advocacy, capacity building and systems change activities that... contribute to the coordinated, consumer-and-family-centered, consumer-and-family directed, comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families."[1]

In addition to our federal mandate, we are commenting in our unique role within the Agency of Human Services (AHS). As per our signed assurances with AHS, the VTDDC advises AHS on quality strategies as they pertain to people with developmental disabilities.[2]

Introduction

VTDDC applauds the Developmental Disabilities Services Division (the Division) for providing robust opportunities for public engagement as part of the rule-making process. The Division provided the State Program Standing Committee (SPSC), the advisory board established in 18 V.S.A. §8733, with an initial draft of the proposed rule, seeking for advice and recommendations in March 2022. A plain language document explaining the proposed changes was developed and shared with the board. DAIL staff and the SPSC members reviewed and discussed the draft. The SPSC members offered comments and suggested some changes to the proposed draft. The process is described in DAIL's filing with the Secretary of State's office[3] and could serve as a model for the Department going forward.

In its summary of the proposed changes, the Division acknowledges its need to align the rules regarding eligibility with the ruling in *In re: R.R.*. VTDDC participated in the R.R.

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[1] Developmental Disabilities Assistance and Bill of Rights Act of 2000. 42 USC 15001 et. seq.

[2] "Section M. The Council will participate in the planning, design or redesign, and monitoring of State quality assurance systems that affect individuals with developmental disabilities." Signed by AHS Secretary Samuelson.

[3] Developmental Disabilities Proposed Rule Filing

case as an Amicus Curiae and commends the clarifying amendments that align with the holding in R.R.

Likewise, VTDDC commends the State for adding transportation to the definition of support services.[4] Transportation is critical to accessing the community. It has long been a point of confusion for individuals supported by direct support providers (DSPs) and by home support providers, as to whether they can expect their DSP or their home provider to transport them to planned activities.

Proposed Additions

1. Supported Decision Making

VTDDC is working with several statewide organizations including DAIL to increase the use of Supported Decision Making in Vermont. VTDDC supports in full the recommendations made by Vermont Legal Aid's Disability Law Project, one of our partners in the Supported Decision-Making project.

In its April, 2022, Comments on the pre-filed proposed rules, the Vermont Legal Aid's Disability Law Project recommended the following:

> "The core principles of the Department for Disabilities, Aging, and Independent Living (DAIL) and of the Developmental Disabilities Services Division closely align with the principles of Supported Decision-Making (SDM). As outlined in the Developmental Disabilities Act for Vermont, these principles include that supports and services are person-centered, that they promote personal and economic independence, self-determination, and flexibility, and that individuals benefit from collaboration. While the concept

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[4] See 7.100.2(q).

> of Supported Decision-Making pre-dates the current System of Care Plan, and most recent DD regulations revisions, the role of DAIL and of Designated and Specialized Services Agencies in enabling SDM as an alternative to guardianship is not mentioned anywhere within either document, nor is it part of the quality review process.
>
> We recommend that the rules on Training, Certification of Providers, and Evaluation be amended to incorporate the use of supported decision-making approaches for beneficiaries with and without guardianships in place.
>
> The training section can be amended so that, in addition to ensuring employees have training on abuse reporting, health and safety, individual specific information, and values, employees and contractors receive training on formal and informal methods of supported decision making and serving as supporters in a more formal supported decision-making agreement if they so choose."

Excerpt from Letter from VT Legal Aid Disability Law Project to DAIL, April 18, 2022

The certification section can be amended so that the guidelines for quality review incorporate adoption of supported decision-making approaches, and providers report on how supported decision making is incorporated into ISAs, and how many beneficiaries served are using some form of supported decision making, just as ISAs reflect supervision needs and communication support.

2. Incorporate CMS Rules

Overview

The definition of Home and Community-based Services (HCBS) references the need for Vermont's HCBS to be provided in a manner consistent with Medicaid's HCBS Rules.[5]

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[5] See 7.100.2 (u).

> (u) "Home and Community-Based Services" (HCBS) means an array of long-term services developed to support individuals to live and participate in their home and community rather than in an institutional setting, ***consistent with Centers for Medicare and Medicaid Services (CMS) federal HCBS Rules.*** (Emphasis added).

The definition of Home Supports also references the need for Vermont's Medicaid-funded services to be in compliance with CMS Rules.[6]

> (v) "Home Supports" means services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. ***Home supports must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.*** (Emphasis Added).

It is VTDDC's understanding that the proposed rules will be in place in early 2023. The Council notes that the HCBS Settings rule, which has been anticipated since 2014, will be in force March 2023. It is therefore especially timely that the Settings Rule be incorporated in Vermont's regulations now.

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[6] See 7.100.2 (v).

Recommendation: VTDDC recommends embedding the core elements of CMS' HCBS Settings into Vermont's DS Regulations.

The CMS Settings Rule is designed to ensure that people with disabilities living in the community have access to the same kind of choice and control over their own lives as those not receiving Medicaid HCBS funding. The requirements that should be specified in the Vermont's rules come directly from the 2014 HCBS Settings Rule. They require that any setting where Medicaid funded HCBS are delivered be:

1. Integrated in the greater community.
2. Support the individual's full access to the greater community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.
3. Selected by the individual from among different setting options, including non-disability specific options and an option for a private unit in a residential setting.
4. Ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.
5. Optimizes individual initiative, autonomy, and independence in making life choices, including in daily activities, physical environment, and personal associations.
6. Facilitates individual choice regarding services and supports and who provides them.

A "provider-owned or controlled residential setting" is one in which the service provider also owns or controls the real estate where the individual lives, as distinct from a setting owned or controlled by the person receiving services or their family where the provider merely arrives to deliver support services. The residences of shared living providers are considered provider-owned or controlled residential settings, as are group homes.

The 2014 Settings Rule contains specific requirements for provider owned and controlled settings. Vermont provides HCBS services to over 3000 individuals residing in provider owned or controlled settings, including the residences of shared living providers and other adult foster care providers. There have been no efforts to date to educate the residents of these settings as to their rights under the CMS Settings Rule, including the right to a lease or lease-like protections.

All shared living residences could be settings that isolate because in most cases, the residents in a shared living residence do not control their own access to the community. The Settings Rule requirements for provider owned or controlled residential settings should also be included in the Rules.

Individuals in provider-owned or controlled residential settings must have:

1. A lease or other legally enforceable agreement providing similar protections.
2. Privacy in their unit, including lockable doors, choice of roommates, and freedom to furnish or decorate their space.
3. The right to control his/her own schedule including access to food at any time.
4. The right to visitors at any time.
5. A setting that is physically accessible.

VTDDCD further recommends that the State include in its rules a model agreement for state-funded shared living providers that contains the lease-like protections required by CMS' HCBS Rules. If each of the 14 designated agencies creates its own lease agreements, there will be confusing differences between beneficiaries receiving the same services.

Recommendation: VTDDC recommends that the Person-Centered Planning Rule Plan of Correction Should be Incorporated in the rules by Reference

Vermont lacks person-centered planning processes that are free from undue conflicts of interest. VTDDC notes that the Vermont Agency of Human Services submitted a proposed plan of correction to CMS to address the lack of conflict-of-interest free case management in Vermont. When the Plan of Correction is approved by CMS it will be added to the Global Commitment to Healthcare waiver as Attachment Q. The Plan of Correction should be incorporated in the new Rule by reference. VTDDC further recommends that knowledge of Person-centered planning and settings rules requirements be added to training requirements.

ADDITIONAL RECOMMENDATIONS

The Council recognizes that the Division of Developmental Disabilities Service is facing a time of unprecedented change. For this reason, we anticipate that there will be opportunities to revise the rule again in the near future. We want to take this opportunity to anticipate some of these changes.

1. Embed an Independent Ombudsman in the Rules: Vermonters with disabilities who are receiving home and community-based services for a developmental disability need an outside independent entity to address complaints and conduct independent investigations. These beneficiaries should have access to a service that has been embedded in Choices for Care since its inception
2. Quality reviews and monitoring of compliance with HCBS rules should be increased to significantly more than a 15% review every 2 years and set out in the Rules.

3. The State must provide a Notice of Rights for HCBS recipients – in plain language – detailing the rights enumerated in the settings and person-centered-planning rules and include it in the Rules.

From: Bascom, June
To: McFadden, Clare
Subject: Regs Edits - Communication and Waiting List
Date: Thursday, November 3, 2022 8:39:22 AM
Attachments: DD Act Regs Training Communication Updates v2.docx
DD Act Regs Waiting List Edits v2.docx

I thought I sent this to you yesterday. Got delayed by your DD Act email – which is good as it got me rethinking about the waiting list wording.

Re: Communication edits – I removed the new language on AAC from 9.5(a)(2) as it didn't really fit there. Being knowledgeable about AAC was the intent behind the new wording in that section so it should be good as is.

Re: Waiting List – The way section 4.9 reads, it just references the DA and the requirement to only put people who do not meet a funding priority on the waiting list. The edits to 4.18 were made to better reflect this original intent. I don't think this change in wording takes anything away from HCBS recipients since they have the right of a periodic review and a new needs assessment if their needs change. However, the wording still requires agencies to follow-up "at least annually" with people on the list, which doesn't really make sense in most cases and doesn't currently happen. This was a concern expressed by the DS Directors and what you brought up as well. It makes more sense to remove (b.)(1) and depend on applicants to let the agency know when their needs have changed (b.)(3). I've proposed that in the attached version for consideration.

Regulations Implementing the Developmental Disabilities Act of 1996
Recommendations from the Vermont Communication Task Force – 10/7/22, amended 11/2/22

9.4 **Pre-Service Training**

Before working alone with an individual who receives support funded by the Department, each worker shall be trained and demonstrate knowledge in (a) through (e) of this section. The employer of record, whether recipient, family, shared living provider or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(a) Abuse reporting requirements:

(1) The requirements of Vermont law to report suspected abuse or neglect of children; and

(2) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

(b) Health and Safety:

(1) Emergency procedures, including where to locate the emergency fact sheet;

(2) What to do if the individual is ill or injured;

(3) Critical incident reporting procedures; and

(4) How to contact a supervisor or emergency on-call staff.

(c) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)

(1) Whether the individual has a guardian, and how to contact the guardian;

(2) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;

(3) Health and safety needs of the individual;

(4) ~~How to~~ Methods of communication~~e~~ used by ~~with~~ the individual including tools, technology, and effective partner support strategies; and

(5) The individual's ISA, including the amount of supervision the individual requires.

(d) Values:

(1) Individual rights, including those specified in 18 V.S.A. § 8728;

(2) Confidentiality;

(3) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand;

(~~3~~4) Respectful interactions with individuals and their families; and

(~~4~~5) Principles of service contained in the Developmental Disabilities Act of 1996.

(e) How to access additional support, training, or information.

9.5 In-Service Training

(a) Within three months of being hired or entering into a contract, workers shall be trained in and demonstrate the knowledge and skills necessary to support individuals in (a)(1) and (2) of this section. Workers shall be trained in or demonstrate knowledge and skills necessary to support individuals, in (a)(3) and (4) of this section. The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(1) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;

(2) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support~~ing~~ methods of communication used by the recipient). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

(3) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and

(4) Basic first aid.

(b) Workers shall be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

Proposed Changes to Regulations Implementing the DD Act of 1996
Submitted by J Bascom and endorsed by the DS Directors – amended 11/2/22

4.9(b)(4) – Notification of decision on application – Consent of notices
If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based ~~s~~Services ~~or~~ funding, the notice shall state that the DA shall continue to offer information and referral services and shall place the person's name on a waiting list (Section 4.18).

4.18 – Waiting list
A person with a developmental disability whose application for Home and Community-Based ~~s~~Services ~~or supports~~ is denied~~, in whole or in part,~~ because the person's needs do not meet the funding priorities outlined in section 4.7 shall be added to a waiting list maintained by the designated agency ~~or Supportive ISO, as applicable~~. The designated agency ~~or Supportive ISO~~ shall notify an applicant that his or her name has been added to the waiting list, and explain the rules for periodic review of the needs of people on the waiting list.

(a) Each designated agency ~~and Supportive ISO~~ maintains a waiting list for services they provide, including:

(1) Individuals eligible for HCBS based on their developmental disability~~, including those already receiving services~~, but whose request for services is denied~~, in whole or in part,~~ because the individual's needs do not meet a funding priority.

(2) Individuals eligible for, but denied, FFF because of insufficient funds (including people who receive partial funding and/or one-time funding).

~~(3) Individuals eligible for, but denied, TCM because of insufficient funds.~~

(3~~4~~) Individuals eligible for, but denied, FMR funds because of insufficient funds.

~~(5) Individuals eligible for, but denied, PSEI funds because of insufficient funds or lack of capacity of the PSEI program to support additional students.~~

(b) Each designated agency ~~and Supportive ISO~~ shall notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list shall occur:

~~(1) At least annually; and~~

(1~~2~~) When there are changes in the funding priorities or funds available; or

(2~~3~~) When notified of significant changes in the individual's life situation.

From:	Bascom, June
To:	McFadden, Clare
Subject:	RE: Regulations and State System of Care Plan Recommended Edits
Date:	Monday, October 31, 2022 12:44:04 PM
Attachments:	DD Act Regs Communication Updates 2022 updated 31Oct2022.docx

Before the public comment period ends, I'd like to amend a section of the Vermont Communication Task Force's recommended edits to the Pre-Service Training section of the Regulations. See highlighted section in attachment. We can discuss when we meet to go over these recommendations. I sent you an invite for Wednesday to discuss the recommended changes from the DS Directors and VCTF.

From: Bascom, June
Sent: Friday, October 07, 2022 5:37 PM
To: McFadden, Clare <Clare.McFadden@vermont.gov>
Subject: Regulations and State System of Care Plan Recommended Edits

Clare,
Attached are the following public input into the DD Act Regulations:

- Waiting List – submitted by me and endorsed by the DS Directors
- Pre-Service/In-Service Training – submitted by the Vermont Communication Task Force

Related to the Waiting List changes to the Regulations, attached are relevant edits to the State System of Care Plan.

Please let me know if you have questions about these recommended changes.
Thank you.
June

Regulations Implementing the Developmental Disabilities Act of 1996
Recommendations from the Vermont Communication Task Force – 10/7/22

9.4 **Pre-Service Training**

Before working alone with an individual who receives support funded by the Department, each worker shall be trained and demonstrate knowledge in (a) through (e) of this section. The employer of record, whether recipient, family, shared living provider or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(a) Abuse reporting requirements:

(1) The requirements of Vermont law to report suspected abuse or neglect of children; and

(2) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

(b) Health and Safety:

(1) Emergency procedures, including where to locate the emergency fact sheet;

(2) What to do if the individual is ill or injured;

(3) Critical incident reporting procedures; and

(4) How to contact a supervisor or emergency on-call staff.

(c) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)

(1) Whether the individual has a guardian, and how to contact the guardian;

(2) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;

(3) Health and safety needs of the individual;

(4) ~~How to~~ Methods of communication~~e~~ used by ~~with~~ the individual including tools, technology, and effective partner support strategies; and

(5) The individual's ISA, including the amount of supervision the individual requires.

(d) Values:

(1) Individual rights, including those specified in 18 V.S.A. § 8728;

(2) Confidentiality;

(3) Presumption of Competence;

(~~3~~4) Respectful interactions with individuals and their families; and

(45) Principles of service contained in the Developmental Disabilities Act of 1996.

(e) How to access additional support, training, or information.

Regulations Implementing the Developmental Disabilities Act of 1996
Recommendations from the Vermont Communication Task Force – 10/7/22

9.5 **In-Service Training**

(a) Within three months of being hired or entering into a contract, workers shall be trained in and demonstrate the knowledge and skills necessary to support individuals in (a)(1) and (2) of this section. Workers shall be trained in or demonstrate knowledge and skills necessary to support individuals, in (a)(3) and (4) of this section. The employer of record, whether recipient, family, shared living provider or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(1) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;

(2) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support~~ing~~ methods of communication used by the recipient including basic knowledge of Augmentative and Alternative Communication). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

(3) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and

(4) Basic first aid.

(b) Workers shall be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

From: Elizabeth Campbell
To: Garabedian, Jennifer
Cc: McFadden, Clare
Subject: DDHI Input to Proposed SOC Plan and DD REGULATIONS
Date: Monday, October 24, 2022 3:35:16 PM

Dear Jennifer and Clare,

As you and your colleagues at DAIL are aware, the parent-led Developmental Disabilities Housing Initiative's (DDHI) primary focus is advocating for and supporting the development of stable, service-supported housing communities for our adult daughters and sons, many of whom have significant support needs and would benefit from the option of living with peers.

Given this, many DDHI parents have expressed disappointment that the current draft SOCP (2023-2025) and the proposed 2022 DD Regulations do little to remove barriers to expanding housing options for adults with ID/DD who benefit from the HCBS waiver.

The specifics of various housing models need not be suggested, at this time, in the Regulations and SOCP; however, given that it was the intention of Act 186 to help promote increased choice and flexibility in housing options as required in the 2014 CMS HCBS Settings Rule, we would expect that these two documents would at least lay the groundwork by removing barriers so that new housing models can emerge.

We suggest the following changes be considered, which would be in keeping with the intent of Act 186:

1. Eliminate the Vermont policy that no more than two adults with developmental disabilities can reside together, in the same home, under the Shared Living arrangement. Federal law allows up to five adults with ID/DD to live together under the same roof.

2. Eliminate the prohibition on family management of 24/7 paid in-home supports. Currently, SFM (self and family management) only allows for 8 hours/day of paid in-home supports.

3. Eliminate the provision that a DA/SSA can refuse to subcontract with a family

or recipient who desires that their authorized services be provided by a non-agency. Currently, granting such a request is “at the discretion of the agency (DA/SSA).”

4. Include and/or clarify that HCBS funding can be used for out-of-state authorized services, including housing, if the recipient’s “needs are so specialized” that no provider within the recipient’s geographic area can accommodate the recipient’s needs.

Thank you both for your work on behalf of our adult children.

Respectfully,

Elizabeth Campbell (on behalf of the 90+ parents behind DDHI)

From:	Bascom, June
To:	McFadden, Clare
Subject:	Regulations and State System of Care Plan Recommended Edits
Date:	Friday, October 7, 2022 5:37:23 PM
Attachments:	DD Act Regs Training Communication Updates.docx DD Act Regs Waiting List Edits.docx SSCP Waiting List Edits.docx

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Clare,

Attached are the following public input into the DD Act Regulations:

- Waiting List – submitted by me and endorsed by the DS Directors
- Pre-Service/In-Service Training – submitted by the Vermont Communication Task Force

Related to the Waiting List changes to the Regulations, attached are relevant edits to the State System of Care Plan.

Please let me know if you have questions about these recommended changes.

Thank you.

June

Regulations Implementing the Developmental Disabilities Act of 1996
Recommendations from the Vermont Communication Task Force – 10/7/22

9.4 Pre-Service Training

Before working alone with an individual who receives support funded by the Department, each worker shall be trained and demonstrate knowledge in (a) through (e) of this section. The employer of record, whether recipient, family, shared living provider or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(a) Abuse reporting requirements:

(1) The requirements of Vermont law to report suspected abuse or neglect of children; and

(2) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

(b) Health and Safety:

(1) Emergency procedures, including where to locate the emergency fact sheet;

(2) What to do if the individual is ill or injured;

(3) Critical incident reporting procedures; and

(4) How to contact a supervisor or emergency on-call staff.

(c) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)

(1) Whether the individual has a guardian, and how to contact the guardian;

(2) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;

(3) Health and safety needs of the individual;

(4) ~~How to~~ Methods of communication~~e~~ used by ~~with~~ the individual including tools, technology, and effective partner support strategies; and

(5) The individual's ISA, including the amount of supervision the individual requires.

(d) Values:

(1) Individual rights, including those specified in 18 V.S.A. § 8728;

(2) Confidentiality;

(3) Presumption of Competence;

(~~3~~4) Respectful interactions with individuals and their families; and

(~~4~~5) Principles of service contained in the Developmental Disabilities Act of 1996.

(e) How to access additional support, training, or information.

Regulations Implementing the Developmental Disabilities Act of 1996
Recommendations from the Vermont Communication Task Force – 10/7/22

9.5 In-Service Training

(a) Within three months of being hired or entering into a contract, workers shall be trained in and demonstrate the knowledge and skills necessary to support individuals in (a)(1) and (2) of this section. Workers shall be trained in or demonstrate knowledge and skills necessary to support individuals, in (a)(3) and (4) of this section. The employer of record, whether recipient, family, shared living provider or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(1) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;

(2) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support~~ing~~ methods of communication used by the recipient). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

(3) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and

(4) Basic first aid.

(b) Workers shall be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

Proposed Changes to Regulations Implementing the DD Act of 1996
Submitted by J Bascom and endorsed by the DS Directors

4.9(b)(4) – Notification of decision on application – Consent of notices

If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based ~~s~~Services ~~or~~ funding, the notice shall state that the DA shall continue to offer information and referral services and shall place the person's name on a waiting list (Section 4.18).

4.18 – Waiting list

A person with a developmental disability whose application for Home and Community-Based ~~s~~Services ~~or supports~~ is denied, in whole or in part, because the person's needs do not meet the funding priorities outlined in section 4.7 shall be added to a waiting list maintained by the designated agency ~~or Supportive ISO~~, as applicable. The designated agency ~~or Supportive ISO~~ shall notify an applicant that his or her name has been added to the waiting list, and explain the rules for periodic review of the needs of people on the waiting list.

(a) Each designated agency ~~and Supportive ISO~~ maintains a waiting list for services they provide, including:

(1) Individuals eligible for HCBS based on their developmental disability~~,~~ ~~including those already receiving services~~, but whose request for services is denied, in whole or in part, because the individual's needs do not meet a funding priority.

(2) Individuals eligible for, but denied, FFF because of insufficient funds (including people who receive partial funding and/or one-time funding).

~~(3) Individuals eligible for, but denied, TCM because of insufficient funds.~~

(3~~4~~) Individuals eligible for, but denied, FMR funds because of insufficient funds.

~~(5) Individuals eligible for, but denied, PSEI funds because of insufficient funds or lack of capacity of the PSEI program to support additional students.~~

(b) Each designated agency ~~and Supportive ISO~~ shall notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list shall occur:

(1) At least annually; and

(2) When there are changes in the funding priorities or funds available; or

(3) When notified of significant changes in the individual's life situation.

Proposed Changes to the State System of Care Plan
Submitted by J Bascom and endorsed by the DS Directors

Section Two: Eligibility
IV. Authorization of Services and Funding and Notification

The DA is responsible for determining whether an applicant meets the criteria for financial and clinical eligibility. The DA will conduct or arrange for an assessment to determine clinical eligibility. If the applicant is found financially and clinically ineligible for services, the DA is responsible to provide the individual information and referrals to other services. If an applicant has been found financially and clinically eligible, an Individual Needs Assessment must be completed to determine whether the applicant meets criteria to access any of the services or funding listed in Section Four of this Plan.

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If the applicant is found financially and clinically ineligible for services, the DA is responsible to provide the individual information and referrals to other services. If the applicant is found ineligible to receive Home and Community-Based Services funding for some or all services, the DA will, as soon as possible, notify the applicant and provide information to the individual about the basis for the decision, the process for appeal and where to obtain legal assistance. The applicant's name will be placed on a waiting list maintained by the DA~~/SSA~~. The applicant will be informed that his or her name has been placed on the waiting list~~,~~ and will be given information about the periodic review of the waiting list. (See the Regulations Implementing the Developmental Disabilities Act of 1996, Section 4.9 for more information on notification of decisions and Part 8 on the appeal process.)

Commented [BJ1]: Move this wording to the 3rd sentence of the first paragraph in this section (see above).

Section Five: Management of Home and Community-Based Services
IV. Guidance for Management of HCBS Funding
G. Waiting List

Each Designated Agency~~, Specialized Service Agency and Supportive ISO~~ maintains a waiting list for the following services they provide~~, including~~:

1. Individuals eligible for HCBS (Home and Community-Based Services) based on their developmental disability~~, including those already receiving services~~, but whose request for services is denied, in whole or in part, because the individual's needs do not meet a funding priority.
2. Individuals eligible for, but denied, FFF (Flexible Family Funding) because of insufficient funds (including people who receive partial funding and/or one-time funding).

~~3. Individuals eligible for, but denied, TCM (Targeted Case Management) because of insufficient funds.~~

3~~4~~. Individuals eligible for, but denied, FMR (Family Managed Respite) funds because of insufficient funds.

~~5. Individuals eligible for, but denied, PSEI (Post-Secondary Education Initiative) funds because of insufficient funds or lack of capacity of the PSEI program to support additional students.~~

Each Designed ~~a~~Agency ~~(DA/SSA) and Supportive ISO~~ shall notify individuals when they have been placed on a waiting list and review needs of all people on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list shall occur:

1. At least annually; and
2. When there are changes in the funding priorities or funds available; or
3. When notified of significant changes in the individual's life situation.

Each Designated Agency~~, Specialized Service Agency and Supportive ISO~~ shall submit waiting list data according to instructions established by the Division. The waiting list for Flexible Family Funding and Family Managed Respite are reviewed by the Division annually. Information regarding the utilization of each Designated Agency's allocation and waiting lists for the FFF and FMR programs is used in determining the following fiscal year allocations.

Information regarding waiting lists will be included in the DDSD annual report.

From: Garabedian, Jennifer
To: McFadden, Clare
Subject: FW: DD Act Feedback
Date: Monday, October 10, 2022 12:53:30 PM

Here is some feedback re: Regs.

From: Feddersen, Melanie <Melanie.Feddersen@vermont.gov>
Sent: Thursday, October 6, 2022 4:36 PM
To: Garabedian, Jennifer <Jennifer.Garabedian@vermont.gov>
Subject: DD Act Feedback

I meet with Jessica Stehle, Dylan Devlin, Marc Carpenter and Anna Hutton yesterday to walk through a handful of eligibility situations.

Marc also wanted me to pass on some additional feedback.

1. The highlighted section- is this still a requirement we want in place? Honestly, I don't think we specifically check this clinical requirement is met for this age group.

Page 13 of DD act
(e) Clinicians shall follow the ethical guidelines for their profession regarding practicing within their area of expertise and referring to other professionals when needed. When a single clinician is conducting the assessment, he or she should determine whether other professionals need to evaluate the person to gain additional information before rendering a diagnosis. Additional evaluators may include psychologists, speech language pathologists, medical sub-specialists, developmental[1]behavioral or neurodevelopmental disabilities pediatricians, occupational therapists, psychiatrists, and neurologists. For evaluations of children from birth to age six, a developmental-behavioral or neurodevelopmental disabilities pediatrician or pediatric neurologist shall perform the assessment or be part of the assessment team.

2. The highlighted section- what if there are not multiple sources available to give a comprehensive history. For example the person is new to VT , has no available family to provide historical info and schools/other sources do not respond to records requests. Can they find the person eligible?

Page 14 of DD act
2.10 (a) Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history;

3. Require Adult assessment tools to be used when determining eligibility for adult services. This usually happens but if someone was assessed at age 16 with a WISC, we currently find them eligible. Marc argued, the WISC and WAIS has certain differences where the WAIS is more

clinically appropriate.

Melanie Feddersen

Developmental Disabilities Services Specialist Supervisor
Department of Disabilities, Aging and Independent Living
Office: (802) 289-0015
Cell: (802) 760-0915

From: Donna Savage
To: McFadden, Clare
Subject: Fwd: Changes to the VT State System of Care Plan DDS
Date: Friday, October 28, 2022 4:56:02 PM

Donna Savage
cell: 802-503-5690

---------- Forwarded message ---------
From: **Donna Savage** <donnasavagevt@gmail.com>
Date: Fri, Oct 28, 2022 at 4:49 PM
Subject: Changes to the VT State System of Care Plan DDS
To: <ahs.DAILDDSDSOCPRegulations@vermont.gov>, <clare.mcfadden@vt.gov>, <Jennifer.Garabedian@vermont.gov>

Dear DDSD,

The purpose of our email is to request changes to the draft VT State System of Care Plan for Developmental Disabilities Services.

Our son, Jack, is now 21 years old and has significant life-long disabilities. Jack is profoundly deaf (with a cochlear implant), visually and cognitively impaired, developmentally delayed, and on the Autism Spectrum Disorder. He is also completely non-verbal and needs full-on personal care support as he is incontinent and wears diapers. Another thing very concerning about our son is his lack of understanding and awareness of danger. All of this has meant that throughout his life Jack has needed 1:1 care and support in all aspects of daily living - as well as eyes on him at all times! We, as his parents, lovingly care for him now, but of course realize that when we are no longer able to do so Jack will need to reside in a safe, stable home that provides round-the-clock care for him.

We are so grateful for the development of the DDHI group of VT parents and the work they are so diligently advocating for. We enthusiastically join them in being a voice for our son, who is completely unable to be a voice for himself. Jack, like others with I/DD with high support needs, deserves to live in a safe, service-supported residential community that offers opportunities to live among friends and enjoy supervised outings. We know this is no small undertaking for the state. It will necessitate the highest quality and competent staffing - and that too will need to be laser-focused on: for training, improved wages and benefits, and overall support to hire and *retain* the best!

Ideally, we'd see transportation be provided and the cost covered for trips back and forth to favorite activities, such as biking along the Burlington bike path, skiing with VT Adaptive Ski & Sports at Sugarbush, and bowling at Spare time (to name a few of Jack's favs!).

We have read the draft Vermont State System of Care Plan for Developmental Disabilities Services, to become effective Jan 1, 2023, and in order to allow our son to live in a permanent, supported home with a few friends, it is our desire to see the following barriers to housing projects changed in the SOCP:

1. Change the DRAFT SOCP Section Five IV.(B) 9. (page 56) AND DRAFT Regulations 7.100.5 (j)(3) (A) so that if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider shall submit a budget to the DA and the DA shall determine its costs to serve the individual, **the individual will have the choice of which of the services they would prefer not based completely or only, on the lowest possible cost.**

Notes:

a. The previous rule wording does not support the individual having choices in housing because the lowest possible housing cost is the SLP, and the cost is so low that it does not provide adequate financial support for any other housing choices.

b. This is particularly true for any individual needing 24/7 service and supports.

c. One reason that 90% of adults receiving Home Supports are in Shared Living is because it is the least expensive to the DAs and the State. The Adult Foster Care payments to Shared Living Providers are exempt from income taxation under Section 131. Additionally, the "operations and maintenance" costs of the real estate is not the responsibility of the DAs.

d. Creating new, sustainable, housing options has to recognize that the current lack of choice is directly tied to inadequate funding for DD services for decades.

e. The fact that Group Living and Staffed Living are more expensive ignores the fact that they are more expensive because the people served in those models have the highest needs. They are also more expensive because both of those models operate entirely on shift-staff.

2. Change Family Management of 24-Hour Home Supports in draft SOCP 2023, , Section Two, III Intake Process Choice of Provider, Family Managed Services so that the Family management can be for 24 hrs of home supports.

Notes:

a. The fact that some families' 24-hour management was "problematic" is not a reason to prohibit every family from doing so.

b. The DD Regulations are currently clear: "In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in (Regulations DRAFT, Section 7.100.6 (b)Self/Family-Managed Services - page 36)

3. Approval by the DDD to provide HCBS Medicaid funding for services to more than 4 adults living in a dwelling unit in a residential setting. in Draft System of Care Plan, Section FIVE, IV.(D)15.a (page 66)

4. Change Licensing requirements in 33 V.S.A., Chapter 71.

The licensing requirements for any residential care provider, whether a Residential Care Home or a Therapeutic Community Residence, start when there are 3 or more individuals being supported under one roof.

Note: The licensing requirements create an extra layer of cost and a significant barrier to creating the choice of small homes with a few friends living together in their chosen community.

REQUEST: We would like **change requirements for Therapeutic Community Residence, to be dependent on criteria other than number of individuals in the residence**, for example dependent on the levels of care needed, but less than licensing.

Respectfully,

Patrick D. and Donna T. Savage (on behalf of our son, Jack D. Savage)

Donna Savage
cell: 802-503-5690

From: Barbara Lee
To: McFadden, Clare; Garabedian, Jennifer
Subject: Re: Comments on Proposed Changes to the Developmental Disabilities Services Regulations
Date: Friday, October 28, 2022 3:22:23 PM

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Dear Clare and Jennifer,

I wish to offer full support to the written input to the Regulations which you received from Jim Caffry (see below). He articulates well the same concerns that I have; so please consider this email my written "input", also.

As a parent, an advocate, a member of DDHI, and as a member of the State Standing Committee and the ACT 186 Steering Committee, I believe it is essential that the DDSD implement significant changes, now, in the Regulations and the SOCP so that Vermonters have meaningful choice in their living arrangements. This is clearly the intention of our recently passed Act 186, and would bring Vermont closer to compliance with the CMS Settings Rule of 2014.

Respectfully,
Barbara Lee

64 Oak Hill Drive
Dummerston, VT 05301

> On Oct 28, 2022, at 2:33 PM, Jim Caffry <jim@caffrylaw.com> wrote:
>
> Clare and Jennifer:
>
> The following are written comments to the Developmental Disabilities Services Division ("DDSD"), within the Vermont Department of Disabilities Aging and Independent Living ("DAIL") regarding the proposed changes to the regulations, now to be referred to as the Developmental Disabilities Services Regulations.
>
> I am filing these written comments individually. However, as you know, I have been part of the parent-led Developmental Disabilities Housing Initiative ("DDHI"), and my comments on the proposed Regulations are made with the goal of encouraging positive changes in the Vermont developmental services system, particularly in the area of providing stable, service-supported housing for Vermonters with developmental disabilities and high support needs.
>
> Most of the changes needed to move forward will come through the development and adoption of new State System of Care Plan for Developmental Disabilities Services.
>
> The comments in this communication are focused on the proposed Developmental Disabilities Services Regulations.

As a starting point, DAIL and DDSD need to acknowledge that the State had fallen short of meeting one of the key principles of service in the Vermont Developmental Disabilities Act of 1996 – specifically the State has not met its obligation to provide meaningful choices when it comes to providing residential living situations for individuals requiring 24-hour supports.

18 V.S.A. § 8724 (Principles of service) states:

> Services provided to people with developmental disabilities and their families shall foster and adhere to the following principles:
>
> ***
>
> > (6) Meaningful choices. People with developmental disabilities and their families cannot make good decisions without meaningful choices about how they live and the kinds of services they receive. Effective services shall be flexible so they can be individualized to support and accommodate personalized choices, values, and needs and assure that each recipient is directly involved in decisions that affect that person's life.

Additionally, the passage of Act 186 requires the DDSD to take affirmative steps to expand housing and residential services for individuals with developmental disabilities.

In some of the materials recently produced by DDSD regarding housing arrangements, the DDSD has stated that of the roughly 1,800 people receiving Home Supports, 76% percent live in Shared Living: https://ddsd.vermont.gov/sites/ddsd/files/documents/Considerations_of_New_Housing_Options.pdf.

As has been expressed numerous times, that figure is very misleading. The 15% of people in Supervised Living have the independence skills that they do not require 24/7 supports. The 4% in Staffed Living and the 5% in Group Living generally have either significant medical needs or behavioral challenges that those 158 individuals have been unsuccessful in one or more Shared Living placements.

With some *very* limited exceptions, Shared Living is the *only* residential option for individuals who require 24/7 supports, but who do not have the medical or behavioral needs that result in Group or Staffed Living arrangements.

With those considerations in mind, turning to the proposed Developmental Disabilities Services Regulations, the DDSD is respectfully requested to consider the following:

1. **<u>7.100.1 (Purpose and Scope)</u>**
   See above. The purpose of the Regulations is to implement the DD Act (18 V.S.A., Chapter 204A), and not be a barrier to implementing the Act.

2. **<u>7.100.2(v) (Definitions – Home Supports)</u>**
   See above.

"Home Supports" means services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. Home supports must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.

Currently, there really is no choice for Home Supports if an individual requires 24-hour supports.

3. **7.100.2(ff) (Definitions – Resident)**

In subsection (ff)(1) a "facility" is not defined, but the Regulations should clearly permit individuals to reside in an out of state residential community (e.g., Visions in New Hampshire) in an adjoining state just as the Regulations allow for a person to remain a Vermont resident if the person lives with a Shared Living Provider in an adjoining state.

4. **7.100.4 (Recipient Criteria)**

Subsection (c) cross-references 7.100.2(ff)(1). Again, if an individual is considered to maintain Vermont residency when the individual resides in an adjoining state, that individual should have that same consideration for a residential community in an adjoining state.

5. **7.100.5(j) (Choice of Provider)**

Subsection (j)(1)(E) states: A recipient or family may request that an agency sub-contract with a non-agency provider to provide some or all of the authorized services; however, the decision to do so is at the discretion of the agency.

This language is currently in Subsection 4.10(a)(5) of the 2017 Regulations. This subsection should include language that makes it clear that an agency's consent to a family's request to have services provided through a subcontract with a non-agency provider must not be unreasonably withheld.

The Regulations should be clear that if an individual or family wants services provided through a non-agency provider, then the presumption should be that the agency will enter such a subcontract, and the agency's discretion not to subcontract should only be exercised in the event that there is a reasonable basis to conclude that the sub-contractor is unable to comply with the applicable programmatic requirements.

Additionally, there should be clear language that if an agency refuses to enter a contract with a non-agency provider, then the individual or Authorized Representative (e.g., parent/guardian), may appeal the refusal to subcontract to the DDSD Director.

6. **7.100.6 (Self/Family Management)**
As expressed in my October 20, 2022 email to the two of you, the prohibition on Self/Family Management of 24-hour home supports should be eliminated. That 8-hour limitation is an arbitrarily imposed barrier to creating alternative, sustainable housing options for individuals and families.

Whatever the "problematic" situations were that led to the 8-hour limitation being imposed by a memo in 2005, and then jammed into the 2011 DD Regulations over the unanimous objection of all public commenters, are not a legitimate basis to prohibit all individuals or families from managing 24-hour Home Supports.

The fact that there was a recent horrible situation of abuse and neglect in the Shared Living Provider Program (https://vtdigger.org/2022/09/13/4-caregivers-for-vulnerable-adults-charged-with-abuse-and-neglect/) does not mean the DDSD is going to ban all Shared Living Providers.

It is the DDSD's job, and the Supportive ISO's job, to administer the Self/Family Management Program. There is a process to terminate individuals or families from the management of services. If the individuals or families are not up to the task, then those individuals or families can have their ability to manage services taken away. It should be no different when it comes to management of 24-hour services.

Because the 8-hour Home Support limitation should finally be eliminated, and the ability to manage 24-hour Home Supports should be restored as it existed before March of 2005, then the requirement in the current 2017 Regulations, Section 5.2(m) should be reinstated ("Follow the requirements of the Housing Safety and Accessibility Review Process to ensure that the individual is living in a safe and accessible home.").

7. **7.100.11 (Certification of Providers)**
See Comment #5 above. The language of Subsection (f)(1) (Status of non-designated providers) should mirror Subsection 7.100.5(j) and be made clear that there is a presumption that the agency will enter a subcontract with a non-designated organization, and the discretion not to subcontract with a non-designated organization will only be exercised if there is a reasonable basis to conclude that the subcontractor is unable to comply with the applicable programmatic requirements.

In short, the Regulations should encourage the expansion of housing and residential service options for individuals with developmental disabilities, and any impediments to new and creative housing options should be removed from the Regulations. This is a requirement of both the DD Act of 1996 and of Act 186.

Thank you for your consideration of these comments.

Jim Caffry

118 Graves Farm Road
Waitsfield, VT 05673

From: Katherine
To: AHS - DAIL DDSD SOCP & Regulations
Subject: Requesting changes to the System of Care Plan
Date: Tuesday, October 25, 2022 1:16:16 PM

To whom it may concern,

I am a mother of an 18 year old daughter who has a diagnosis of autism, schizophrenia, and a receptive language impairment. She currently is attending the private school, Bellcate , where she receives 1:1 support throughout the day. We are working with her DA to find suitable housing options for her, but we have not found any that are suitable, given her complex profile. I am very concerned about her future options for supported housing and ongoing services, based on what is currently available, due to the difficulties in finding/funding alternative housing options, as well as difficulties finding staff to provide home/community supports.

These are the changes that I'd like to see made to the System of Care Plan as it now stands, to reduce barriers to the creation of stable, long-term supported housing options.

1. First of all, there needs to be more housing options presented as choices, beyond SLP's. SLP settings are presented now as the only option. I was told by my DA that other options are only to be considered if a client "fails out" of multiple SLP settings. The practice of "fail out of SLP" is damaging to clients, increases client anxiety, and decreases stability and security. I understand that SLP settings work most of the time, and many clients are happy with this as a choice. However, it should not be the only choice.
2. Ensure that Family Management of 24 hour home supports can be actualized/happen.
3. Increase the number of DD individuals who can live together in the same household/address, and still receive all of their benefits and services. One option might be to allow 2 SLP's two are interested to live under the same roof and job-share 2-3 clients during a week. (job-sharing SLP responsibilities would be part of the contract). Another might be to allow 2 DD clients, who choose to live together, to live in a 2 bedroom Section 8 apartment and still receive all their benefits.
4. Change the requirements for licensing of TCR's, and make those requirements dependent on criteria other than the number individuals in the residence... it should be dependent on the levels of care needed.
5. Ensure that adequate home and community supports are available and are delivered. My daughter is supposed to get 15 hrs/week of after-school home/community supports. However, due to staffing (which we have heard for three years now), she only gets 4 hours. There should be a way to monitor at the state level whether or not clients' services, are being delivered. Also, if these are delivered by people beyond who those managing the household, it allows for "more eyes on a client," in order to help ensure

safety.

Thank you for your consideration. -Katherine Barwin

Sent from Outlook

From: Garabedian, Jennifer
To: McFadden, Clare; Bascom, June; Feddersen, Melanie; Conant, Hilary
Subject: FW: SDM and the System of Care
Date: Tuesday, September 27, 2022 6:03:23 PM
Attachments: Revisions to SOC for SDM Ver 1.5 final.pdf

Here is the feedback from the Guardianship and SDM group. We have talked a little about how this would be a group that we would be receiving input from and possibly an area that we could include a Special Initiative around.

From: Murphy, Kirsten <Kirsten.Murphy@vermont.gov>
Sent: Tuesday, September 27, 2022 11:37 AM
To: Garabedian, Jennifer <Jennifer.Garabedian@vermont.gov>
Cc: McFadden, Clare <Clare.McFadden@vermont.gov>; Rachel Seelig <rseelig@vtlegalaid.org>
Subject: SDM and the System of Care

Dear Jennifer,

Attached please find comment regarding the System of Care Plan written on behalf of the Committee on Guardianship and Supported Decision Making.

My apologies that it is late due to a miscommunication between Rachel and I. Still, I believe you have been aware to these comments.

I hope this is helpful and look forward to seeing the Division's new draft System of Care.

Best,

Kirsten
Kirsten Murphy (she/her/hers)
Executive Director
Vermont Developmental Disabilities Council
Kirsten.Murphy@Vermont.gov
OFFICE PHONE: 802-828-1312 (preferred)
CELL PHONE: 603-443-0652

Bringing Vermonters with Developmental Disabilities
Into the Heart of Vermont Communities.

Jennifer Garabedian
Director
Developmental Disabilities Services Division
Agency of Human Services

Via Electronic transmission

Dear Ms. Garabedian,

We write as a group of disability advocates both within and outside of state government who are concerned about the overuse of court-ordered guardianships in Vermont. We seek to promote alternatives, especially Supported Decision Making (SDM). Our community of practice has met monthly for more than five years. It includes representatives from the Agency of Education, the Developmental Disabilities Council, Green Mountain Self-Advocates, the Office of Public Guardian, Vermont Family Network, Vermont Legal Aide, and your division, among others.

We are concerned that the concept of Supported Decision-Making and the role of DAIL and of Designated and Specialized Services Agencies in enabling SDM is absent from the System of Care and the quality review process for developmental services. We provide recommendations below for incorporating SDM into the next System of Care Plan and the standards for quality review.

Introduction

The core principles of the Department for Disabilities, Aging, and Independent Living (DAIL) and of the Developmental Disabilities Services Division (DDSD) closely align with the founding principles of Supported Decision Making (SDM). Specifically, SDM recognizes that all people seek support when making important decisions. People with disabilities should not have their rights and autonomy regarding decision making restricted through a guardianship order. More importantly, they should have access to the same sort of assistance that people without disabilities use when making important decisions. SDM is a means of formalizing that support. Consistent with the Principles of Service outlined in Developmental Disabilities Act for Vermont,[1] SDM promotes personal and economic independence, self-determination, and flexibility. Creating an individualized plan for decision making support also reinforces the individualized, person-centered nature of support that is expected under Medicaid's rules for Home and Community-Based Services.

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[1] V.S.A. Title 18, Section 8724.

Annotated Text

~~Regulations Implementing~~

~~The Developmental Disabilities Act of 1996~~

~~Effective: October 1, 2017~~

~~Developmental Disabilities Services Division~~
~~Vermont Department of Disabilities, Aging and Independent Living~~
~~October 1, 2017~~

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7.100.1 Developmental Disabilities Services Purpose and Scope (04/15/2020, GCR 19-059)

(a) The purpose of these regulations is to fulfill the requirements of the Developmental Disabilities Act of 1996 (DD Act) (18 V.S.A Chapter~~,~~ 204A) to include specific details for implementation of the Act. These rules are adopted pursuant to 18 V.S.A. § 8726.

(b) The Developmental Disabilities Services program operates within the State's Global Commitment to Health 1115 Waiver, providing long-term services and supports to individuals with developmental disabilities.

(c) The Program is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

~~Part 1.~~ 7.100.2 Definitions

The following terms are defined for the purpose of these regulations.

~~1.1~~(a)**"Adult"** means a person age 18 or older. The term includes people age 18 or older who attend school.

~~1.2~~(b)**"Agency"** means the responsible designated agency or specialized service agency.

~~1.3 **"Appeal"** means a request for an internal review of an action by the Department or a designated agency or a specialized service agency (DA/SSA). (See Part 8).~~

~~1.4~~(c)**"Applicant"** means a person who files a written application for services, supports or benefits in accordance with ~~Part 4~~ 7.100.5 of these regulations. If the applicant is a guardian or family member or a designated agency, the term "applicant" also includes the person with a developmental disability.

~~1.5~~(d)**"Authorized Funding Limit"** (AFL) means all funding related to an individual's home and community-based services budget, including the administration amount available to transfer (as specified in division policy), but does not include: funding for state and local crisis services, ~~the~~ the employment program base ~~Fiscal Employer/Agent~~ and statewide communication resources.

(e) **"Authorized Representative"** means an individual or organization, either appointed, by an applicant or beneficiary, or authorized under State or other applicable law, to act on behalf of the applicant or beneficiary in assisting with the application and renewal of eligibility, the internal appeal, grievance, or State fair hearing processes, and in all other matters with the Department, as permitted under 42 CFR § 435.923. Unless otherwise stated in law, the authorized representative has the same rights and responsibilities as the applicant or beneficiary in obtaining a benefit determination and in dealing with the internal appeal, grievance, and State fair hearing processes.

~~1.6~~ (f) **"Certification"** means the process by which the Department of Disabilities, Aging, and Independent Living determines whether a provider meets minimum standards for receiving funds it administers to provide services or supports to people with developmental disabilities.

~~1.7~~ (g) **“Certified provider”** means an agency that has as one of its primary purposes to deliver services and supports for people who have developmental disabilities and that currently is certified by the Department of Disabilities, Aging and Independent Living in accordance with ~~Part 10~~7.100.11 of these regulations.

~~1.8~~(h) **“Clinical Services”** means assessment; individual, family and group therapy; and medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist, or nurse. Clinical Services are medically necessary services and equipment (such as dentures, eyeglasses, assistive technology) that cannot be accessed through the Medicaid State Plan.

~~1.9~~(i) **“Commissioner”** means the Commissioner of the Department of Disabilities, Aging, and Independent Living.

~~1.10~~(j) **“Community Supports”** means support provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (two or more people). Community supports includes transportation to access the community. Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal home and community-based services rules.

~~1.11~~ (k) **“Crisis Services”** means time-limited, intensive supports provided for individuals who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Crisis Services may include crisis assessment, support and referral or crisis beds and may be individualized, regional, or statewide.

~~1.12~~ (l) **“Day”** means calendar day, not business day, unless otherwise specified.

~~1.13~~ (m) **“Department”** means the Department of Disabilities, Aging, and Independent Living.

~~1.14~~ (n) **“Designated Agency”** (DA) means an agency designated by the Department, pursuant to 18 V.S.A. § 8907, and the regulations implementing that law, to oversee, provide and ensure the delivery of services and/or service authorizations for eligible individuals with developmental disabilities in an identified geographic area of the state. The requirements for being a DA are explained in the Department’s *Administrative Rules on Agency Designation.*

~~1.15 **“Designated Representative”** means an individual, either appointed by an applicant for or recipient of developmental disabilities services or authorized under State or other applicable law, to act on behalf of the applicant or recipient in obtaining a determination or in participating in any of the levels of the appeal, fair hearing or grievance process. Unless otherwise stated in these regulations, the designated representative has all of the rights and responsibilities of an applicant or recipient in obtaining a determination or in dealing with any of the levels of the appeal, fair hearing or grievance process.~~

~~1.16~~ (o) **“Developmental Disability”** (DD) means an intellectual disability or an a~~A~~utism s~~S~~pectrum d~~D~~isorder which occurred before age 18 and which results in significant deficits in adaptive behavior that manifested before age 18 (See ~~Part 2~~7.100.3). Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

~~1.17~~ (p) **“Division”** means the Developmental Disabilities Services Division (DDSD) within the

Department.

~~1.18~~ (q) **"Employment Supports"** means support provided to assist transition age youth and adults in Establishing and achieving work and career goals. Employment supports include assessment, employer and job development, job training and ongoing support to maintain a job, and may include environmental modification, adaptive equipment, and transportation, as necessary.

~~1.19~~ (r) **"Family"** means a group of individuals that includes a person with a developmental disability and that is related by blood, marriage, or adoption or that considers itself a family based upon bonds of affection, which means enduring ties that do not depend upon the existence of an economic relationship.

~~1.20~~(s) **"Fiscal/-Employer/Agent"** (F/E/A) means an organization that is:

~~(a)~~(1) Qualified under Internal Revenue Service rules to pay taxes and provide payroll services for employers as a fiscal agent; and

~~(b)~~(2) Under contract with the Department to handle payroll duties for shared living providers who hire workers and recipients or families who choose to self/family-manage or share-manage services.

~~1.21~~(t) **"Global Commitment to Health Section 1115 Demonstration ("Demonstration")"** means the Section 1115 Demonstration under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title XIX of the Social Security Act.

~~1.22~~(u) **"Home and Community-Based Services"** (HCBS) means an array of long term services developed to support ~~an~~ individuals to live and participate in ~~his/her~~ their home and community rather than in an institutional setting, consistent with Centers for Medicare and Medicaid Services (CMS) federal HCBS Rules.

~~1.23~~ (v) **"Home Supports"** means services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. Home supports ~~shall~~must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.

~~1.24~~ (w) **"Individual"** means a young child, a school-age child or an adult with a developmental disability.

~~1.25~~(x) **"Individual Support Agreement"** (ISA) means the agreement between an individual and an agency or Supportive Intermediary Service Organization that describes the plan of services and supports.

~~1.26~~ (y) **"In-service training"** means training that occurs after a worker has been employed or is under contract. In-service training is intended to promote professional development and increase skills and knowledge.

~~1.27~~(z) **"Network"** means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner to provide or arrange developmental disabilities services and who provide services on an ongoing basis to recipients.

~~1.28~~(aa) **"Pre-service training"** means training that occurs before workers are alone with a person with developmental disabilities.

~~1.29~~(bb) **"Provider"** means a person, facility, institution, partnership, or corporation licensed, certified or authorized by law to provide health care service to a recipient during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless they are enrolled with Medicaid; however, a provider may enroll to serve only a specific recipient. A ~~developmental home~~shared living provider, employee of a shared living provider, or an individual or family that self/family-manages services is not a provider for purposes of these regulations.

~~1.30~~ (cc) **"Psychologist"** means a person licensed to practice psychology in the state where the evaluation occurred.

~~1.31~~(dd) **"Qualified Developmental Disabilities Professional"** (QDDP) means a person who meets the Department's qualifications as specified in Department policy for education, knowledge, training, and experience in supporting people with developmental disabilities and their families.

~~1.32~~(ee) **"Recipient"** means a person who meets the criteria contained in these regulations, and who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

~~1.33~~(ff) **"Resident"** means a person who is physically present in Vermont and intends to remain in Vermont and to make his or her home in Vermont, except a resident may also be:

- ~~(a)~~(1) A person placed in an out of state ~~school, facility, correctional center, or hospital~~ institution, as defined by Health Benefits Eligibility and Enrollment (HBEE) Rule 3.00, by a department of the State of Vermont.~~;~~ or
- ~~(b)~~(2) A person placed and supported in an unlicensed home in an adjoining state by a Vermont agency,~~;~~ or
- ~~(c)~~(3) A person who meets criteria listed in ~~Section 3.2~~7.100.4 (b)

~~1.34~~(gg) **"Respite Supports"** means alternative caregiving arrangements for family members or ~~home~~shared living providers/foster families and the individual being supported, on an intermittent or time limited basis, because of the absence of or need for relief of those persons normally providing the care to the individual, when the individual needs the support of another caregiver.

(hh) **School-age child"** means a child age 6 and younger than age 18.

~~1.35~~(ii) **"Self/family-managed"** services means the recipient or his or her family plans, establishes, coordinates, maintains, and monitors all developmental disabilities services and manages the recipient's budget within federal and state guidelines.

~~1.36~~(jj) **"Self/family-managed worker"** means a person who is employed or contracted and directed by a recipient or by a family member and paid with Department funds to provide supports or services for the recipient.

~~1.37~~(kk) **"Service"** means a benefit:

(1) Covered under the Global Commitment to Health Section 1115 Demonstration as set out in the Special Terms and Conditions approved by CMS,~~;~~
(2) Included in the State Medicaid Plan if required by CMS,~~;~~
(3) Authorized by state regulation or law,~~;~~ or
(4) Identified in the Intra-governmental Agreement (IGA) between DVHA and the Agency of Human Services (AHS), DVHA and the departments within AHS, or DVHA and the Agency of Education for the administration and operation of the Global Commitment to Health Section 1115 Demonstration.

~~1.38~~(ll) **"Service Coordination"** means assistance to recipients in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Service Coordination responsibilities include:~~, but are not limited to,~~

(1) D~~d~~eveloping, implementing and monitoring the ISA~~;~~
(2) C~~c~~oordinating medical and clinical services~~;~~
(3) E~~e~~stablishing and maintaining a case record~~;~~
(4) R~~r~~eviewing and signing off on critical incident reports~~; and~~
(5) P~~p~~roviding general oversight of services and supports~~.~~

The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.

~~1.39~~(mm) **"Shared management of services"** means that the recipient or his or her family manages some but not all Medicaid-funded developmental disabilities services, and an agency manages the remaining services.

~~1.40~~(nn) **"Special care procedure"** means nursing procedures that a lay individual (a person who is not a qualified health professional) does not typically have the training and experience to perform.

~~1. 41~~(oo) **"Specialized service agency"** (SSA) means an agency designated by the Department that meets criteria for contracting with the Department as an SSA, as described in the Department's *Administrative Rules on Agency Designation*, and that contracts with the Department to provide services to individuals with developmental disabilities.

~~1.42~~(pp) **"Supportive Intermediary Service Organization"** (Supportive ISO) means an organization under contract with the Department to provide support to individuals and families to learn and understand the responsibilities of self/family-managed services.

~~1.43~~(qq) **"Supportive Services"** means therapeutic services that cannot be accessed through State Plan Medicaid. These are therapeutically or medically appropriate services that include behavior support and consultation; assessment, consultation and training for communication supports; skills-based training such as dialectical behavior therapy skills groups or sexuality groups. This includes other therapeutic or medically appropriate services not covered under State Plan Medicaid when provided by licensed or certified individuals (such therapeutic horseback riding).

~~1.44~~(rr) **"System of Care Plan"** means the plan required by 18 V.S.A. §8725 describing the nature, extent, allocation and timing of services that ~~shall~~will be provided to people with developmental disabilities and their families.

~~1.45~~(ss) **"Transportation Services"** means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member or reimbursement for mileage for transportation to access Community or Employment Supports.

~~1.46~~ (tt) **"Worker"** means any employee or contractor compensated with funds paid or administered by the

Department to provide services to one or more people with a developmental disability. Professionals, such as nurses or psychologists practicing under a license granted by the State of Vermont are not included within this definition. Family-hired respite workers paid by Flexible Family Funding are not included within this definition.

~~1.47~~ (uu) **"Young child"** means a person who is under age 6~~not yet old enough to enter first grade~~.

~~Part 2.~~ 7.100.3 Criteria for determining developmental disability

~~2.1~~ (a) Young child with a developmental disability defined.

A young child with a developmental disability is a child who has one of the three following conditions:

~~(a)~~ (1) A diagnosed physical or mental condition so severe that it has a high probability of resulting in intellectual disability. This ~~means a diagnosed physical or mental condition and~~ includes conditions such as~~, but is not limited to, the following~~:

Anoxia
Congenital or ~~D~~degenerative central nervous system disease (such as Tay Sachs syndrome)
Encephalitis
Fetal alcohol syndrome
Fragile X syndrome
Inborn errors of metabolism (such as untreated PKU)
Traumatic brain injury
~~Multisystem developmental disorder~~
Shaken baby syndrome
Trisomy 21, 18, and 13
Tuberous sclerosis

~~(b)~~ (2) A condition of clearly observable and measurable delays in cognitive development and significant,~~ and~~ observable and measurable delays in at least two of the following~~-~~ developmental domains~~areas of adaptive behavior~~:

Communication
Social~~/~~emotional ~~development~~
Motor (physical)~~development~~
~~Daily living~~ Self-help skills

~~(c)~~ (3) An a~~A~~utism s~~S~~pectrum d~~D~~isorder (~~Section 2.8-2.10~~7.100.3(h)-(j)) resulting in significant, observable and measurable delays in at least two of the following developmental domains ~~areas of adaptive behavior~~:

Communication
Social/emotional ~~development~~
Motor (physical)~~development~~
~~Daily living~~ Self-help skills.

~~2.2~~ (b) Criteria for assessing developmental disability in a young child.

~~(a)~~ (1) The diagnosis of a condition which has a high probability of resulting in intellectual disability (~~Section 2.1~~7.100.3(a)(1)) must~~shall~~ be made by a physician~~ or psychologist~~.

~~(b)~~ (2) The documentation of ~~significant~~ delays in cognitive and other developmental domains~~adaptive behavior~~ (~~Section 2.1(b)~~7.100.3(a) (2)-(3))~~or significant delays in adaptive behavior for a young child with Autism Spectrum Disorder (Section 2.1(c))~~ must~~shall~~ be made through a family-centered evaluation process which includes the family. The evaluation process must~~shall~~ include:

~~(1)~~ (A)Observations and reports by the family and other members of the assessment team, such as a physician, behavior consultant, psychologist, speech therapist, audiologist, physical therapist, occupational therapist, childcare provider, representative from the ~~Part C~~ Children's Integrated Services - Early Intervention (CIS-EI) Team, representative from Early ~~Essential~~ Childhood Special Education (ECSE~~EE~~), representative from Children with Special Health Needs, representative from an agency;

~~(2)~~ (B) A review of pertinent medical/educational records, such as assessments used to determine eligibility for CIS-EI and ECSE, as needed; and

~~(3)~~ (C) Appropriate screening and assessment instruments.

~~(c)~~ (3) The diagnosis of a~~A~~utism s~~S~~pectrum d~~D~~isorder must~~shall~~ be made according to ~~Section 2.8-2.10~~7.100.3(h)-(j).

~~2.3~~ (c) School-age child or adult with developmental disability defined.

~~(a)~~ (1) A school-age child (~~old enough to enter first grade~~ age 6 and younger than age 18) or adult with a developmental disability is an individual who:

~~(1)~~ (A) Has intellectual disability (~~Section 2.4~~7.100.3(d)-(f)) or a~~A~~utism s~~S~~pectrum d~~D~~isorder (~~Section 2.8~~7.100.3(h)-(j)) which manifested before age 18 (~~section 2.13~~7.100.3(m)); and

~~(2)~~ (B) Has significant deficits in adaptive behavior (~~Section 2.11~~7.100.3(k)-(l)) which manifested before age 18 (~~section 2.13~~7.100.3(m)).

~~(b)~~ (2) Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

~~2.4~~ (d) Intellectual disability defined.

~~(a)~~ (1) **“Intellectual disability”** means significantly sub-average cognitive functioning that is at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by a ~~full scale~~full-scale score of 70 or below, or up to 75 or below when taking into account the standard error of measurement, on an appropriate norm-referenced standardized test of intelligence and resulting in significant deficits in adaptive behavior manifested before age 18.

~~(b)~~ (2) **“Intellectual disability”** includes severe cognitive deficits which result from brain injury or disease if the injury or disease resulted in deficits in adaptive functioning before age 18. A person with a diagnosis of “learning impairment” has intellectual disability if the person meets the criteria for determining “intellectual disability” outlined in ~~Section 2.5~~7.100.3(e).

~~2.5~~ (e) Criteria for determining whether a school-age child or adult has intellectual disability.

~~(a)~~ (1) The determination of whether a school-age child or adult has intellectual disability for the purpose of these regulations requires documentation of the following components:

~~(1)~~ (A) Significantly sub-average cognitive functioning (~~Section 2.6 (b) – (h)~~7.100.3(d) and (f));

~~(2)~~ (B) Resulting in significant deficits in adaptive behavior; and (~~Section 2.11~~7.100.3(k)-(l))

~~(3)~~ (C) Manifested before age 18 (~~Section 2.13~~7.100.3(m)).

(2) The criteria for determining whether a school-aged child or adult has an intellectual disability is as defined in these regulations as outlined in ~~Sections~~ 7.100.3(e-f) and not as described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

~~2.6~~ (f) Process for determining whether a school-aged child or adult has an intellectual disability.

~~(a)~~ (1) To determine whether or not a school-age child or adult has intellectual disability, a psychologist must~~shall~~:

~~(1)~~ (A) Personally perform, supervise, or review assessments that document significantly sub-average cognitive functioning and deficits in adaptive behavior manifested before age 18; and

~~(2)~~ (B) Integrate current and past~~these~~ test results with other information about the individual's abilities in arriving at a determination.

~~(b)~~ (2) The most universally used standardized intelligence test for school-aged children up to age 16 is the Wechsler Intelligence Scale for Children (WISC), current edition. The most universally used measure for children over age 16 and adults is the Wechsler Adult Intelligence Scale (WAIS), current edition. For people with language, motor, or hearing disabilities, a combination of assessment methods must~~shall~~ be used and the psychologist must~~shall~~ use clinical judgment to determine the best tests to use for the individual. Diagnosis based on interpretation of test results takes into account a standard error of measurement for the test used.

~~(c)~~ (3) A determination that a person has intellectual disability for the purpose of these regulations must~~shall~~ be based upon current assessment of cognitive functioning *and* a review of any previous assessments of cognitive functioning. It is the responsibility of the psychologist to decide whether new cognitive testing is needed. In general, for school-aged children, "current" means testing conducted within the past three years. For adults, "current" means cognitive testing conducted in late adolescence or adulthood. Situations where new testing may be indicated include the following:

~~(1)~~ (A) There is reason to believe the original test was invalid (e.g., the person was sick, was not wearing glasses, was in the midst of a psychiatric crisis, etc.).

~~(2)~~ (B) The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

~~(3)~~ (C) The individual had mild intellectual disability on a previous test and has since made gains in adaptive behavior.

~~(d)~~ (4) If IQ~~past~~ testing of the person has resulted in some Full-Scale IQ (FSIQ) scores above 70 and some FSIQ scores below 70, taking into account the standard error of measurement, it is the responsibility of the psychologist to determine which FSIQ scores are the best ~~most accurately reflect~~ estimate of the person's cognitive ability. When there is a wide variation between test scores, the psychologist should render his/her clinical opinion, including the rationale, regarding which FSIQ scores are the best estimate of the person's cognitive ability. A determination that a person has intellectual disability for the purpose of these regulations cannot be made if all of the person's FSIQ test scores are ~~consistently~~ greater than 75~~0~~.

~~(e)~~ (5) The diagnosis in questionable cases should be based upon scores over time and multiple sources of measurement.

~~(f)~~ (6) The diagnosis of intellectual disability must~~shall~~ not be based upon assessments conducted when the individual was experiencing a short-term psychiatric, medical, or emotional crisis which could affect performance. Cognitive testing should not ordinarily be performed when a person is in the midst of a hospital stay.

~~(g)~~ (7) If the psychologist determines that standardized intellectual testing is inappropriate or unreliable for the person, the psychologist can make a clinical judgment based on other information, including an adaptive behavior instrument.

~~(h) The criteria for determining whether a school-aged child or adult has an intellectual disability for the purposes of these regulations is as outlined in Sections 2.5 -2.6 and not as described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).~~

~~2.7~~ (g)~~-~~Criteria for determining whether a school-age child or adult has an a~~A~~utism s~~S~~pectrum d~~D~~isorder and is a person with a developmental disability.

The determination of whether a school-age child or adult has an a~~A~~utism s~~S~~pectrum d~~D~~isorder and is a person with a developmental disability for the purpose of these regulations requires documentation of the following components:

~~(a)~~ (1) Diagnosis of an a~~A~~utism s~~S~~pectrum d~~D~~isorder made according to process outlined in ~~section 2.8-2.10~~7.100.3(h)-(j)~~;~~

~~(b)~~(2) Resulting in significant deficits in adaptive behavior (~~Section 2.11~~7.100.3(k)-(l)); and

~~(c)~~(3) Manifested before age 18 (~~Section 2.13~~7.100.3(m)).

~~2.8~~ (h) Autism s~~S~~pectrum d~~D~~isorder defined.

"Autism s~~S~~pectrum d~~D~~isorder" means the same as it is defined in the current DSM. People receiving services as of ~~the effective date of these regulations~~October 1, 2017, who were found eligible with a diagnosis of pervasive developmental disorder under previous versions of the DSM continue to be eligible for services if they continue to present the symptoms that resulted in the diagnosis. Autism s~~S~~pectrum d~~D~~isorder means the same as the term "autism" in the Developmental Disabilities Act.

~~2.9~~ (i) -Criteria for determining whether a person has a~~A~~utism s~~S~~pectrum d~~D~~isorder.

~~(a)~~(1) The diagnostic category of a~~A~~utism s~~S~~pectrum d~~D~~isorder includes considerable variability in the presence and intensity of symptoms. Many of the symptoms of a~~A~~utism s~~S~~pectrum d~~D~~isorder overlap with other childhood diagnoses. Because of the complexity in differentially diagnosing a~~A~~utism s~~S~~pectrum d~~D~~isorder, it is essential that clinicians rendering these diagnoses have specific training and experience in child development, a~~A~~utism s~~S~~pectrum d~~D~~isorder, other developmental disorders, and other childhood psychiatric disorders.

~~(b)~~(2) Preferably a comprehensive diagnostic evaluation is conducted by an interdisciplinary team of professionals with specific experience and training in diagnosing a~~A~~utism s~~S~~pectrum d~~D~~isorder. In the absence of an interdisciplinary team, a single clinician with the qualifications listed below may conduct a multidisciplinary assessment integrating information from other professionals.

~~(c)~~(3) At a minimum, an evaluation must~~shall~~ be performed by a single clinician who has the following qualifications or an interdisciplinary team that includes:

~~1.~~ (A) A board certified or board eligible psychiatrist; or

~~2.~~ (B) A psychologist; or

~~3.~~ (C) A board certified or board eligible neurologist or developmental-behavioral or neurodevelopmental disabilities pediatrician.

~~(d)~~(4) The psychiatrist, psychologist, neurologist, or pediatrician must~~shall~~ have the following additional experience and training:

~~1.~~(A) Graduate or post-graduate training encompassing specific training in child development, a~~A~~utism s~~S~~pectrum d~~D~~isorder, and other developmental and psychiatric disorders of childhood, and a process for assessment and differential diagnosis of a~~A~~utism s~~S~~pectrum d~~D~~isorder; or supervised clinical experience in the assessment and differential diagnosis of a~~A~~utism s~~S~~pectrum d~~D~~isorder;

~~2.~~(B) Training and experience in the administration, scoring and interpreting of psychometric tests, or training in understanding and utilizing information from psychometric testing in the diagnosis of a~~A~~utism s~~S~~pectrum d~~D~~isorder; and

~~3.~~(C) Experience in the evaluation of individuals with the age range of the person being evaluated.

~~(e)~~(5) Clinicians must~~shall~~ follow the ethical guidelines for their profession regarding practicing within their area of expertise and referring to other professionals when needed. When a single clinician is conducting the assessment, he or she should determine whether other professionals need to evaluate the person to gain additional information before rendering a diagnosis. Additional evaluators may include psychologists, speech language pathologists, medical sub-specialists, developmental-behavioral or neurodevelopmental disabilities pediatricians, occupational therapists, psychiatrists, and neurologists. ~~For evaluations of children from birth to age six, a developmental-behavioral or neurodevelopmental disabilities pediatrician or pediatric neurologist shall perform the assessment or be part of the assessment team.~~

~~(f)~~(6) In the event a shortage of qualified assessors prevents timely evaluations, the state will~~shall~~ assist agencies to identify available qualified assessors or may, in its discretion, waive the provision of rule~~ 2.9(d)~~(i)(4).

~~2.10~~(j) Essential components of an assessment to determine a~~A~~utism s~~S~~pectrum d~~D~~isorder.

New applicants must be assessed using the DSM criteria in effect at the time of application. An assessment to determine whether an individual has an a~~A~~utism s~~S~~pectrum d~~D~~isorder must~~shall~~ include all of the following components:

~~(a)~~(1) Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history;

~~(b)~~(2) Systematic a~~A~~utism s~~S~~pectrum d~~D~~isorder diagnostic interview with primary caregivers;

~~(c)~~(3) A systematic observation with the individual to assess social interaction, social communication, and presence of restricted interests and behaviors;

~~(d)~~(4) For older children and adults who can report symptoms, a systematic clinical interview;

~~(e)~~(5) Referral for multidisciplinary assessment, as indicated;

~~(f)~~(6) Comprehensive clinical diagnostic formulation, in which the clinician weighs all the information from (~~a-e~~ 7.100.3(j)(1)-through (5) ~~above~~, integrates findings and provides a well-formulated differential diagnosis using the criteria in the current version of the DSM; and

~~(g)~~(7) Current assessments based upon the individual's typical functioning.

~~(1)~~(A) A determination of a~~A~~utism s~~S~~pectrum d~~D~~isorder for the purpose of these regulations must~~shall~~ be based upon current assessment. It is the responsibility of the clinician or team performing the assessment to decide whether new observations or assessments are needed. In general, for school-age children, "current" means a comprehensive assessment conducted within the past three years. However, for school-age children applying for limited services such as Flexible Family Funding, Targeted Case Management, the Bridge Program, or Family Managed Respite, "current" means a comprehensive assessment conducted any time prior to age 18; for such children, a new assessment is required if the DA believes the child may not have a~~A~~utism s~~S~~pectrum d~~D~~isorder or when applying for HCBS.

~~(2)~~(B) The initial diagnosis of a~~A~~utism s~~S~~pectrum d~~D~~isorder must~~shall~~ not be based upon assessments and observations conducted when the individual is experiencing a psychiatric, medical or emotional crisis or when a person is in the midst of a hospital stay. Further assessment should be completed when the person stabilizes and/or returns to the community.

~~(3)~~(C) For adults, "current" means a comprehensive assessment conducted in late adolescence or adulthood and adaptive testing within the past three years. Situations where new testing may be indicated include the following:

~~(A)~~ (i)The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

~~(B)~~ (ii)New information indicates that an alternate diagnosis better explains the individual's functioning and behavior.

~~2.11~~(k) Significant deficits in adaptive behavior defined.

~~(a)~~ ~~"~~**Significant deficits in adaptive behavior**~~"~~ means deficits in adaptive functioning which result in~~:A~~an overall composite score on a standardized adaptive behavior scale at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by an overall composite score of 70 or below, taking into account the standard error of measurement for the assessment tool used.~~; and~~

~~(b) A score at least two standard deviations below the mean for a similar age normative comparison group in two or more of the following areas of adaptive behavior: communication; self- care; home living; social/interpersonal skills; use of community resources; self direction; functional academic skills; work; health; or safety.~~

~~2.12~~(l) Criteria for assessing adaptive behavior in a school-age child or adult.

~~(a)~~(1) Adaptive functioning must~~shall~~ be measured by the current version of a standardized norm-referenced assessment instrument. The assessment tool must~~shall~~ be standardized with reference to people of similar age in the general population. Adaptive functioning must~~shall~~ not be measured with an instrument that is norm-referenced only to people in institutions or people with intellectual disability or a~~A~~utism s~~S~~pectrum d~~D~~isorder.

~~(b)~~(2) The assessment instrument must~~shall~~ be completed by a person qualified to administer, score, and interpret the results as specified in the assessment tool's manual. The administration of the tool must follow the protocol for administration specified in the assessment tool's manual.

~~(c)~~(3) The assessment must~~shall~~ be current. A current assessment is one which was completed within the past three years, unless there is reason to think the individual's adaptive functioning has changed.

~~(d)~~(4) Based upon the assessment, the evaluator must~~shall~~ determine whether the person is performing two or more standard deviations below the mean with respect to adaptive functioning, compared to a national sample of similar-aged people.

~~(e)~~(5) Ordinarily, assessments must~~shall~~ be based upon the person's usual level of adaptive functioning. Assessments should~~shall~~ not ordinarily be performed when the individual is in the midst of an emotional, behavioral or health crisis, or must~~should~~ be repeated once the individual stabilizes. An assessment performed while the individual was in a nursing facility or residential facility must~~shall~~ be repeated when the individual is in a community setting.

~~(f)~~(6) It is the responsibility of the psychologist to ensure that the adaptive behavior assessment is based upon information from the most accurate and knowledgeable informant available. It may be necessary to integrate information on adaptive functioning from more than one informant.

~~2.13~~(m) Manifested before age 18

“Manifested before age 18” means that the impairment and resulting significant deficits in adaptive behavior were observed before age 18. Evidence that the impairment and resulting significant deficits in adaptive behavior occurred before the age 18 may be based upon records, information provided by the individual, and/or information provided by people who knew the individual in the past.

~~2.14~~(n) Nondiscrimination in assessment

Assessment tools and methods must~~shall~~ be selected to meet the individual needs and abilities of the person being assessed.

~~(a)~~(1) People whose background or culture differs from the general population must~~shall~~ be assessed with methods and instruments that take account of the person's background.

~~(b)~~(2) A person must~~shall~~ be assessed in the language with which he or she communicates most comfortably.

~~(c)~~(3) People with language, motor, and hearing disabilities must~~shall~~ be assessed with tests which do not rely upon language, motor ability, or hearing.

~~(d)~~(4) If a person uses hearing aids, glasses, or other adaptive equipment to see, hear, or communicate, the evaluator must~~shall~~ ensure that the individual has access to the aids or adaptive equipment during the evaluation.

~~(e)~~(5) If a person uses a language interpreter or a method of augmentative and alternative communication and or needs a personal assistant for communication, the evaluator (e.g., the psychologist) is responsible for deciding how best to conduct the overall assessment in order to achieve the most authentic and valid results. However, scores for standardized tests are valid only if testing was performed in accordance with the criteria set forth in the test manual.

(o) Missing information to document developmental disability

There may be circumstances in which considerable effort is made to obtain all the required history and documentation to determine whether a person has a developmental disability, but the required information cannot be obtained. This may include situations in which there are no available informants to document a person's functioning prior to age 18, previous records cannot be obtained, or do not exist. In these circumstances, the determination of whether the person meets the criteria for having a developmental disability should be based upon the current assessment and all available information, including other life factors that occurred after age 18 that could potentially impact cognitive, adaptive, or other functioning.

~~Part 3.~~ 7.100.4 —Recipient Criteria

~~3.1~~ (a) Who can be a recipient

~~(a)~~ (1) A recipient ~~shall be~~ is an individual with a developmental disability, as defined in ~~Part 1~~7.100.2 (o) and (ee), who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

~~(b)~~(2) Services or supports to a family member of a recipient ~~shall~~must be in the context of supporting the recipient and are for the purpose of assisting the family to provide care and support for their family member with a developmental disability.

~~3.2~~ (b) Recipients ~~shall~~must be Vermont residents

~~(a)~~(1) A recipient ~~shall~~must be a resident of Vermont as defined in 7.100.2(ff). In the case of a minor child, at least one custodial parent of the child ~~shall~~must be a resident of Vermont.

~~(b)~~(2) A person or family who leaves Vermont for a vacation, visit, temporary move, or trial move may continue to be a recipient for a period not to exceed six months.

~~3.3~~ (c) Exceptions

The Commissioner may make exceptions to the requirements of the program access criteria in ~~Section~~ 7.100.4~~3.1~~(a), in order to promote the purposes of the Developmental Disabilities Act, if the exception will not deprive other people who meet the criteria for being recipients of needed services or benefits (e.g., when funds are provided by another state, or by another Vermont state agency or department).

~~3.4~~(d) People receiving services on July 1, 1996

People with developmental disabilities who were receiving services on July 1, 1996, ~~shall~~may continue to receive services consistent with their needs and the System of Care Plan and these regulations.

~~3.5~~(e) Eligibility after leave of service

Any person who leaves services for one year or longer for any reason and later reapplies for services ~~shall~~must be assessed based upon the eligibility criteria in effect on the date of the person's reapplication.

~~Part 4.~~7.100.5 ~~——~~Application, Assessment, Funding Authorization, Programs and Funding Sources, Notification, Support Planning and Periodic Review

~~4.1~~ (a) Who may apply

~~(a)~~(1) Any person who believes he or she has a developmental disability or is the family member or authorized representative of such a person may apply for services, supports, or benefits. In addition, the guardian of the person may apply.

~~(b)~~(2) Any other person may refer a person who may need services, supports, or benefits.

~~(c)~~(3)-An agency or a family member may initiate an application for a person with a developmental disability or a family member but ~~shall~~must obtain the consent of the person or guardian to proceed with the application.

~~4.2~~ (b) Application form

~~(a)~~(1) Department ~~shall~~will adopt an application form to be completed by or on behalf of all applicants. The DA ~~shall~~must provide a copy of the application to all people who contact the DA saying they wish to apply for services.

~~(b)~~(2) Copies of the application form ~~shall~~will be available from the Department, on the Department's website, and from every office of a DA. A person may request an application form in person, by mail, by electronic format, by facsimile (FAX), or by telephone.

~~(c)~~(3) The DA ~~shall~~must provide assistance to an applicant who needs or wants help to complete the application form.

~~4.3~~ (c) Where to apply

~~(a)~~(1) An application ~~shall~~must be filed at an office of the DA for the geographic area where the person with a developmental disability lives.

~~(b)~~(2) An application for a person, who is new to services, who is incarcerated or living in a residential school, facility or hospital ~~shall~~must be filed at an office of the DA for the geographic area where the person was living before going to the school, facility or hospital. For individuals who were receiving services just prior to being in one of these facilities, an application ~~shall~~must be filed at the DA which was last responsible prior to the individual entering the facility.

~~(c)~~(3) An application for a person who is in the custody of the Department for Children and Families (DCF) ~~shall~~must be filed at an office of the DA for the region in which the individual was placed in DCF custody. Applications for children under 18 who are in the custody of their parents should be filed at the DA where a custodial parent lives.

~~(d)~~(4) An application may be submitted by mail, facsimile (FAX), secure electronic format, or in person.

~~4.4~~ (d) Screening

~~(a)~~(1) Within five (5) ~~working~~business days of receiving an application, the DA ~~shall~~must complete the application screening process. If there are extenuating circumstances that prevent completion in five (5) business days, the agency ~~shall~~must document those in the individual's record. The screening process includes all of these steps:

~~(1)~~ (A) Explaining to the applicant the application process, potential service options, how long the process takes, how and when the applicant is notified of the decision, and the rights of applicants, including the right to appeal decisions made in the application process;

~~(2)~~ (B) Notifying the applicant of the rights of recipients in plain language, including the procedures for filing a grievance or appeal and their rights as outlined in the federal CMS HCBS rules;

~~(3)~~ (C) Discussing options for information and referral; and

~~(4)~~ (D) Determining whether the person with a developmental disability or the person's family is in crisis or will be in crisis within 60 days. If the DA determines that the person or family is facing an immediate crisis, the DA ~~shall~~must make a temporary or expedited decision on the application.

~~(b)~~(2) At the point of initial contact with an applicant, the DA ~~shall~~must inform the applicant of all certified providers in the region and the options to:

~~(1)~~(A) Receive services and supports through any certified provider in the region.~~;~~

~~(2)~~(B) Share the management of those services with the DA or SSA, ~~;~~ or

~~(3)~~(C) Self/family-manage their services through the Supportive ISO.

~~(c)~~(3) Contact and referral information for options for services outside of the DA must be provided to each applicant and referral assistance provided to ensure the applicant is informed of his or her choice of all the service options listed in 7.100.5-(d)(2) ~~4.4(b)~~. The DA ~~shall~~must have documentation that the applicant was informed of all of these options.

~~(d)~~(4) If the applicant wants more information about options or chooses to pursue services outside the DA, then the DA ~~shall~~must contact the SSA or Supportive ISO on behalf of the applicant.

~~4.5~~ (e) Assessment

~~(a)~~(1) The DA is responsible for conducting the assessment or assuring that it is conducted. The assessment process ~~shall~~must involve consultation with the applicant, and, with the consent of the applicant, other organizations which support the applicant.

~~(b)~~(2) The DA ~~-shall~~must offer information and referral to the applicant at any time that it may be helpful.

~~(c)~~(3) Assessment consists of in-depth information-gathering to answer the four following questions:

~~(1)~~(A) Is this a person with a developmental disability, as defined in ~~Part 1~~ 7.100.2(o) of these regulations, and a person eligible to be a recipient, as defined in ~~Part 3~~ 7.100.4? If so,

~~(2)~~(B) What does the person or his or her family need? This question is answered through a uniform needs assessment and process approved by the Department, which determines with each person or family their service or support needs, including identification of existing supports and family and community resources.

~~(3)~~(C) Does the situation of the person or family meet the criteria for receiving any services or funding defined as a funding priority in the *System of Care Plan* ~~Section 4.7 of these regulations~~? If so,

~~(4)~~(D) What are the financial resources of the person with a developmental disability and his or her family to pay for some or all of the services?

~~4.6~~ (f) Authorization of funding for services

Based on the answers to the questions in ~~Section~~ 7.100.5 (e)~~4.5(e)~~, the DA ~~shall~~will seek or authorize funding for services to meet identified needs or ~~shall~~will determine that the individual is not eligible for the requested funding for services. The procedures for authorizing funding or services are described in the *System of Care Plan.* Services and the funding amount authorized must~~shall~~ be based upon the most cost-effective method of meeting an individual's assessed needs, the eligibility criteria listed in the *System of Care Plan* ~~Section 4.7~~, as well as guidance in the *System of Care Plan* and current *Medicaid Manual for Developmental Disabilities Services.* When determining cost effectiveness, consideration ~~shall~~will be given to circumstances in which less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful.

~~4.7~~ (g) Available Programs and Funding Sources

The Department's programs reflect its current priorities for providing services for Vermont residents with developmental disabilities. The availability of the Department's current programs~~, which are described below,~~ is subject to the limits of the funding appropriated by the Legislature on an annual basis. The nature, extent, allocation and timing of services are addressed in the *System of Care Plan* (SOCP) as specified in the DD Act~~,~~. ~~and~~ A~~a~~dditional details, eligibility criteria, limitations and requirements for each program are included in the SOCP, the current *Medicaid Manual for Developmental Disabilities Services*, and in specific Division guidelines. Programs will be continued, and new programs will be developed, based on annual demographic data obtained regarding Vermont residents with developmental disabilities, the use of existing services and programs, the identification of the unmet needs in Vermont communities and for individual residents of Vermont, and the reasons for any gaps in service.

~~(a)The Bridge Program: Care Coordination for Children with Developmental Disabilities~~

~~The Bridge Program is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) service that provides support to families in need of care coordination to help them access and/or coordinate medical, educational, social or other services for their children with developmental disabilities.~~

~~(1) Eligibility~~

~~(A)Clinical:~~

~~Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(B) Financial:~~

~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~

~~Individual must be under the age of 22. Care coordination is available in all counties either through the Bridge Program or through an Integrating Family Services (IFS) program administered by the Department of Mental Health. Children who are receiving care coordination, case management or service coordination from another AHS funded source listed in the Bridge Program Guidelines are not eligible to receive Bridge Program Care Coordination.~~

~~(b) Developmental Disabilities Specialized Services Fund~~

~~This fund pays for dental services for adults and adaptive equipment and other one-time ancillary services needs that individuals and families cannot meet or are not covered by other funding sources.~~

~~(1) Eligibility~~

~~(A) Clinical:~~

~~Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(B)Financial:~~

~~None~~

~~(C)Access Criteria:~~

~~The goods and services requested must be related to the person's disability and meet the Division's *Special Services Fund Guidelines.*~~

~~**(c) Employment Conversion**~~

~~The Employment Conversion Initiative is intended to support people to convert their community supports funding to work supports.~~

~~(1) **Eligibility**~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disabilities as defined in these regulations.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~Individuals with HCBS funding who must have transferred at least 50% of their existing community supports funding to work supports.~~

~~**(d) Family Managed Respite**~~

~~Family Managed Respite (FMR) funding is allocated by DAs to provide families with a break from caring for their child with a disability, up to age 21. Respite can be used as needed, either planned or in response to a crisis.~~

~~**(1) Eligibility**~~

~~(A) Clinical:~~
~~Individual with a developmental disability or eligible to receive services from Children's Mental Health Services.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~FMR is available to children up to, but not including, age 21 living with their biological/adoptive families or legal guardian and who are not receiving HCBS funding.~~

~~**(e) Flexible Family Funding**~~

~~Flexible Family Funding (FFF) provides funding for families caring for a family member with a developmental disability at home. Funding is provided to eligible families of individuals with developmental disabilities to help pay for any legal good or activity that the family chooses such as respite, assistive technology, home modification, or individual and household needs. These income- based funds, determined by a sliding scale, are used at the discretion of the family. FFF is available at DAs in all counties.~~

~~(1) **Eligibility**~~

~~(A) Clinical:~~

~~Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(B) Financial:~~
~~Income-based on sliding fee scale outlined in *Flexible Family Funding Guidelines.*~~

~~(C) Access Criteria:~~
~~An individual who lives with their family (i.e., unpaid biological, adoptive and/or step-parents, adult siblings, grandparents, aunts/uncles, nieces/nephews and legal guardians) or an unpaid family member who lives with and supports an individual with a developmental disability is eligible. Individuals living independently or with their spouse, and those receiving HCBS are not eligible.~~

~~**(f) Growth and Lifelong Learning**~~

~~These Department-approved programs provide lifelong learning and teaching experiences to adults with developmental disabilities and increases the individual's ability to become an expert in topics of interest through supported research, inquiry, community networking and full examination of a topic.~~

~~**(1) Eligibility**~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disabilities as defined in these regulations.~~

~~(B) Financial:~~
~~Vermont Medicaid-eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~Access is limited to the geographic area where the approved program is provided.~~

~~**(g) Home and Community Based Services (HCBS)**~~

~~Developmental Disabilities HCBS are long term services and supports provided throughout the state by private, non-profit developmental disabilities services providers, or through self/family management, to adults and children with developmental disabilities with the most intensive needs. Individual HCBS budgets are based on an all-inclusive daily rate that combines all applicable services and supports provided to the individual in accordance with their assessed needs plus associated administrative costs. Services and supports may include: Service Coordination, Community Supports, Employment Supports, Respite Supports, Clinical Services, Supportive Services, Crisis Services, Home Supports and Transportation Services.~~

~~Abbreviated definitions of these services are included in Part 1. Full definitions are included in the current *System of Care Plan* and the current *Medicaid Manual for Developmental Disabilities Services.*~~

~~**(1) Eligibility**~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(B) Financial:~~

~~Vermont Medicaid-eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~

~~(i) Must meet all 3 of the following criteria:~~

~~(1) Individual would otherwise be eligible for Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD) level of care;~~

~~(2) The individual has an unmet need related to their developmental disability; and~~

~~(3) The individual's unmet need meets one of the following six funding priorities for HCBS.~~

~~(A)Health and Safety: Ongoing, direct supports and/or supervision are needed to prevent imminent risk to the individual's personal health or safety. [Priority is for adults age 18 and over.]~~

~~(i) "Imminent" is defined as presently occurring or expected to occur within 45 days.~~

~~(ii) "Risk to the individual's personal health and safety" means an individual has substantial needs in one or more areas that without paid supports put the individual at serious risk of danger, injury or harm (as determined through a needs assessment).~~

~~(B) Public Safety: Ongoing, direct supports and/or supervision are needed to prevent an adult who poses a risk to public safety from endangering others. To be considered a risk to public safety, an individual must meet the Public Safety Funding Criteria (see Section (g)(2), infra). [Priority is for adults age 18 and over.]~~

~~(C) Preventing Institutionalization – Nursing Facilities: Ongoing, direct supports and/or supervision needed to prevent or end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. [Priority is for children and adults.]~~

~~(D) Preventing Institutionalization – Psychiatric Hospitals and ICF/DD: Ongoing, direct supports and/or supervision needed to prevent or end stays in inpatient public or private psychiatric hospitals or end institutionalization in an ICF/DD. [Priority is for children and adults.]~~

~~(E) Employment for Transition Age Youth/Young Adults: Ongoing, direct supports and/or supervision needed for a youth/young adult to maintain employment. [Priority for adults age 18 through age 26 who have exited high school.]~~

~~(F) Parenting: Ongoing, direct supports and/or supervision~~

~~needed for a parent with developmental disabilities to provide training in parenting skills to help keep a child under the age of 18 at home. Services may not substitute for regular role and expenses of parenting. [Priority is for adults age 18 and over.]~~

~~(2)(Public Safety Funding Criteria~~

~~The following describes the criteria to access HCBS under the Public Safety funding priority:~~

~~(A) Criteria for Eligibility for Public Safety Funding:~~

~~(i) For new applicants, the public safety risk must be identified at the time of application and applicants must meet the Public Safety Funding priority criteria below.~~

~~(ii) For individuals currently receiving services, the public safety risk must be newly identified and recipient must meet the Public Safety Funding priority criteria below.~~

~~(iii) The Department's Public Safety Risk Assessment must be completed or updated for each individual who applies for Public Safety Funding in accordance with the *Protocols for Evaluating Less Restrictive Placements and Supports for People with I/DD who Pose a Risk to Public Safety.*~~

~~(iv) An individual must have proposed services that reflect offense-related specialized support needs and meet at least one of the following criteria:~~

~~(1) Committed to the custody of the Commissioner under Act 248 due to being dangerous to others. Services are legally mandated.~~

~~(2) Convicted of a sexual or violent crime, has completed their maximum sentence, and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense. Examples of "evidence" may include; recent clinical evaluations and/or recent treatment progress reports which indicate a continued risk to the public; recent critical incident reports which describe risks to public safety; and/or new criminal charges or DCF substantiations which involve harm to a person. Additional supporting evidence may be taken into account.~~

~~(3) Substantiated by the Department or DCF for sexual or violent abuse, neglect, or exploitation of a vulnerable person and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense.~~

~~(4) In the custody of DCF for committing a sexual or violent act that would have been a crime if committed by an adult, now aging out of DCF custody, and there is evidence that the individual still poses a~~

~~substantialrisk of committing a sexual or violent offense.~~

~~(5) Not charged with or convicted of a crime, but the individual's risk assessment contains evidence that the individual has committed an illegal act and still poses a substantial risk of committing a sexual or violent offense.~~

~~(6) Convicted of a crime and under supervision of the Department of Corrections (DOC) (e.g., probation, parole, pre-approved furlough, conditional re-entry) and DOC is actively taking responsibility for supervision of the individual for public safety. Public Safety Funding only pays for supports needed because of the individual's developmental disability. Offense-related specialized support needs, such as sex offender therapy, cannot be funded by the Department for an individual who is under the supervision of DOC.~~

~~(B) Access Restrictions:~~

~~It is not a priority to use Division funding to prevent an individual who has been charged with or convicted of a crime from going to or staying in jail or to prevent charges from being filed.~~

~~(i) Public Safety Funding shall not be used to fund services for individuals believed to be dangerous to others but for whom there is no clear evidence they pose a risk to public safety, and who have not committed an act that is a crime in Vermont. These individuals may be funded if the individual meets another funding priority.~~

~~(ii) Public Safety Funding shall not be used to fund services for individuals who have committed an offense in the past, and:~~

~~(1) Whose proposed services do not reflect any offense-related specialized support needs, or~~

~~(2) Who do not still pose a risk to commit a sexual or violent offense.~~

~~(h) **Intermediate Care Facility for Individuals with Developmental Disabilities**~~

~~Vermont has one six-person ICF/DD. This residence enables Vermont to provide comprehensive and individualized health care and rehabilitation services to individuals, as an alternative to HCBS, to promote their functional status and independence at an ICF/DD level of care.~~

~~(1) **Eligibility**~~

~~(A) Clinical:~~

~~(i) Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(ii) Individual must have significant medical needs.~~

~~(iii) Individuals must meet nursing home level of care, as well as ICF/DD level of care as defined by CMS.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~Access to the ICF/DD is based upon availability of a bed and prioritization of referrals by the operating DA and the Division.~~

~~(i) **One Time Funding**~~

~~One time funds are generated from the new and returned caseload dollars for the Equity and Public Safety funding pools. One time funds are used to address short term needs and cannot be used for long term needs. When there are one time funds available, a portion of those funds shall be distributed to agencies. The amount and timing of distribution is at the discretion of the Department.~~

~~(1) **Eligibility**~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disabilities as defined in these regulations.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~Recipients and individuals who meet clinical and financial eligibility who are not current recipients of funding to meet one of the needs listed below:~~

~~(2) Allowable Uses for One Time Funding by Agencies and Supportive ISO:~~

~~(A) One-time funding must be prioritized for use as Flexible Family Funding (FFF). One-time allocations used as FFF for individuals with developmental disabilities and families waiting for FFF are not to exceed the FFF maximum allocation per person per year, regardless of source.~~

~~(B) One-time allocations to address personal health or safety or public safety issues for individuals with developmental disabilities.~~

~~(C) Short term increases in supports to individuals already receiving services to resolve or prevent a crisis.~~

~~(D) Assistive technology, adaptive equipment, home modifications to make the individual's home physically accessible, and other special supports and services not covered under the Medicaid State Plan.~~

~~(E) Supports that may not meet funding priorities but are proactive and short term in nature.~~

~~(F) Transitional support to assist an adult to become more independent in order to reduce or eliminate the need for services.~~

~~(G) Small grants to self advocates, families and others that promote the Principles of Developmental Disabilities Services; for innovative programs that increase a consumer's ability to make informed choices, promote independent living, and offer mentorship or career building opportunities.~~

~~(H) Funding for people receiving developmental disabilities services to attend a training or conference that increases consumer ability to make informed choices, promote independent living, offer mentorship or career building opportunities. One time funds can only be used to cover the costs of training/conference registration fee and/or transportation costs for the individual, if needed, to attend a training or conference.~~

~~(j) Post-Secondary Education Initiative~~

~~The Post-Secondary Education Initiative (PSEI) is a program funded through a combination of grants and HCBS funding that assists transition age youth 18 to 28 with developmental disabilities to engage in typical college experiences through self designed education plans that lead to marketable careers in competitive employment and independent living. Supports are arranged with the Department's approved PSEI college support organizations to provide academic, career and independent living skill development through a peer mentoring model.~~

~~(1) Eligibility~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by the Department of Vermont Health Access.~~

~~(C) Access criteria:~~
~~Adults who have graduated from high school or have a GED who have been accepted for enrollment in post-secondary programs facilitated by the PSEI support programs. The individual must also have access to resources that are needed to participate beyond what is provided by the PSEI program.~~

~~(k) Pre-Admission Screening and Resident Review (PASRR) Specialized Services~~

~~PASRR Specialized Services are available to individuals living in a nursing facility and who needs additional services related to their developmental disability (e.g., social, behavior, communication) that are beyond the scope of the nursing facility.~~

~~(1) Eligibility~~

~~(A) Clinical:~~
~~Individual with a developmental disability or related condition as defined by Federal PASRR regulations.~~

~~(B) Financial:~~

~~None~~

~~(C) Access Criteria:~~
~~Individual over 18 years of age living in a nursing facility and having been determined to be in need of Specialized Services through PASRR evaluation.~~

~~(l) **Projects for Transition Support**~~

~~These Department approved projects prepare student interns who are in their last year of high school with technical skills through internship rotations at a host business location. The cornerstone of these projects is immersion in a single business for the entire school year where students learn career development skills through job coaching and direct guidance provided by the business' department managers.~~

~~**(1) Eligibility**~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disability as defined in these regulations (see exceptions in Access Criteria Section (l)(1)(C).~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~This program serves students in their last year of high school who have been determined to have developmental disabilities. If space allows, adults between the ages of 21 and 28 may apply to the program on a case-by-case basis. In addition, if space allows, students who receive special education and do not have developmental disabilities, but do have other challenges that are supported by an Individual Education Plan (IEP), may apply on a case-by-case basis.~~

~~(m) **Public Guardianship Fund**~~

~~This fund pays for unanticipated services and for small expenses directly related to the well-being of individuals receiving public guardianship services. Access to funds is at the discretion of the Division's Office of Public Guardian.~~

~~(n) **Special Populations Clinic and Rehabilitation Services**~~

~~Clinic and Rehabilitation services are mental health services provided within a community mental health or developmental disability service setting for individuals who are not receiving HCBS funding. Services include:~~

- ~~diagnosis and evaluation (D & E)~~
- ~~individual psychotherapy~~
- ~~group therapy~~
- ~~emergency care~~
- ~~Medication Evaluation, Management and Consulting Services (Chemotherapy, med-check~~

~~(1) Eligibility~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disabilities as defined in these regulations.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~Access to these service is determined by the agency based upon need and available resources. An agency may not bill for these services and HCBS on the same day.~~

~~(o)~~ **~~Targeted Case Management for Persons with Developmental Disabilities~~**

~~Targeted Case Management (TCM) is a Medicaid State Plan service that provides assessment, care planning, referral and monitoring. Services are provided by the agency and designed to assist adults and children to gain access to needed services.~~

~~(1) Eligibility~~

~~(A) Clinical:~~
~~Individuals who meet the criteria for developmental disability as defined in these regulations.~~

~~(B) Financial:~~
~~Vermont Medicaid eligible as determined by Department of Vermont Health Access.~~

~~(C) Access Criteria:~~
~~TCM is available for adults age 21 and over, and children under 21 when the agency has exhausted Bridge Program funding. An agency may not bill for TCM and HCBS or other Medicaid funded case management services on the same day.~~

(h) ~~4.8~~ Special Initiatives

The Division may invest in initiatives that enhance the overall system of support for people with developmental disabilities and their families. The Division may use funding to support initiatives that ~~shall~~will enhance choice and control and increase opportunities for individuals receiving developmental disabilities services and their families. The timing and amount of funding for any initiative ~~shall~~will be identified in the *System of Care Plan*. For all special initiatives, specific outcome measures will be required, and results will be reported by DDSD.

~~4.9~~ (i) Notification of decision on application

~~(a)~~ (1) Timing of the notices

~~(1)~~(A) Within 45 days of the date of the application, the DA ~~shall~~must notify the applicant in writing of the results of the assessment and the amount of funding, if any, which the applicant ~~shall~~will receive.

~~(2)~~(B) If the assessment and authorization of funding is not going to be completed within 45 days of the date of application, the DA ~~shall~~must notify the applicant in writing of the estimated date of completion of the assessment and authorization of services or funding. A pattern of failure to complete the process within 45 days ~~shall~~will be ~~taken into account~~considered in determining whether to continue the designation of an agency.

~~(b)~~ (2) Content of notices

~~(1)~~(A) If some or all of the services requested by the applicant are denied, or the applicant is found not eligible, the written notice ~~shall~~must include ~~information about the basis for the decision, and how to the appeal the decision, including:~~

~~(A) The policy or citations the action is based on (e.g., funding priorities, regulations);~~

~~(B) T~~the right to appeal the decision, ~~and~~ the procedures for doing so, and the content of notices as specified in ~~(see Part 8~~7.100.9 and 8.100).~~;~~ Denials of eligibility must follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 must be followed regarding the timing and content of those notices.

~~(C) (ii) Resources for legal representation (such as Disability Law Project).~~

~~(2)~~(B) If the assessment determines the applicant has a developmental disability and has needs that fit within the funding priorities outlined in ~~section 4.7~~ the *System of Care Plan*, the notice ~~shall~~must state the amount of funding and services the applicant ~~shall~~will receive. The notice ~~shall~~must also state what costs, if any, the recipient is responsible to pay (~~Section 6~~7.100.7).

~~(3)~~(C) If the assessment determines the applicant does not have a developmental disability, the notice ~~shall~~must state that the DA ~~shall~~will continue to offer information and referral services to the applicant.

~~(4)~~(D) If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based S~~s~~ervices ~~or funding~~, the notice ~~shall~~must state that the DA ~~shall~~will continue to offer information and referral services and ~~shall~~will place the person's name on a waiting list (~~Section~~ 7.100.5 (q) ~~4.18~~).

~~4.10~~ (j) Choice of provider

~~(a)~~ (1) The DA ~~shall~~must help a recipient learn about service options, including the option of self/family-managed services.

~~(1)~~ (A) It is the DA's responsibility to ensure the individual is informed of his or her choice of all services options listed in 7.100.5-(d)(2)~~4.4(b)~~, ~~in order to~~so that the individual can make an informed decision when ~~making the choice of~~choosing between and among management options/service providers. The DA ~~shall~~must document options discussed and information shared as part of this process. The DA ~~shall~~must provide the choices in an unbiased manner to reduce the potential for conflict of interest.

~~(2)~~(B) If the recipient is not self/family-managing services, the DA ~~shall~~will ensure that at least one provider within the geographic area offers the authorized services at or below the amount of funding authorized at the DA.

~~(3)~~(C) If no other provider is available to provide the authorized services and the recipient or family does not wish to self/family-manage services, the DA ~~shall~~must provide the authorized services in accordance with its ~~Master Grant~~ Provider Agreement.

~~(4)~~(D) The recipient or family may receive services from any willing agency in the state.

~~(5)~~(E) A recipient or family may request that an agency sub-contract with a non-agency provider to provide some or all of the authorized services~~,~~; however, the decision to do so is at the discretion of the agency.

~~(b)~~ (2) If the recipient's needs are so specialized that no provider in the geographic area can provide the authorized services, the DA may, with the consent of the recipient, contract with a provider outside the geographic region to provide some or all of the authorized services.

~~(c)~~ (3) The recipient may choose to receive services from an agency other than the DA if the agency agrees to provide the authorized services at or below the amount of funding authorized for the DA to provide services.

~~(1)~~(A) When requesting new funding, if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider ~~shall~~will submit a budget to the DA and the DA ~~shall~~will determine its costs to serve the individual and ~~shall~~must submit the lower of the two budgets to the funding committee. If an alternative provider is not able to provide the services at the lower approved budget, the DA must do so at the amount of funding authorized for the DA to provide services.

~~(2)~~ (B) If at any time a recipient chooses or consents to receive some or all authorized services or supports from a different agency, the agency currently serving the recipient ~~shall~~must promptly transfer the individual's authorized funding limit to the agency selected according to the procedures outlined in Division guidelines.

~~(3)~~ (C) When an individual chooses to transfer to another agency or to self/family-manage, the receiving agency or Supportive ISO must fully inform the recipient and the individual's authorized ~~designated~~ representative, if applicable, prior to the transfer, of the impact on the amount of services that can be provided within the approved budget based upon the agency or Supportive ISO's costs for services.

~~(4)~~(D) Any disputes about the amount of funding to be transferred ~~shall~~will be resolved by the director of the Division.

~~(d)~~(4) The recipient may choose to self/family-manage services (See ~~Part 5~~ 7.100.6).

~~4.11~~ (k) Individual support agreement (ISA)

~~(a)~~(1) Once a recipient has received written authorization of services or funding (~~Section 4.7~~ 7.100.5 (f)), the recipient, together with the agency or Supportive ISO, writes an ISA that defines the services and supports to be provided. The recipient may ask any person to support him or her in establishing a person-centered process, making decisions, and choosing services, supports and/or providers.

~~(b)~~(2) The agency or, in the case of self/family-managed services, the Supportive ISO ~~(in the case of self/family-managed services)~~, has ultimate responsibility to ensure that an initial ISA is developed within thirty (30) ~~calendar~~ days of the first day of billable services/supports or authorized start date for HCBS. This timeline may be extended at the request of the recipient, as specified in the *ISA Guidelines*.

~~(c)~~(3) Initial and ongoing ISAs ~~shall~~must be written and reviewed in accordance with the Department's *ISA Guidelines*. A written ISA is required even if the recipient chooses to self/family-manage services.

~~(d)~~(4) The ISA is a contract between the recipient and provider(s) who provides the service or support.

~~(e)~~(5) An ISA may be revised at any time.

~~4.12~~(l) Periodic review of needs

~~(a)~~ (1) The needs of each individual currently receiving services ~~shall~~must be re-assessed annually by the agency or Supportive ISO, together with the individual and his or her team, using the needs assessment to assure the individual's budget reflects current needs, strengths and progress toward personal goals. An Annual Periodic Review ~~shall~~will take place as part of the planning for the individual's next ISA or ISA review. This ~~shall~~ will -include an examination of the utilization of services in the past year as compared to the authorized funding limit. The individual's budget ~~shall~~must be adjusted to reflect current needs.

~~(b)~~(2) The agency or Supportive ISO ~~shall~~must make adjustments in a recipient's budget and/or services, if indicated, based upon the following:

~~(1)~~ (A) Changes in the recipient's needs;

~~(2)~~(B) Changes in use of funded services;

~~(3)~~(C) Changes in the cost of services to meet the needs;

~~(4)~~(D) Changes in the *System of Care Plan* or these regulations; or

~~(5)~~(E) Changes in funds available due to insufficient or reduced appropriation or an administrative arithmetic error.

~~(c)~~(3) As part of the periodic review, the agency or Supportive ISO ~~shall~~must ask each recipient about his or her satisfaction with services and provide each recipient and individual's authorized~~designated~~ representative with an explanation of the rights of recipients, including those outlined in the federal CMS HCBS rules, and how to initiate a grievance or appeal (See ~~Part 8~~ 7.100.9 and 8.100).

~~(d)~~(4) If a periodic review results in a determination that services or funding should be reduced, changed, suspended or terminated, the agency or Supportive ISO ~~shall~~must notify the recipient as provided in Section ~~4.16~~ 7.100.5 (p)and Part ~~8~~7.100.9 and 8.100.

~~4.13~~(m) Full reassessment of a young child

~~(a)~~(1) The agency or Supportive ISO ~~shall~~must conduct or arrange for a full clinical reassessment of a child at the time he or she ~~enters first grade~~ turns six to determine whether the child is a person with a developmental disability. Assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

~~(b)~~(2) *Exception:* A child receiving limited services as the result of a diagnosis of a~~A~~utism s~~S~~pectrum d~~D~~isorder does not need to be reassessed to confirm the diagnosis of ASD at the time he or she~~ enters first grade~~ turns six. An adaptive behavior assessment is required at this time to confirm the child continues to have significant deficits in adaptive behavior as defined in ~~Part 2~~ 7.100.3.

~~(c)~~(3) If the reassessment determines that the child is no longer a person with a developmental disability, benefits for the child and family must~~shall~~ be phased out as provided in ~~section 4.15(b)~~ 7.100.5 (o)(2) of these regulations.

~~4.14~~(n) Full reassessment (transition from high school to adulthood)

~~(a)~~(1) The agency or Supportive ISO ~~shall~~must conduct or arrange for a full clinical reassessment and a reassessment of needs of a recipient one year prior to his or her last month of high school. If the agency or Supportive ISO has less than one year's prior notice of the person's leaving high school, it ~~shall~~must conduct the reassessment as soon as it learns that the person is going to leave high school or has left high school. The reassessment ~~shall~~must consider: ~~(1)~~(A) whether the young adult is a person with a developmental disability; and ~~(2)~~(B) the future service and support needs of the person and his or her family. The needs assessment should be reviewed and updated prior to requesting funding if there have been significant changes in circumstances that impact services and supports needed. Any assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

~~(b)~~(2) If the reassessment determines that the young adult is no longer a person with a developmental disability, services to the young adult and his or her family ~~shall~~must be phased out as provided in ~~Section 4.15((b)~~7.100.5(o)(2) of these regulations.

~~(c)~~(3) If the reassessment determines that the support needs of the person or family will change or increase when the young adult is no longer in school, the ISA and budget ~~shall~~must be reviewed in accordance with this section.

~~4.15~~(o) Full reassessment

~~(a)~~(1) The agency or Supportive ISO ~~shal~~must conduct or arrange for full clinical reassessment of an adult or child if there is reason to believe the person may no longer have substantial deficits in adaptive behavior~~,~~ or may no longer have a developmental disability.

~~(b)~~(2) If the reassessment determines that the individual is no longer a person with a developmental disability, services to the person ~~shall~~must be phased out within twelve months or less, unless the individual is eligible to continue to receive services based on ~~Section 3.4~~7.100.4 (d). Upon the determination of ineligibility, the agency or Supportive ISO ~~shall~~must provide timely notice of the decision to the recipient and the individual's authorized~~designated~~ representative, if applicable, and as provided for in ~~Section 4.16~~ 7.100.5 (p).~~ and Part 8~~ 7.100.9, and 8.100.

~~4.16~~ (p) Notification of results of reassessment or periodic review

~~(a)~~ If a reassessment or review results in a determination that the recipient is no longer eligible, or services should be reduced, suspended, or terminated, the agency or Supportive ISO must~~shall~~ notify the recipient and individual's authorized~~designated~~ representative, if applicable, in writing of the results of the review or reassessment, and of the right to appeal the decision and the procedures for doing so. The notice will include the content as specified in 7.100.9 and 8.100. Denials of eligibility should follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 would be followed regarding the timing and content of those notices.
~~The notification shall be mailed at least 11 days prior to the planned change unless an exception in Medicaid Rule 4150(B) is met.~~

~~(b) The notice shall include the following:~~

~~(1) A statement of the adverse benefit determination the agency or Supportive ISO intends to take;~~

~~(2) When it intends to take the adverse benefit determination;~~

~~(3) The reasons for the intended adverse benefit determination;~~

~~(4) The policy or citations on which the adverse benefit determination is based (e.g., *System of Care Plan*, these regulations);~~

~~(5) The right to appeal the decision and the procedures for doing so (See Part 8);~~

~~(6) A statement that services may continue at the current level if the appeal is filed in accordance with the timelines contained in Part 8; and~~

~~(7) Resources for legal representation (such as the Disability Law Project).~~

~~4.17 Notices~~

~~(a) Notices shall be written in language and in a form that the applicant or recipient can understand.~~

~~(b) The agency or Supportive ISO shall ensure that someone shall explain the contents of any written notice to an applicant or recipient who cannot read.~~

~~4.18~~(q) Waiting list

A person with a developmental disability whose application for Home and Community-Based Services, Flexible Family Funding or Family Managed Respite ~~services or supports~~ is denied~~, in whole or in part, because the person's needs do not meet the funding priorities outlined in~~ the ~~section 4.7 shall~~must be added to a waiting list maintained by the Designated A~~a~~gency ~~or Supportive ISO, as applicable~~. The Designated A~~a~~gency ~~or Supportive ISO shall~~must notify an applicant that his or her name has been added to the waiting list~~,~~ and explain the rules for periodic review of the needs of people on the waiting list.

~~(a)~~(1) ~~Each agency and Supportive ISO maintains a waiting list for services they~~

~~provide, including:~~
~~(1)(A) Individuals eligible for HCBS based on their developmental disability, including those already receiving services, but whose request for services is denied, in whole or in part, because the individual's needs do not meet a funding priority.~~

~~(2)(B) Individuals eligible for, but denied, FFF because of insufficient funds (including people who receive partial funding and/or one-time funding).~~

~~(3)(C) Individuals eligible for, but denied, TCM because of insufficient funds.~~

~~(4)(D) Individuals eligible for, but denied, FMR funds because of insufficient funds.~~

~~(5)(E) Individuals eligible for, but denied, PSEI funds because of insufficient funds or lack of capacity of the PSEI program to support additional students.~~
The Division will provide instructions to the Designated Agency for reporting waiting list information to the Division.

~~(b)~~(2) Each Designated A~~a~~gency ~~and Supportive ISO shall~~must notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list ~~shall~~must occur:

~~(1)(A) At least annually; and~~

~~(2)~~(A) When there are changes in the funding priorities or funds available; or

~~(3)~~(B) When notified of significant changes in the individual's life situation.

(3) Waiting list information will be included the DDS Annual Report and will be reviewed annually by the DDS State Program Standing Committee.

~~Part 5.~~ 7.100.6 Self/Family-Managed Services

Many individuals receiving services, or a family member of an individual receiving services, may be eligible to ~~can~~ manage the services instead of having the services managed by an agency. Individuals may manage their services either independently or with the help of their families. An individual or a family member may manage up to 12~~8~~ hours a day of ~~paid home supports~~ In-home Family Supports or Supervised Living, but may not self/family manage Staffed Living, Group Living or Shared Living.

Self/family-management is a service option that is designed to provide choice and control to an individual or family. Self/family-management requires individuals or their family members to hire and oversee their own employees and function as the employer of record. Except for supportive services, clinical services provided by licensed professionals, or camps that provide respite, individuals and families may not purchase services from a non-certified entity or organization.

In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in ~~Section 5.2~~ 7.100.6(b). A Supportive ISO, ~~makes~~in making this determination, must consider the reasons set forth in 7.100.6(f)(2), as well as any and all criteria established by the Department. An individual or a family member also has the option of managing *some, but not all,* of the services and have an agency manage some of them. This arrangement is called shared-managing. ~~Section 5.7~~ 7.100.6(g) explains how shared-managing works.

~~5.1~~(a) Self/Family-Management Agreement

An individual or family member who is allowed to manage services must sign an agreement with a Supportive ISO. The Department ~~shall~~will provide an approval form for agreements. The agreement must set out the responsibilities of the individual or family member and the responsibilities of the Supportive ISO.

~~5.2~~(b) Responsibilities of an individual or family member who manages services

An individual or family member who manages services must be capable of and carry out the following functions:

~~(a)~~(1) Maintain Medicaid eligibility for the individual receiving services. Immediately notify the Supportive ISO of any circumstances that affect Medicaid eligibility.

~~(b)~~(2) Develop an ISA that reflects what services the individual needs and how much money the individual has been provided in their budget to spend for those services. Follow the Department's *ISA Guidelines* to ensure that all required information is included and completed according to specified timelines. The plan must specify what each service is supposed to be and how much each service ~~shall~~will cost on an annual basis. The ISA must also identify the individual's service provider(s) and explain how the services received ~~shall~~must be documented.

~~(c)~~(3) Ensure that services and supports are provided to the individual in accordance with the ISA and the budget.

~~(d)~~(4) Maintain a complete and up-to-date case record that reflects details regarding the delivery of services. Follow the *Guide to Self/Family Management ~~for People who are Self-Family-Managing~~* regarding what needs to be included in the case record. Retain case records in accordance with the record retention schedule adopted by the Department.

~~(e)~~(5) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are set forth in ~~Section 10.5~~ 7.100.11(e) ~~of these regulations~~.

~~(f)~~(6) Understand the individual's ISA and their budget. Make necessary changes based on the individual's needs. Follow these regulations and the Department's *ISA Guidelines* regarding what to do when there is a change.

~~(g)~~(7) Follow the Department's *Health and Wellness Guidelines* to take care of the individual's health and safety.

~~(h)~~(8) Follow the rules about reporting critical incidents to the Supportive ISO. Make sure the reports are filed in accordance with the specific timeline required by the Department's *Critical Incident Reporting Guidelines.*

~~(i)~~(9) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

~~(j)~~(10) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

~~(k)~~(11) Prepare written back-up plans for when the plan cannot be followed (e.g., a worker gets sick and/or does not show up for work). Include in the plan who ~~shall~~will come and work and what ~~shall~~will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

~~(l)~~(12) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.

~~(m) Follow the requirements of the Housing Safety and Accessibility Review Process to ensure the individual is living in a safe and accessible home.~~

~~(n)~~(13) Take the following steps when hiring workers:

~~(1)~~(A) Write a job description. Complete reference checks before allowing the worker to start work;

~~(2)~~(B) Interview and hire workers that meet the requirements of the Department's Background Check Policy, or who receive a variance when there is an issue with the background check;

~~(3)~~(C) Sign up with the state contracted ~~FE/A~~F/EA. Give the ~~FE/A~~F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

~~(4)~~(D) Train or have someone else train all workers in accordance with these regulations. The rules are in the Department's pre-service and in-service standards in ~~Part 9~~ 7.100.10;

~~(5)~~(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets to verify they reflect the actual hours worked. Sign and send accurate timesheets to the ~~FE/A~~F/EA;

~~(6)~~(F) Suspend or fire workers as necessary; and

~~(7)~~(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

~~(o)~~(14) Manage services in accordance with the Department's *Guide to Self/Family Management* ~~*Guidelines for People who are Self- Family-Managing Services*~~.

~~(p)~~(15) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the Supportive ISO for assistance in determining what expenses are reimbursable. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

~~5.3~~ (c) Role of the Designated Agency

For existing recipients who are self/family managing who have a new need as determined by a new needs assessment and need an increase in services and funding, the Supportive ISO develops and submits proposals to the Supportive ISO funding committee and then to the appropriate statewide funding committee. For complex situations, the Supportive ISO may consult with an independent evaluator, the Division or the local DA to determine strategies regarding how an individual's needs may best be met. This may include a collaborative effort between the Supportive ISO and DA regarding assessments and funding proposals as needed.

~~5.4~~(d) Role of Qualified Developmental Disability Professional (QDDP)

~~(a)~~(1) An individual or family member who manages services must choose someone to be his or her independent QDDP or must ask the Supportive ISO to find a QDDP for him or her.

~~(b)~~(2) All QDDP's must meet the criteria specified in the Division's *Vermont Qualified Developmental Disabilities Professional Protocol*~~*: Definitions, Qualifications and Roles*~~. For QDDPs employed by an agency, the agency is responsible for ensuring that the QDDP meets that criteria. QDDPs not employed by an agency, including those working for the Supportive ISO, must be endorsed by the Department as an independent QDDP, before being paid as a QDDP.

~~(c)~~(3) The QDDP ~~shall~~must:

~~(1)~~ (A) Approve the individual's ISA and ensure that it is signed by the individual and guardian, if there is one;

~~(2)~~ (B) Confirm that the ISA is being carried out the way it is supposed to be and that it meets the needs of the individual;

~~(3)~~(C) Confirm that services and supports are delivered the way the Department and Medicaid regulations and guidelines require;

~~(4)~~(D) Contribute to the periodic review of the individual's needs conducted by the Supportive ISO;

~~(5)~~(E) Confirm the ISA is updated to show the changes in the individual's needs and goals;

~~(6)~~(F) Approve any changes to the ISA; ~~and~~

~~(7)~~(G) Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996~~.~~ and the rights outlined in the federal CMS HCBS rules; and

(H) Review and sign off on all critical incident reports according to the *Critical Incident Reporting Guidelines.*

~~5.5~~(e) Responsibilities of a Supportive ISO when an individual or family member manages services

When an individual or family member manages services, the Supportive ISO ~~shall~~must:

~~(a)~~(1) Provide support and assistance to the individual or family member to ensure he or she understands the responsibilities of managed services including following all policies and guidelines for the Division. Explain managed services and the individual's or family member's employer role and responsibilities;

~~(b)~~(2) Conduct periodic reviews with contributions from the QDDP, make adjustments to budgets as needed and notify the individual of his or her rights under these regulations;

~~(c)~~(3) Confirm the individual's Medicaid eligibility on an annual basis;

~~(d)~~(4) Help the individual or family member to develop an authorized funding limit (AFL), provide guidance in self-managing the AFL, ensure the AFL is not managed by a third party, as well as, provide assistance in determining whether a service is reimbursable under Department rules. Provide the ~~FE/A~~F/EA with the individual's AFL;

~~(e)~~(5) Bill Medicaid according to the procedures outlined in the provider agreement between the Supportive ISO and the Department;

~~(f)~~(6) Review requests for more money and seek funding according to the process outlined in ~~Section 4~~7.100.5 of these regulations and the *System of Care Plan*. Requests for short term increases in funding ~~shall~~will be addressed internally by the Supportive ISO. Requests for long term increases ~~shall~~will be sent to the appropriate statewide funding committee;

~~(g)~~(7) Confirm that the individual has a current ISA that reflects the areas of support funded in the budget and identifies and addresses any known health and safety concerns; Nofify the individual/family that funding may need to be suspended if there is not a current signed ISA, according to the timelines outlined in the ISA guidelines;

~~(h)~~(8) Provide QDDP services when requested. QDDP services are a separately purchased service;

~~(i)~~(9) Maintain a minimum case record in accordance with the requirements outlined in the *Guide-to Self/Family Management*~~*for People who are Self- or Family-Managing*~~. Make sure that the individual or family member responsible for managing services understands that the individual must have a complete case record in accordance with the requirements outlined in the *Guide-to Self/Family Management*~~*for People who are Self- or Family- Managing*~~. Retain case records in accordance with the record retention schedule adopted by the Department;

~~(j)~~(10) Review and appropriately manage all reported critical incidents. If applicable, report the critical incidents to the Department in accordance with requirements in the *Critical Incident Reporting Guidelines*;

~~(k)~~(11) Provide information about the Division's crisis network to the individual or family member responsible for managing services;

~~(l)~~(12) Determine that the individual or family member who is managing the services is capable of carrying out the duties by conducting an initial assessment and providing ongoing monitoring;

~~(m)~~(13) Provide required pre-service and in-service training to the individual's support workers if the individual or family member does not provide that training. The training requirements are located in Part ~~9~~ 7.100.10 of these regulations; and

~~(n)~~(14) Form and consult with an advisory committee.

~~5.6~~ (f) Determination that the individual or family member is unable to manage services

~~(a)~~(1) The Supportive ISO ~~can~~ may deny a request to self- or family-manage, or may terminate the management agreement, if it decides that the individual or family member is not capable of ~~managing services~~ carrying out the functions listed in 7.100.6(b). If the individual's or family member's request is denied, or a management agreement is terminated, then the individual's services ~~shall~~must be provided by the individual's DA or from a SSA willing to provide services. Unless it is an emergency, the Supportive ISO has to inform the individual or family member at least thirty (30) days before terminating the agreement.

~~(b)~~(2) The Supportive ISO may decide that the individual or family member is not capable of ~~managing services~~ carrying out the functions listed in 7.100.6(b) for ~~one or more of these~~ reasons which include the following:

~~(1)~~(A) The managed services put the individual's health or safety at risk (the agreement can be terminated immediately if the individual is in imminent danger);

~~(2)~~(B) The individual or family member is not able to consistently arrange or provide the necessary services;

~~(3)~~(C) The individual or family member refuses to participate in the Division's quality assurance reviews; or

~~(4)~~(D) Even after receiving training and support, the individual or family member is not substantially or consistently performing his or her responsibilities for self/family-management as outlined in Section ~~5.2~~ 7.100.6 (b). This includes not following policies, regulations, guidelines, or funding requirements or not maintaining and/or ensuring proper documentation for developmental disabilities services. The Supportive ISO ~~shall~~must document substantial non-performance as follows:

~~(A)~~(i) When the Supportive ISO discovers an issue, they ~~shall~~must notify the individual or family member in writing of the issue and what is needed to correct the issue along with a timeline to do so; and offer support and training to the individual or family member as needed;

~~(B)~~(ii) If the individual or family member has not corrected the issue according to the required timeframe, the Supportive ISO ~~shall~~must send written notice to the individual or family member indicating that if the issues are not corrected in 30 days, the agreement for self/family-management may be terminated.

~~(C)~~(iii) Repeated documented failures to follow requirements ~~shall~~will be evidence to justify termination of the self/family-management agreement.

~~(c)~~(3) If the Supportive ISO decides an individual or family member is not able to manage services, the individual or family member may ~~appeal~~ file a request for a fair hearing with the Human Services Board, as provided in 3 V.S.A. § 3091. The Supportive ISO must provide written notice to the individual or family member at least 30 days prior to terminating ~~the~~a self/family-management agreement and the Supportive ISO's notice must include the individual~~'s~~ or family member's rights ~~to appeal~~ request a fair hearing within 30 days of the date of the notice. ~~The~~

~~appeal process is outlined in Part 8 of these regulations.~~

~~5.7~~(g) Responsibilities of an individual or family member who share-manages services

An individual or family member may manage some services and let an agency manage some services. That is called shared-managing. The agency is responsible for providing information and guidance to the individual or family member regarding his or her responsibilities for share-management. An individual or family member who share-manages with an agency must do all of the following:

~~(a)~~(1) Ensure services and supports are provided to the individual in accordance with the ISA and his or her budget.

~~(b)~~(2) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are in ~~Section 10.5~~ 7.100.11(e).

~~(c)~~(3) Make and keep all papers and records as required by the agency.

~~(d)~~(4) Report critical incidents to the agency. Make sure the reports are filed in accordance with the specific timelines required by the Department's *Critical Incident Reporting Guidelines.*

~~(e)~~(5) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

~~(f)~~(6) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

~~(g)~~(7) Prepare written back-up plans for when the plan cannot be followed (e.g., the worker gets sick and/or does not show up for work). Include in the plan who ~~shall~~will come and work and what ~~shall~~will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

~~(h)~~(8) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.

~~(i)~~(9) Take the following steps when hiring workers:

~~(1)~~(A) Write a job description. Complete reference checks before allowing the worker to start work;

~~(2)~~(B) Interview and hire workers that meet the requirement of the Department's ~~b~~Background ~~c~~Check ~~p~~Policy, or upon receipt of a variance when there is an issue with the background check;

~~(3)~~(C) Sign up with the state contracted ~~FE/A~~F/EA. Give the ~~FE/A~~F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

~~(4)~~(D) Train or have someone else train all workers in accordance with these regulations. See the Department's pre-service and in-service standards in ~~Part 9~~ 7.100.10;

~~(5)~~(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets. Sign and send accurate timesheets to the ~~FE/A~~F/EA;

~~(6)~~(F) Suspend or fire workers as necessary; and

~~(7)~~(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

~~(j)~~(10) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the agency for assistance in determining what are reimbursable expenses. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

~~Part 6.~~ 7.100.7 Recipient Financial Requirements

~~6.1~~(a) Income and resources; Medicaid-funded programs

For all supports and services funded by Medicaid, the income and resource rules of Department of Vermont Health Access (DVHA) governing eligibility for Medicaid programs apply~~,~~ and are incorporated here by reference.

~~6.2~~(b) Room and board; personal spending money

Medicaid developmental disabilities funding does not cover room and board, clothing, or personal effects.

~~(a)~~(1) At least annually, the Commissioner or the Commissioner's designee ~~shall~~will publish a schedule of rates for room and board and rates for personal spending allowances for recipients. The personal spending allowance ~~shall~~will not be less, and may be more, than the personal spending allowance for nursing home residents. The sum of the room and board rates and the personal spending allowance ~~shall~~will be equal to the current Supplemental Security Income (SSI) rates, including state supplement.

~~(b)~~(2) Payment of the rate set by the Commissioner's schedule ~~shall~~will be considered payment in full for the recipient's room and board if the recipient receives residential services funded by the Department. Recipients who receive income from a source other than SSI ~~shall~~will be charged the same rate for room and board as SSI recipients.

~~(c)~~(3) In unusual circumstances the Division Director may permit non-Medicaid funds of the Department to be used to subsidize the excess costs of a recipient's room and board.

~~(d)~~(4) Recipients who rent or own their own home or apartment~~,~~ and have room and board costs in excess of the Commissioner's schedule ~~shall~~ will receive assistance in accessing rent subsidy, low interest loans, fuel assistance, and other sources of housing assistance for low income Vermonters. To the extent authorized by the *System of Care Plan*, the Commissioner may provide non-Medicaid funds to subsidize the excess costs of a recipient's rent or house payment, if the recipient is unable to afford the cost.

~~(e)~~(5) Recipients who rent or own their own home or apartment and who work may elect to use their earnings to pay rent or mortgage or room and board costs in excess of the Commissioner's schedule.

~~(f)~~(6) The recipient, in consultation with his or her representative payee, if any, ~~shall~~will determine how to spend the personal spending allowance.

~~6.3~~(c) Financial responsibility of parents

The parents of a child under age 18 with a developmental disability are financially responsible for costs not covered by any Medicaid program or funded by the Department, specifically: housing; food; clothing; non-medical transportation; personal items; and child-care necessary for a parent to work.

~~Part 7~~ 7.100.8 Special Care Procedures

~~7.1~~ (a) Purpose

The purpose of these regulations is to ensure that people with developmental disabilities who have specialized health care needs receive safe and competent care while living in home and community settings funded by the Department.

~~7.2~~ (b) Special Care Procedure

~~(a)~~(1) The purpose of classifying a procedure as a "special care procedure" is to provide a system for ensuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for. These regulations follow the Vermont State Board of Nursing Position Statement – The role of the nurse in delegating nursing interventions.

~~(b)~~(2) Examples of special care procedures are as follows:

~~(1)~~(A) Enteral care procedures. Procedures that involve giving medications, hydration, and/or nutrition through a gastrostomy or jejunostomy tube. Special care procedures include replacement of G and J tubes, trouble-shooting a blocked tube, care of site, checking for placement, checking for residuals, use, care and maintenance of equipment; follow up regarding dietitians' recommendations, obtaining and following up lab work, mouth care, and care of formula.

~~(2)~~(B) Procedures to administer oxygen therapy. Use of O2 tanks, regulators, humidification, concentrators, and compressed gas. This may include need for O2 assistance through use of SaO2 monitor, use of cannulas, tubing, and masks.

~~(3)~~(C) Procedures that require suctioning techniques. Oropharyngeal (using Yankeur), nasopharyngeal (soft flexi tube) and tracheal components, which may include suctioning; clean versus sterile suctioning, care and maintenance of equipment, including stationary and portable systems.

~~(4)~~(D) Administration of respiratory treatments. Using nebulizer set-up, care and maintenance of equipment.

~~(5)~~(E) Tracheotomy care. Including cleaning of site and replacement of trach.

~~(6)~~(F) Procedures that include placement of suprapubic and urethral catheters, intermittent catheterization, use and care of leg bags, drainage bags, when and how to flush, clean versus sterile catheterization.

~~(7)~~(G) Procedures that include care of colostomy or ileostomy. Care of the stoma and maintenance of equipment.

~~(8)~~(H) Diabetes care, including medications, use of insulin, monitoring.

~~7.3~~(c) Application and limitations

~~(a)~~(1) These sections (~~Part 7~~ 7.100.8) apply to DAs and SSAs (including their staff and contractors).

~~(b)~~(2) These sections (~~Part 7~~ 7.100.8) apply to managed services, but they do not apply to care provided by natural or adoptive family members unless the family member is compensated for providing the care with funds administered or paid by the Department.

~~(c)~~(3) These regulations do not apply to care provided by~~in~~ hospital~~s~~ or nursing home~~s~~ staff.

~~7.4~~(d) Determining that a procedure is a special care procedure

The determination that a care procedure is a "special care procedure" has three components:

~~(a)~~(1) The procedure requires specialized nursing skill or training not typically possessed by a lay individual;

~~(b)~~(2) The procedure can be performed safely by a lay individual with appropriate training and supervision; and

~~(c)~~(3) The individual needing the procedure is stable in the sense that outcomes are predictable.

~~7.5~~(e) Who determines special care procedures

~~(a)~~(1) The initial identification of the possible need for a special care procedure may be made by the agency that serves the individual, by nursing staff of the Department, or by any other health providers.

~~(b)~~(2) A registered nurse ~~shall~~must determine whether a procedure is a special care procedure.

~~7.6~~(f) Who may perform a special care procedure

~~(a)~~(1) A special care procedure may be performed only by a person over the age of 18 who receives training, demonstrates competence, and receives monitoring in accordance with these regulations.

~~(b)~~(2) Competence in performing a special care procedure is individualized to the particular needs, risks, and characteristics of an individual. The fact that an employee or contractor may have been approved to perform a special care procedure for one individual does not create or imply approval for that person to perform a similar procedure for another individual.

~~(c)~~(3) The agency responsible for the health needs of the individual ~~shall~~must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or by a qualified health professional.

~~(d)~~(4) The agency is responsible for having a back-up plan for situations where the person or people trained to perform a special care procedure for an individual are unavailable. If a trained lay person is not available, the procedures ~~shall~~ must be performed by a qualified health professional. In the case of managed services, the services coordinator bears responsibility for having a back-up plan.

~~7.7~~(g) Specialized care plan

~~(a)~~(1) If a nurse has determined that an individual needs a special care procedure, the agency is responsible for ensuring that a specialized care plan is attached to the ISA and that every person who is authorized to perform a special care procedure has a copy of the specialized care plan. ~~(b)~~(2) A registered nurse ~~shall~~must complete an assessment of the person prior to developing the specialized care plan. The specialized care plan ~~shall~~must be developed by the registered nurse and ~~shall~~must identify the specialized care procedures and the nurse responsible for providing training, determining competence, and reviewing competence. The specialized care plan ~~shall~~must also include a schedule for the nurse to monitor the performance of specialized care procedures. (~~Section 7.10~~ 7.100.8(j)

~~7.8~~ (h) Training

~~(a)~~(1) Qualifications of trainer. Training ~~shall~~must be provided by a nurse. The nurse ~~shall~~must have a valid State of Vermont nursing license.

~~(b)~~(2) Timeliness. Training -~~shall~~must be provided before any caregiver who is not a health professional provides a special care procedure without supervision. Training ~~shall~~must be provided in a timely manner so as not to impede services for an individual.

~~(c)~~(3) Best practice. Training in special care procedures ~~shall~~must conform to established best practice for performance of the procedure.

~~(d)~~(4) Individual accommodations. Individuals with developmental disabilities have had unique experiences that may enhance or obstruct the ability to provide care. Within the framework of special care procedures, a combination of best practice and accommodation of individual characteristics ~~shall~~will define the procedures to be used with a particular individual.

~~(e)~~(5) Documentation of training. The agency responsible for the health needs of the individual is responsible for ensuring that the nurse provides a record of training for any person who is carrying out a special care procedure. The records ~~shall~~must include information about who provided the training, when the training was provided, who received training, what information was provided during the training, and the conditions under which reassessment and retraining need to occur.

~~(f)~~(6) Emergencies. The nurse ~~shall~~must -be notified of any changes in an individual's condition or care providers. The agency responsible for the health needs of the individual ~~shall~~must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or else by nursing personnel. If the nurse determines that, as a result of the emergency, a trained lay person cannot safely perform the procedure, the procedure ~~shall~~ must be performed by a qualified health professional.

~~7.9~~(i) Competence

The determination of competence is a determination that a person demonstrates adequate knowledge to perform a task, including use of equipment and basic problem-solving skills. Competence includes capability, and adequate understanding.

~~(a)~~(1) Determination of competence. Determination of competence ~~shall~~ must be made by a nurse. The specialized care plan ~~shall~~ must identify the nurse responsible for making this determination.

~~(b)~~(2) Supervised practice. An individual who is working toward but has not yet achieved status of a competent special care provider ~~shall~~must provide specialized care under the supervision of a nurse.

~~(c)~~(3) Competence defined. Competence involves demonstrating safe performance of each step of the special care procedure and proper use and maintenance of equipment, basic problem-solving skills, consistency of performance, and sufficient theoretical understanding.

~~(d)~~(4) Documentation of competence. The record ~~shall~~must document which people are determined competent to perform a special care procedure.

~~(e)~~(5) Review of competence. A specialized care provider's competence ~~shall~~must be reviewed by a nurse at least annually, and also when that worker's competence is in question, or at any time when there is change in the condition of the individual.

~~7.10~~ (j) Monitoring

Ongoing monitoring by a nurse ensures that a special care provider's skills and knowledge continue to be current. The individual's specialized care plan ~~shall~~must include monitoring requirements, including expectations for monitoring the performance of special care procedures and patient outcomes at least annually,

~~Part 8.~~ 7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings~~Grievance, Internal Appeal and Fair Hearing~~

~~8.1 Global Commitment and Grievances~~

~~(a) Medicaid-funded services for eligible individuals with developmental disabilities are part of the Global Commitment to Health 1115(a) Medicaid Waiver, which is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Department of Vermont Health Access (DVHA), as a Managed Care Entity (MCE) under the Global Commitment 1115(a) waiver, is required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between recipients and MCE employees, representatives of the MCE, and state-designated agencies, including Designated Agencies and Specialized Service Agencies.~~

~~(b) The MCE and any part of the MCE receiving funds for the provision of services under the Global Commitment to Health shall be responsible for resolving all grievances and all appeals initiated under these rules.~~

~~(c) Recipients and providers shall not be subject to retribution or retaliation for filing a grievance or an appeal with the MCE.~~

~~(d) Services funded with investments dollars are not included, as they are separate from the Global Commitment to Health waiver.~~

~~NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.~~

~~Note: Collaborative decisions of any type made by multi-disciplinary groups that include MCE and non-MCE members such as local interagency teams (LIT), the State Interagency Team (SIT), the State or Local Team for Functionally Impaired, and the Case Review Committee (CRC) are not actions of the MCE and therefore are not governed by these regulations.~~

~~8.2 Definitions~~

~~(a) "Action" means an occurrence of one or more of the following by the agency for which an internal agency appeal may be requested:~~

~~(1) Denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;~~

~~(2) Reduction, suspension or termination of a previously authorized covered service or a service plan;~~

~~(3) Denial, in whole or in part, of payment for a covered service;~~

~~(4) Failure to provide a clinically indicated, covered service, when the provider is a state agency, or a designated agency or a specialized service agency (DA/SSA);~~

~~(5) Failure to act in a timely manner when required by state rule;~~

~~(6) Denial of a recipient's request to obtain covered services outside the network.~~

~~(b) "Agency" for purposes of this section means a designated agency or a specialized service agency. In addition, a Supportive Intermediary Service Organization is considered an "agency" for the purposes of this section when making decisions about reductions or denials of services or funding.~~

~~(c) "Appeal" means a request for an internal review of an action by the Department or agency.~~

~~(d) "Decision maker" means the person or people empowered to make a decision under Sections 8.4 and 8.5.~~

~~(e) "Expedited Appeal" means an internal MCE appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the recipient's life, health or ability to attain, maintain, or regain maximum functioning.~~

~~(f) "Fair Hearing" means an appeal filed with the Human Services Board, whose procedures are~~

~~specified in rules separate from the MCE grievance and appeal process.~~

~~(g) "Filed" or "notified" means personally delivered, or deposited in the U.S. mail with first class postage affixed.~~

~~(h) "Grievance" means an expression of dissatisfaction about any matter that is not an action. Possible subjects for a grievance include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the recipient's rights. If a grievance is not acted upon within the timeframes specified in rule, the recipient may ask for an appeal under the definition above of an action as being a "failure to act in a timely manner when required by state rule." If a grievance is composed of a clear report of alleged physical harm or potential harm, the agency or Department will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulations board, Adult Protective Services).~~

~~(i) "Managed Care Entity" (MCE) means:~~

~~(1) The Department of Vermont Health Access (DVHA);~~

~~(2) Any state department with which DVHA has an Intergovernmental Agreement under the Global Commitment to Health 1115(a) waiver, excluding the Department of Education, that results in that department administering or providing services under the Global Commitment waiver (i.e. Department for Children and Families; Department of Disabilities, Aging and Independent Living; Department of Health; Department of Mental Health);~~

~~(3) A designated agency or a specialized services agency; and~~

~~(4) Any contractor authorizing service authorizations or performing prior authorizations on behalf of the MCE.~~

~~(j) "Network" means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner of the Department of Disabilities, Aging and Independent Living and who provide services on an ongoing basis to recipients. It does not include a provider who enrolls on a one-time basis for the purpose of serving a specific recipient.~~

~~(k) "Provider" means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that manages services is not a provider for purposes of this rule.~~

~~(l) "Service" means a benefit 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Department of Vermont Health Access and Agency of Human Services departments or the Department of Education for the administration and operation of the Global Commitment to Health waiver.~~

~~8.3 Grievances~~

~~(a) A grievance may be initiated by a recipient or the designated representative of a recipient. A grievance may be expressed orally or in writing.~~

~~(b) Grievances shall be filed within 60 days of the pertinent issue in order for the grievance to be considered. Staff members shall assist a recipient if the recipient or his or her representative requests such assistance.~~

~~(c) A written acknowledgement of a grievance shall be mailed within 5 calendar days of receipt by the MCE. The acknowledgement shall be made by the part of the MCE responsible for the service area that is the subject of the grievance. If the MCE decides the issue within the five-day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.~~

~~(d) Recipients or their designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within 5 calendar days.~~

~~(e) All grievances shall be addressed within 90 calendar days of receipt. The person making the decision shall provide the recipient with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the recipient, the notice shall also inform the recipient of his or her right to initiate a grievance review with the MCE as well as information on how to initiate such review.~~

~~(f) If a grievance is decided in a manner adverse to the recipient, the recipient may request a review by the MCE within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.~~

~~(g) The MCO shall acknowledge grievance review requests within 5 calendar days of receipt.~~

~~(h) The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The recipient shall be notified in writing of the finding of the grievance review within 90 days.~~

~~(i) Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the recipient may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V. S. A. § 3091 (a).~~

~~8.4 Right to an internal MCE appeal~~

~~(a) When the agency issues an action subject to appeal, including a decision to deny, reduce, or terminate eligibility, or deny, reduce, or terminate services, or when an agency fails to act within 45 days upon an application for services, it shall notify the applicant or recipient of the right to appeal. Notice shall be provided as described herein. In the event the agency fails to provide notice of appeal rights, the time limit for an applicant or recipient to submit an appeal shall be extended.~~

~~(b) An applicant or recipient may request an internal MCE appeal of an MCE action, and a fair hearing before the Human Services Board. An applicant or recipient may use the internal MCE appeal process while a fair hearing is pending or before a fair hearing is requested (8.11), except when a benefit or~~

~~service is denied, reduced or eliminated as mandated by federal or state law or rule, in which case the recipient cannot use the MCE appeal process and shall challenge the decision only by requesting a fair hearing.~~

~~(1) The agency shall notify the Department within one working day of receipt of the request for appeal. The agency and the Department shall render a final MCE decision.~~

~~(2) The applicant or recipient shall have 30 calendar days from the date of the final MCE decision to request a fair hearing.~~

~~(3) An internal MCE appeal under this rule may only be filed regarding the denial of aservice that is covered under Medicaid.~~

~~(c) If an applicant or recipient requests an internal MCE appeal regarding only a Medicaid eligibility or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (DCF), Economic Services Department. They will then notify the applicant or recipient in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the internal MCE appeal process and will be considered a request for fair hearing as of the date the MCE received it.~~

~~(d) Applicants or recipients may file requests for internal MCE appeals orally or in writing for any MCE action. Representatives of the applicant or recipient may initiate internal appeals only after a determination that the third party involvement is being initiated at the applicant's or recipient's request. Internal MCE appeals of actions shall be filed with the MCE within 90 calendar days of the date of the MCE notice of action. The date of the appeal, if mailed, is the postmark date. The internal MCE appeal process will include assistance by staff members of the MCE, as needed, for the applicant or recipient to initiate and participate in the appeal. Recipients shall not be subject to retribution or retaliation for appealing an MCE action.~~

~~(e) An initial applicant who files an appeal shall not receive benefits pending the appeal.~~

~~(f) Written acknowledgement of the internal MCE appeal shall be mailed within 5 calendar days of receipt by the part of the MCE that receives the appeal request. If a recipient files an appeal with the wrong entity, that entity will notify the recipient in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the MCE, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part of the MCE. This does not extend the deadline by which an internal MCE appeal shall be determined.~~

~~(g) Recipients or their designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within 5calendar days.~~

~~(h) The recipient or his or her designated representative has the right to participate in person, by telephone or in writing in the meeting in which the MCE is considering the final decision regarding the internal MCE appeal. If the appeal involves an agency decision, a representative of the DA/SSA may also participate in the meeting. Recipients or their designated representative may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting. Upon request, the MCE shall provide the recipient or his or her designated representative with all the information in its possession or control relevant to the internal appeal process and the~~

~~subject of the internal appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The MCE will not charge the recipient for copies of any records or other documents necessary to resolve the internal appeal.~~

~~(j) The individual who hears the internal MCE appeal shall not have made the decision that is subject to appeal and shall not be a subordinate of the individual who made the original decision.~~

~~(k) Internal MCE appeals shall be decided and written notice sent to the applicant or recipient within 45 calendar days of receipt of the appeal. The applicant or recipient shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 45-day time limit, the time frame may be extended up to an additional 14 days, by request of the applicant or recipient or by the MCE if the extension is in the best interest of the applicant or recipient. If the extension is at the request of the MCE, it shall give the applicant or recipient written notice of the reason for the delay. The maximum total time period for the resolution of an internal MCE appeal, including any extension requested either by the applicant/recipient or the MCE, is 59 days. If a meeting cannot be scheduled within these timeframes, a decision will be rendered by the MCE without a meeting with the applicant or recipient, or the designated representative.~~

~~8.5 Expedited internal MCE appeal requests~~

~~(a) Expedited internal MCE appeals may be requested in emergent situations in which the recipient or designated representative indicates that taking the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the MCE for any MCE actions subject to appeal. The MCE will not take any punitive action against a provider who requests an expedited resolution or supports a recipient's appeal.~~

~~(b) If the request for an expedited internal MCE appeal is denied because it does not meet the criteria, the MCE will inform the recipient that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited internal MCE appeal shall be promptly communicated (within 2 calendar days) to the recipient and followed up within 2 calendar days of the oral notification with a written notice.~~

~~(c) If the expedited internal MCE appeal request meets the criteria for such appeals, it shall be resolved within 3 working days. If an expedited appeal cannot be resolved within 3 working days, the time frame may be extended up to an additional 14 calendar days by request of the recipient, or by the MCE if the extension is in the best interest of the recipient. If the extension is at the request of the MCE, it shall give the recipient written notice of the reason for the delay. An oral notice of the expedited appeal decision shall be promptly communicated (within 2 calendar days) to the recipient and followed up within 2 calendar days of the oral notification with a written notice. The written notice for any expedited internal MCE appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the recipient's right to request a fair hearing if not already requested.~~

~~8.6 Participating provider decisions~~

~~(a) Provider decisions shall not be considered MCE actions and are not subject to appeal using this process.~~

~~(b) A state agency shall be considered a provider if it provides a service that is:~~

~~(1) Claimed at the Medicaid service matching rate;~~

~~(2) Based on medical or clinical necessity; and~~

~~(3) Not prior-authorized.~~

~~(c) Designated agencies/specialized service agencies (DA/SSA) are providers when their decisions do not affect recipient eligibility or services.~~

~~8.7 Notices~~

~~(a) The part of the MCE issuing a services decision that meets the definition of an action shall provide the recipient with written notice of its decision. In cases involving a termination or reduction of services, such notice of decision shall be mailed at least 11 days before the change will take effect. Where the decision is adverse to the recipient, the notice shall inform the recipient when and how to file an internal MCE appeal or fair hearing. In addition, the notice shall inform the recipient that he or she may request that covered services be continued without change as well as the circumstances under which the recipient may be required to pay the costs of those services pending the outcome of any internal MCE appeal or fair hearing.~~

~~(b) The agency shall provide notice, including reference to the applicable policy or citation the action is based on, as described in Sections 4.7, 4.12, 4.14, 4.15 and throughout Part 8, to an applicant or recipient of the rights provided in the Developmental Disabilities Act, 18 V.S.A. §§ 8727 (a) and 8728, and any other rights under state and federal law, as well as the right of grievance.~~

~~(c) All agencies and the Department shall post notices of the right to appeal and the procedure for appealing or initiating a grievance within the public areas of the agency. The Department shall provide such notices for posting, which shall include telephone numbers for receiving help in initiating a grievance, appeal, or fair hearing request.~~

~~8.8 Continued services~~

~~(a) If requested by the recipient, services shall be continued during an appeal regarding a Medicaid-covered service termination, suspension or reduction under the following circumstances:~~

~~(1) The appeal was filed in a timely manner, meaning before the effective date of the proposed action;~~

~~(2) The recipient has paid any required premium(s) in full; and~~

~~(3) The appeal involves the termination, suspension or reduction of a previously-authorized course of treatment or services plan.~~

~~(b) Where properly requested, a service shall be continued until any one of the following occurs:~~

~~(1) The recipient withdraws the appeal;~~

~~(2) Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;~~

~~(3) The MCE issues an appeal decision adverse to the recipient, and the recipient does not request a fair hearing within the applicable time frame;~~

~~(4) A fair hearing is conducted and the Human Services Board issues a decision adverse to the recipient; or~~

~~(5) The time period or service limits of a previously authorized service has been met.~~

~~(c) Continuation of benefits without change does not apply when the appeal is based solely on a reduction, suspension or elimination of a benefit or service required by federal or state law or rule affecting some or all recipients, or when the decision does not require the minimum advance notice as specified in Medicaid Rule 4150.~~

~~(d) Recipients may waive their right to receive continued benefits pending appeal.~~

~~8.9 Recipient liability~~

~~(a) A recipient may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.~~

~~(b) The MCE may recover from the recipient the value of any continued benefits paid during the appeal period when the recipient withdraws the appeal before the relevant internal MCE appeal or fair hearing decision is made, or following a final disposition of the matter in favor of the MCE. Recipient liability will occur only if an internal MCE appeal, fair hearing decision, secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCE also determines that the recipient should be held liable for service costs.~~

~~(c) If the provider notifies the recipient that a service may not be covered by Medicaid, the recipient can agree to assume financial responsibility for the service. If the provider fails to inform the recipient that a service may not be covered by Medicaid, the recipient is not liable for payment. Benefits will be paid retroactively for recipients who assume financial responsibility for a service and who are successful on such service coverage appeal.~~

~~8.10 Appeals regarding proposed services~~

~~(a) If an appeal is filed regarding a denial of service eligibility, the MCE is not required to initiate service delivery.~~

~~(b) The MCE is not required to provide a new service or any service that is not a Medicaid-covered service while a fair hearing determination is pending.~~

~~8.11 Fair hearing~~

~~(a) A recipient may use the MCE internal appeal process and be entitled to a fair hearing before the Human Services Board. Fair hearings or internal MCE appeals shall be filed within 90 days of the date the notice of action was mailed by the MCE, or if not mailed, within 90 days after the action occurred. A request for a fair hearing challenging an MCE internal appeal decision shall be made within 90 days of the date of the original notice of the MCE internal appeal decision, or within 30 days of the date the MCE internal appeal decision was mailed. If the recipient's original request for an MCE internal appeal was filed before the effective date of the adverse action, the recipient has requested continuing benefits before the effective date of the adverse action, and the recipient has paid in full any required premium(s), the recipient's services will continue consistent with Section 8.8.~~

~~(b) The Department shall have standing to be a party to any request for fair hearing filed with the Human Services Board.~~

~~(1) Appeals to the Human Services Board shall be conducted in accordance with the rules governing the conduct of fair hearings by the Human Services Board, 3 V.S.A. Section 3091.~~

~~(2) The fair hearing officer shall assure that the person with a developmental disability has access to legal representation, if desired.~~

~~(3) The fair hearing officer may order an independent evaluation at no cost to the person with a developmental disability if he or she finds that it would aid in resolution of the issue on appeal.~~

~~(c) The Human Services Board may reverse or modify a decision of the Department or an agency only if the decision is inconsistent with the System of Care Plan and the rules and policies of the Department. The Human Services Board shall not reverse a decision of the MCE if the decision is consistent with the System of Care Plan and the rules and policies of the Department, unless the Board finds that the System of Care Plan rules, or policies of the Department conflict with state or federal law.~~

~~(d) The Secretary of the Agency of Human Services shall review all decisions and orders of the Human Services Board in accordance with 18 V.S.A. §8727 (b) (2).~~

Medicaid-funded services for eligible individuals with developmental disabilities are part of the Global Commitment to Health 1115(a) Medicaid Waiver, which is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. As set forth in the Demonstration, the Agency of Human Services (AHS), as the state, and the Department of Vermont Health Access (DVHA), as if it were a non-risk prepaid in-patient health plan (PIHP), must comply with all aspects of 42 C.F.R. Part 438, Subpart F, regarding a grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Medicaid services, including developmental disabilities services.

AHS has adopted Health Care Administrative Rule (HCAR) 8.100, which fully sets forth the responsibilities of the Vermont Medicaid Program, as required by 42 CFR Part 438, Subpart F. This rule details, among other things, the content and timing of notices of an Adverse Benefit Determination, the circumstances relating to continuing services pending appeal and potential beneficiary liability, and the State fair hearing and grievance processes.

For provisions that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical, and clinical eligibility for developmental disabilities services, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

The Division will develop a plain language guide to the Internal Appeals, Grievances, Notices, and State Fair Hearings, in collaboration with stakeholders. The guide will be made available to all applicants and authorized representatives during the initial screening and all recipients during the annual periodic review, as well as whenever an applicant or recipient is notified of a decision regarding eligibility or service authorization. The plain language guide will include specifics related to how to file a grievance or appeal, to whom it should be directed, timelines and where to get assistance in filing.

~~Part 9~~ 7.100.10 Training

~~9.1~~(a) Purpose

Training is an ongoing process that helps ensure safety and quality services and reflects the principles of services of the Developmental Disabilities Act of 1996, generally accepted best practices, and promising practices and the priorities of the *System of Care Plan* and these regulations.

~~9.2~~(b) Standards

~~(a)~~(1) The Division ~~shall~~will develop training standards and periodically update them to ensure that workers:

~~(1)~~(A) Understand the values and philosophy underlying services and supports;

~~(2)~~(B) Acquire skills necessary to address the individual needs of the recipient for whom they provide services and support;

~~(3)~~(C) Acquire skills to implement the principles and purposes of the Developmental Disabilities Act of 1996; and

~~(4)~~(D) Are exposed to best and promising practices in supporting individuals with developmental disabilities.

~~(b)~~(2) In developing the standards, the Division ~~shall~~will endeavor to involve individuals with developmental disabilities and their families in the design, delivery, and evaluation of training.

(3) The minimum standards for training are outlined in (c) – (f).

~~9.3~~(c) Agency and Supportive Intermediary Support Organization responsibilities

~~(a)~~(1) Each agency ~~shall~~must adopt and implement a training plan which ensures adherence to the following minimum standards:

~~(1)~~(A) Workers compensated with funds paid or administered by the agency ~~shall~~must receive pre-service and in-service training or have knowledge and skills in the areas addressed by pre-service and in-service training consistent with Department and Division standards and these regulations.

~~(2)~~(B) Workers, on an ongoing basis, ~~shall~~ must have opportunities to broaden and develop their skills and knowledge in the following areas:

~~(A)~~(i) Best and promising practices;

~~(B)~~(ii)-Values including:

The principles of supporting people to have valued roles in their community including:

- (1) The dignity of valued roles
- (2) Sharing ordinary places
- (3) Making choices and the dignity of risk

- (4) Relationships in living a full life
- (5) Making contributions to others

The principles of person-centered thinking including:

- (1) How to respectfully address significant issues of health or safety while supporting choice
- (2) How to sort what is important for people from what is important to the people we support
- (3) How rituals and routines play a role in what is important to the people we support
- (4) The importance of having power with rather than power over the people we support;

~~(C)~~(iii) Current and emerging worker responsibilities; and

~~(D)~~(iv) Current and emerging needs of the individual.

~~(b)~~(2) The training plan ~~shall~~must be written and based on the agency's assessment of its ability and capacity to meet the needs of the people it serves, the local *System of Care Plan*, and the training needs of its staff and board members.

~~(c)~~(3) The training plan ~~shall~~must be updated as needed but at least every three years.

~~(d)~~(4) Each agency, and Supportive ISO ~~shall~~must:

~~(1)~~(A) Have a system to verify that all workers compensated with funds administered or paid by the organization have received pre-service and in-service training in accordance with these regulations~~,~~ or have knowledge and skills in the areas addressed by pre-service and in-service training.

~~(2)~~(B) Make pre-service and in-service training available to all workers at no cost to the family or recipient.

~~(3)~~(C) Involve people with disabilities and their families in the design, delivery, and evaluation of training and invite them to participate in training.

~~(4)~~(D) Have a system to verify that all workers have been told about and understand the requirement to report abuse and neglect of children to the DCF, and abuse, neglect and exploitation of vulnerable adults to APS.

~~(e)~~(5) Each agency and Supportive ISO ~~shall~~must:

~~(1)~~(A) Inform each person that self/family-manages services or share-manages services about the recipients or family's responsibility for ensuring that all workers receive pre-service and in-service training in accordance with these regulations.

~~(2)~~(B) Inform each person that self/family-manages or share-manages services about the availability of pre-service and in-service training at no cost to the family.

~~9.4~~(d) Pre-service training

Before working alone with an individual who receives support funded by the Department, each worker ~~shall~~must be trained and demonstrate knowledge in (1~~a~~) through (5~~e~~) of this section. The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

~~(a)~~(1) Abuse reporting requirements:

~~(1)~~(A) The requirements of Vermont law to report suspected abuse or neglect of children; and

~~(2)~~(B) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

~~(b)~~(2) Health and Safety:

~~(1)~~(A) Emergency procedures, including where to locate the emergency fact sheet;

~~(2)~~(B) What to do if the individual is ill or injured;

~~(3)~~(C) Critical incident reporting procedures; and

~~(4)~~(D) How to contact a supervisor or emergency on-call staff.

~~(c)~~(3) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)

~~(1)~~(A) Whether the individual has a guardian, and how to contact the guardian;

~~(2)~~(B) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;

~~(3)~~(C) Health and safety needs of the individual;

~~(4)~~(D) ~~How to~~ Methods of communicat~~e~~ion used by ~~with~~ the individual including tools, technology and effective partner support strategies; and

~~(5)~~(E) The individual's ISA, including the amount of supervision the individual requires.

~~(d)~~(4) Values:

~~(1)~~(A) Individual rights, as specified in 18 V.S.A. §~~section~~ 8728 ~~of the DD Act~~ and as outlined in the federal CMS HCBS rules;

~~(2)~~(B) Confidentiality;

~~(3)~~(C) Respectful interactions with individuals and their families; and

~~(4)~~(D)-Principles of service contained in the Developmental Disabilities Act of 1996.

(E) Respecting that people can make decisions for themselves, with support when needed.

(F) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand.

~~(e)~~(5) How to access additional support, training, or information.

~~9.5~~(e) In-service training

~~(a)~~(1) Within three months of being hired or entering into a contract, workers ~~shall~~must be trained in and demonstrate the knowledge and skills necessary to support individuals in 7.100.10(e)(1~~a~~)(A~~1~~) and (B~~2~~)~~ of this section~~. Workers ~~shall~~must be trained in or demonstrate knowledge and skills necessary to support individuals, in 7.100.10(e)(1~~a~~)(C~~3~~) and (D~~4~~)~~ of this section~~. The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

~~(1)~~(A) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;

~~(2)~~(B) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support~~ing~~ methods of communication used by the recipient, and supporting decision making). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite, the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

~~(3)~~(C) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and

~~(4)~~(D) Basic first aid.

~~(b)~~(2) Workers ~~shall~~must be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

(f) Exception for emergencies

~~(a)~~(1) For the purposes of this section, "emergency" means an extraordinary and unanticipated situation of fewer than 72 consecutive hours.

~~(b)~~(2) In an emergency, if the unavailability of a trained worker creates a health or safety risk for the individual, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 72 hours after the worker first begins to work with the individual in response to the emergency, as long as essential information about the individual is communicated to the worker and he or she has immediate access to all the documents and information covering all areas of Pre-service training (see ~~Section 9.4~~ 7.100.10 (d)).

~~(c)~~(3) This exception does not apply to workers performing special care procedures. All requirements in ~~section 7~~ 7.100.8 of these regulations must be met prior to staff performing special care procedures.

~~Part 10~~ 7.100.11Certification of Providers

~~10.1~~(a) Purpose of certification

In order to receive funds administered by the Department to provide services or supports to people with developmental disabilities, providers ~~shall~~must be certified to enable the Department to ensure that an agency can meet certain standards of quality and practice.

~~10.2~~(b) Certification status

~~(a)~~(1) To meet certification standards, an agency must:

~~(1)~~(A) Meet the standards for designation as a DA or SSA (see *Administrative Rules on Agency Designation*);

~~(2)~~(B) Meet the Department's *Quality Standards for Services* (~~section 10.5~~ 7.100.11(e)); and

~~(3)~~(C) Provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728) and the rights outlined in the federal CMS HCBS rules.

~~(b)~~(2) Current providers. Any agency receiving Department funds on the effective date of these regulations is presumed to be certified.

~~(c)~~(3) New provider. A new provider that wishes to be certified by the Department ~~shall~~must first establish that it meets the standards for designation. Upon being designated, an organization ~~shall~~must apply in writing to the Department for certification. The application ~~shall~~must include policies, procedures, and other documentation demonstrating that the organization is able to meet the quality standards for certification contained in ~~section 10.5~~ 7.100.11(e) and provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728).

~~(d)~~(4) Providers that are not designated ~~shall~~will not be certified.

~~(e)~~(5) If a certified provider loses its designation status, the provider is automatically de-certified.

~~(f)~~(6) The Department ~~shall~~will send the applicant a written determination within 30 days after receiving an application for certification. In order to receive funds administered by the Department, an organization must be certified and have a ~~Master Grant~~ Provider Agreement with the Department~~AHS~~.

~~10.3~~(c) Monitoring of certification

The Department ~~shall~~ will monitor certified providers through a variety of methods including~~, but not limited to,~~ quality reviews, other on-site visits, review of critical incident reports and mortality reviews, investigation of complaints from recipients and the public, input from Department staff and staff or employees of other departments of AHS.

~~10.4~~(d) Services available regardless of funding source

~~(a)~~(1) Any services or supports which are provided to people who are eligible for Medicaid ~~shall~~must be made available on the same basis to people who are able to pay for the services or who have other sources of payment.

~~(b)~~(2) The rate charged to recipients who are able to pay for services or who have payment sources other than Medicaid ~~shall~~must be the same as the rate charged to Medicaid-eligible recipients, *except that* the rate may be discounted to reflect lower administrative or implementation costs, if any, for non-Medicaid recipients. If a provider establishes a sliding fee scale for such services, the provider ~~shall~~must have a source of funding (such as United Way, state funds, donated services) for the difference between the cost of providing the service and the fee charged.

~~(c)~~(3) Any services not funded by Medicaid may be made available in accordance with a sliding fee schedule.

~~10.5~~(e) Quality standards for services

To be certified, an agency ~~shall~~must provide or arrange for services that achieve the following outcomes as specified in *Guidelines for the Quality Review Process of Developmental Disabilities Services.*

~~(a)~~(1) Respect: Individuals feel that they are treated with dignity and respect.

~~(b)~~(2) Self Determination: Individuals direct their own lives and receive support in decision making when needed.

~~(c)~~(3) Person Centered: Individuals' needs are met, and their strengths and preferences are honored.

~~(d)~~(4) Independent Living: Individuals live and work as independently and interdependently as they choose.

~~(e)~~(5) Relationships: Individuals experience positive relationships, including connections with family and their natural supports.

~~(f)~~(6) Participation: Individuals participate in their local communities.

~~(g)~~(7) Well-being: Individuals experience optimal health and well-being.

~~(h)~~(8) Communication: Individuals communicate effectively with others.

~~(i)~~(9) System Outcomes.

~~10.6~~(f) Status of non-designated providers

~~(a)~~(1) Any non-designated entity or organization that provides services or supports to individuals with funds administered by the Department must be a subcontractor of an agency. This requirement does not apply to persons employed as independent direct support providers. The decision to subcontract with an entity or organization is at the discretion of the agency.

~~(b)~~(2) The Department quality service reviews ~~shall~~will be responsible for including people served by subcontracted providers to verify that they meet quality review standards.

~~(c)~~(3) Any subcontract ~~shall~~must contain provision for operations in accordance with all applicable state and federal policies, rules, guidelines, and regulations that are required of agencies.

~~(d)~~(4) Agencies ~~shall~~must require the following through all of its subcontracts: reserve the right to conduct inquiries or investigations without prior notification in response to incidents, events or conditions that come to its attention that raise concerns as to person-specific allegations regarding safety, quality of supports, the well-being of people who receive services or any criminal action. Further, the Department may conduct audits without advanced notice.

~~(e)~~(5) Having a subcontract does not terminate an agency receiving funds under Vermont's Medicaid program from its responsibility to ensure that all activities and standards under their ~~Master Grant~~ Provider Agreement with the Department~~AHS~~ are carried out by their subcontractors.

~~Part 11.~~ 7.100.12 Evaluation and Assessment of the Success of Programs

The Department ~~shall~~will evaluate and assess the success of programs using the following processes:

(a) The review of services provision, as outlined in the *Guidelines for Quality Review of Developmental Disabilities Services*, as well as those processes outlined in Appendix B of the quality review guidelines *Sources of Quality Assurance and Protection for Citizens with Developmental Disabilities;*

(b) The designation process for DA and SSAs as outlined in the *Administrative Rules on Agency Designation;*

(c) Review of the data reported by agencies on required performance measures and monitoring of programs, as described in the agencies' ~~Master Grant~~ Provider Agreements with the Department~~AHS~~; and

(d) Review of performance measures submitted to AHS as required by Act 186.

The information gathered ~~shall~~ will -be used for informing the continuation of programs, quality improvement, innovations in service delivery and policy development

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7.100.1 Developmental Disabilities Services Purpose and Scope (04/15/2020, GCR 19-059)

(a) The purpose of these regulations is to fulfill the requirements of the Developmental Disabilities Act of 1996 (DD Act) (18 V.S.A Chapter 204A) to include specific details for implementation of the Act. These rules are adopted pursuant to 18 V.S.A. § 8726.

(b) The Developmental Disabilities Services program operates within the State's Global Commitment to Health 1115 Waiver, providing long-term services and supports to individuals with developmental disabilities.

(c) The Program is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

7.100.2 Definitions

The following terms are defined for the purpose of these regulations.

(a) **"Adult"** means a person age 18 or older. The term includes people age 18 or older who attend school.

(b) **"Agency"** means the responsible designated agency or specialized service agency.

(c) **"Applicant"** means a person who files a written application for services, supports or benefits in accordance with 7.100.5 of these regulations. If the applicant is a guardian or family member or a designated agency, the term "applicant" also includes the person with a developmental disability.

(d) **"Authorized Funding Limit"** (AFL) means all funding related to an individual's home and community-based services budget, including the administration amount available to transfer (as specified in division policy), but does not include: funding for state and local crisis services, the employment program base and statewide communication resources.

(e) **"Authorized Representative"** means an individual or organization, either appointed, by an applicant or beneficiary, or authorized under State or other applicable law, to act on behalf of the applicant or beneficiary in assisting with the application and renewal of eligibility, the internal appeal, grievance, or State fair hearing processes, and in all other matters with the Department, as permitted under 42 CFR § 435.923. Unless otherwise stated in law, the authorized representative has the same rights and responsibilities as the applicant or beneficiary in obtaining a benefit determination and in dealing with the internal appeal, grievance, and State fair hearing processes.

(f) **"Certification"** means the process by which the Department of Disabilities, Aging, and Independent Living determines whether a provider meets minimum standards for receiving funds it administers to provide services or supports to people with developmental disabilities.

(g) **"Certified provider"** means an agency that has as one of its primary purposes to deliver services and supports for people who have developmental disabilities and that currently is certified by the Department of Disabilities, Aging and Independent Living in accordance with 7.100.11 of these regulations.

(h) **"Clinical Services"** means assessment; individual, family and group therapy; and medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist, or nurse. Clinical Services are medically necessary services and equipment (such as dentures, eyeglasses, assistive technology) that cannot be accessed through the Medicaid State Plan.

(i) **"Commissioner"** means the Commissioner of the Department of Disabilities, Aging, and Independent Living.

(j) **"Community Supports"** means support provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (two or more people). Community supports includes transportation to access the community. Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal home and community-based services rules.

(k) **"Crisis Services"** means time-limited, intensive supports provided for individuals who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Crisis Services may include crisis assessment, support and referral or crisis beds and may be individualized, regional, or statewide.

(l) **"Day"** means calendar day, not business day, unless otherwise specified.

(m) **"Department"** means the Department of Disabilities, Aging, and Independent Living.

(n) **"Designated Agency"** (DA) means an agency designated by the Department, pursuant to 18 V.S.A. § 8907, and the regulations implementing that law, to oversee, provide and ensure the delivery of services and/or service authorizations for eligible individuals with developmental disabilities in an identified geographic area of the state. The requirements for being a DA are explained in the Department's *Administrative Rules on Agency Designation.*

(o) **"Developmental Disability"** (DD) means an intellectual disability or an autism spectrum disorder which occurred before age 18 and which results in significant deficits in adaptive behavior that manifested before age 18 (See 7.100.3). Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

(p) **"Division"** means the Developmental Disabilities Services Division (DDSD) within the Department.

(q) **"Employment Supports"** means support provided to assist transition age youth and adults in Establishing and achieving work and career goals. Employment supports include assessment, employer and job development, job training and ongoing support to maintain a job, and may include environmental modification, adaptive equipment, and transportation, as necessary.

(r) **"Family"** means a group of individuals that includes a person with a developmental disability and that is related by blood, marriage, or adoption or that considers itself a family based upon bonds of affection, which means enduring ties that do not depend upon the existence of an economic relationship.

(s) **"Fiscal/Employer Agent"** (F/EA) means an organization that is:

(1) Qualified under Internal Revenue Service rules to pay taxes and provide payroll services for employers as a fiscal agent; and

(2) Under contract with the Department to handle payroll duties for shared living providers who

hire workers and recipients or families who choose to self/family-manage or share-manage services.

(t) **"Global Commitment to Health Section 1115 Demonstration ("Demonstration")"** means the Section 1115 Demonstration under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title XIX of the Social Security Act.

(u) **"Home and Community-Based Services"** (HCBS) means an array of long term services developed to support individuals to live and participate in their home and community rather than in an institutional setting, consistent with Centers for Medicare and Medicaid Services (CMS) federal HCBS Rules.

(v) **"Home Supports"** means services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. Home supports must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.

(w) **"Individual"** means a young child, a school-age child or an adult with a developmental disability.

(x) **"Individual Support Agreement"** (ISA) means the agreement between an individual and an agency or Supportive Intermediary Service Organization that describes the plan of services and supports.

(y) **"In-service training"** means training that occurs after a worker has been employed or is under contract. In-service training is intended to promote professional development and increase skills and knowledge.

(z) **"Network"** means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner to provide or arrange developmental disabilities services and who provide services on an ongoing basis to recipients.

(aa) **"Pre-service training"** means training that occurs before workers are alone with a person with developmental disabilities.

(bb) **"Provider"** means a person, facility, institution, partnership, or corporation licensed, certified or authorized by law to provide health care service to a recipient during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless they are enrolled with Medicaid; however, a provider may enroll to serve only a specific recipient. A shared living provider, employee of a shared living provider, or an individual or family that self/family-manages services is not a provider for purposes of these regulations.

(cc) **"Psychologist"** means a person licensed to practice psychology in the state where the evaluation occurred.

(dd) **"Qualified Developmental Disabilities Professional"** (QDDP) means a person who meets the Department's qualifications as specified in Department policy for education, knowledge, training, and experience in supporting people with developmental disabilities and their families.

(ee) **"Recipient"** means a person who meets the criteria contained in these regulations, and who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

(ff) **"Resident"** means a person who is physically present in Vermont and intends to remain in Vermont and to make his or her home in Vermont, except a resident may also be:

(1) A person placed in an out of state institution, as defined by Health Benefits Eligibility and Enrollment (HBEE) Rule 3.00, bya department of the State of Vermont, or

(2) A person placed and supported in an unlicensed home in an adjoining state by a Vermont agency, or

(3) A person who meets criteria listed in 7.100.4 (b).

(gg) **"Respite Supports"** means alternative caregiving arrangements for family members or shared living providers/foster families and the individual being supported, on an intermittent or time limited basis, because of the absence of or need for relief of those persons normally providing the care to the individual, when the individual needs the support of another caregiver.

(hh) **School-age child"** means a child age 6 and younger than age 18.

(ii) **"Self/family-managed"** services means the recipient or his or her family plans, establishes, coordinates, maintains, and monitors all developmental disabilities services and manages the recipient's budget within federal and state guidelines.

(jj) **"Self/family-managed worker"** means a person who is employed or contracted and directed by a recipient or by a family member and paid with Department funds to provide supports or services for the recipient.

(kk) **"Service"** means a benefit:

(1) Covered under the Global Commitment to Health Section 1115 Demonstration as set out in the Special Terms and Conditions approved by CMS,
(2) Included in the State Medicaid Plan if required by CMS,
(3) Authorized by state regulation or law, or
(4) Identified in the Intra-governmental Agreement (IGA) between DVHA and the Agency of Human Services (AHS), DVHA and the departments within AHS, or DVHA and the Agency of Education for the administration and operation of the Global Commitment to Health Section 1115 Demonstration.

(ll) **"Service Coordination"** means assistance to recipients in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Service Coordination responsibilities include:

(1) Developing, implementing and monitoring the ISA
(2) Coordinating medical and clinical services
(3) Establishing and maintaining a case record
(4) Reviewing and signing off on critical incident reports
(5) Providing general oversight of services and supports

The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.

(mm) **"Shared management of services"** means that the recipient or his or her family manages some but not all Medicaid-funded developmental disabilities services, and an agency manages the remaining services.

(nn) **"Special care procedure"** means nursing procedures that a lay individual (a person who is not a qualified health professional) does not typically have the training and experience to perform.

(oo) **"Specialized service agency"** (SSA) means an agency designated by the Department that meets criteria for contracting with the Department as an SSA, as described in the Department's *Administrative Rules on Agency Designation*, and that contracts with the Department to provide services to individuals with developmental disabilities.

(pp) **"Supportive Intermediary Service Organization"** (Supportive ISO) means an organization under contract with the Department to provide support to individuals and families to learn and understand the responsibilities of self/family-managed services.

(qq) **"Supportive Services"** means therapeutic services that cannot be accessed through State Plan Medicaid. These are therapeutically or medically appropriate services that include behavior support and consultation; assessment, consultation and training for communication supports; skills-based training such as dialectical behavior therapy skills groups or sexuality groups. This includes other therapeutic or medically appropriate services not covered under State Plan Medicaid when provided by licensed or certified individuals (such therapeutic horseback riding).

(rr) **"System of Care Plan"** means the plan required by 18 V.S.A. §8725 describing the nature, extent, allocation and timing of services that will be provided to people with developmental disabilities and their families.

(ss) **"Transportation Services"** means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member or reimbursement for mileage for transportation to access Community or Employment Supports.

(tt) **"Worker"** means any employee or contractor compensated with funds paid or administered by the Department to provide services to one or more people with a developmental disability. Professionals, such as nurses or psychologists practicing under a license granted by the State of Vermont are not included within this definition. Family-hired respite workers paid by Flexible Family Funding are not included within this definition.

(uu) **"Young child"** means a person who is under age 6.

7.100.3 Criteria for determining developmental disability

(a) Young child with a developmental disability defined.

A young child with a developmental disability is a child who has one of the three following conditions:

(1) A diagnosed physical or mental condition so severe that it has a high probability of resulting in intellectual disability. This includes conditions such as:

Anoxia
Congenital or degenerative central nervous system disease (such as Tay Sachs syndrome)
Encephalitis
Fetal alcohol syndrome
Fragile X syndrome
Inborn errors of metabolism (such as untreated PKU)
Traumatic brain injury
Shaken baby syndrome
Trisomy 21, 18, and 13
Tuberous sclerosis

(2) A condition of clearly observable and measurable delays in cognitive development and significant, observable and measurable delays in at least two of the following developmental domains:

Communication
Social/emotional Motor
(physical)
Self-help skills

(3) An autism spectrum disorder (7.100.3(h)-(j)) resulting in significant, observable and measurable delays in at least two of the following developmental domains:

Communication
Social/emotional Motor
(physical)
Self-help skills.

(b) Criteria for assessing developmental disability in a young child.

(1) The diagnosis of a condition which has a high probability of resulting in intellectual disability (7.100.3(a)(1)) must be made by a physician.

(2) The documentation of delays in cognitive and other developmental domains (7.100.3(a) (2)-(3)) must be made through a family-centered evaluation process which includes the family. The evaluation process must include:

(A) Observations and reports by the family and other members of the assessment team, such as a physician, behavior consultant, psychologist, speech therapist, audiologist, physical therapist, occupational therapist, childcare provider, representative from the Children's Integrated Services - Early Intervention (CIS-EI) Team, representative from Early Childhood

Special Education (ECSE), representative from Children with Special Health Needs, representative from an agency;

(B) A review of pertinent medical/educational records, such as assessments used to determine eligibility for CIS-EI and ECSE, as needed; and

(C) Appropriate screening and assessment instruments.

(3) The diagnosis of autism spectrum disorder must be made according to 7.100.3(h)-(j).

(c) School-age child or adult with developmental disability defined.

(1) A school-age child (age 6 and younger than age 18) or adult with a developmental disability is an individual who:

(A) Has intellectual disability (7.100.3(d)-(f)) or autism spectrum disorder (7.100.3(h)-(j)) which manifested before age 18 (7.100.3(m)); and

(B) Has significant deficits in adaptive behavior (7.100.3(k)-(l)) which manifested before age 18 (7.100.3(m)).

(2) Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

(d) Intellectual disability defined.

(1) **"Intellectual disability"** means significantly sub-average cognitive functioning that is at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by a full-scale score of 70 or below, or up to 75 or below when taking into account the standard error of measurement, on an appropriate norm-referenced standardized test of intelligence and resulting in significant deficits in adaptive behavior manifested before age 18.

(2) **"Intellectual disability"** includes severe cognitive deficits which result from brain injury or disease if the injury or disease resulted in deficits in adaptive functioning before age 18. A person with a diagnosis of "learning impairment" has intellectual disability if the person meets the criteria for determining "intellectual disability" outlined in 7.100.3(e).

(e) Criteria for determining whether a school-age child or adult has intellectual disability.

(1) The determination of whether a school-age child or adult has intellectual disability for the purpose of these regulations requires documentation of the following components:

(A) Significantly sub-average cognitive functioning (7.100.3(d) and (f));

(B) Resulting in significant deficits in adaptive behavior; and (7.100.3(k)-(l))

(C) Manifested before age 18 (7.100.3(m)).

(2) The criteria for determining whether a school-aged child or adult has an intellectual disability is as defined in these regulations as outlined in 7.100.3(e-f) and not as described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(f) Process for determining whether a school-aged child or adult has an intellectual disability.

(1) To determine whether or not a school-age child or adult has intellectual disability, a psychologist must:

(A) Personally perform, supervise, or review assessments that document significantly sub-average cognitive functioning and deficits in adaptive behavior manifested before age 18; and

(B) Integrate current and past test results with other information about the individual's abilities in arriving at a determination.

(2) The most universally used standardized intelligence test for school-aged children up to age 16 is the Wechsler Intelligence Scale for Children (WISC), current edition. The most universally used measure for children over age 16 and adults is the Wechsler Adult Intelligence Scale (WAIS), current edition. For people with language, motor, or hearing disabilities, a combination of assessment methods must be used, and the psychologist must use clinical judgment to determine the best tests to use for the individual. Diagnosis based on interpretation of test results takes into account a standard error of measurement for the test used.

(3) A determination that a person has intellectual disability for the purpose of these regulations must be based upon current assessment of cognitive functioning *and* a review of any previous assessments of cognitive functioning. It is the responsibility of the psychologist to decide whether new cognitive testing is needed. In general, for school-aged children, "current" means testing conducted within the past three years. For adults, "current" means cognitive testing conducted in late adolescence or adulthood. Situations where new testing may be indicated include the following:

(A) There is reason to believe the original test was invalid (e.g., the person was sick, was not wearing glasses, was in the midst of a psychiatric crisis, etc.).

(B) The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

(C) The individual had mild intellectual disability on a previous test and has since made gains in adaptive behavior.

(4) If IQ testing of the person has resulted in some Full-Scale IQ (FSIQ) scores above 70 and some FSIQ scores below 70, taking into account the standard error of measurement, it is the responsibility of the psychologist to determine which FSIQ scores are the best estimate of the person's cognitive ability. When there is a wide variation between test scores, the psychologist should render his/her clinical opinion, including the rationale, regarding which FSIQ scores are the best estimate of the person's cognitive ability. A determination that a person has intellectual disability for the purpose of these regulations cannot be made if all of the person's FSIQ test scores are greater than75.

(5) The diagnosis in questionable cases should be based upon scores over time and multiple sources of measurement.

(6) The diagnosis of intellectual disability must not be based upon assessments conducted when the individual was experiencing a short-term psychiatric, medical, or emotional crisis which could affect performance. Cognitive testing should not ordinarily be performed when a person is in the midst of a hospital stay.

(7) If the psychologist determines that standardized intellectual testing is inappropriate or unreliable for the person, the psychologist can make a clinical judgment based on other information, including an adaptive behavior instrument.

(g) Criteria for determining whether a school-age child or adult has an autism spectrum disorder and is a person with a developmental disability.

The determination of whether a school-age child or adult has an autism spectrum disorder and is a person with a developmental disability for the purpose of these regulations requires documentation of the following components:

(1) Diagnosis of an autism spectrum disorder made according to process outlined in 7.100.3(h)-(j)

(2) Resulting in significant deficits in adaptive behavior (7.100.3(k)-(l)); and

(3) Manifested before age 18 (7.100.3(m)).

(h) Autism spectrum disorder defined.

Autism spectrum disorder means the same as it is defined in the current DSM. People receiving services as of October 1, 2017, who were found eligible with a diagnosis of pervasive developmental disorder under previous versions of the DSM continue to be eligible for services if they continue to present the symptoms that resulted in the diagnosis. Autism spectrum disorder means the same as the term "autism" in the Developmental Disabilities Act.

(i) Criteria for determining whether a person has autism spectrum disorder.

(1) The diagnostic category of autism spectrum disorder includes considerable variability in the presence and intensity of symptoms. Many of the symptoms of autism spectrum disorder overlap with other childhood diagnoses. Because of the complexity in differentially diagnosing autism spectrum disorder, it is essential that clinicians rendering these diagnoses have specific training and experience in child development, autism spectrum disorder, other developmental disorders, and other childhood psychiatric disorders.

(2) Preferably a comprehensive diagnostic evaluation is conducted by an interdisciplinary team of professionals with specific experience and training in diagnosing autism spectrum disorder. In the absence of an interdisciplinary team, a single clinician with the qualifications listed below may conduct a multidisciplinary assessment integrating information from other professionals.

(3) At a minimum, an evaluation must be performed by a single clinician who has the following qualifications or an interdisciplinary team that includes:

(A) A board certified or board eligible psychiatrist; or

(B) A psychologist; or

(C) A board certified or board eligible neurologist or developmental-behavioral or neurodevelopmental disabilities pediatrician.

(4) The psychiatrist, psychologist, neurologist, or pediatrician must have the following additional experience and training:

(A) Graduate or post-graduate training encompassing specific training in child development, autism spectrum disorder, and other developmental and psychiatric disorders of childhood, and a process for assessment and differential diagnosis of autism spectrum disorder; or supervised clinical experience in the assessment and differential diagnosis of autism spectrum disorder;

(B) Training and experience in the administration, scoring and interpreting of psychometric tests, or training in understanding and utilizing information from psychometric testing in the diagnosis of autism spectrum disorder; and

(C) Experience in the evaluation of individuals with the age range of the person being evaluated.

(5) Clinicians must follow the ethical guidelines for their profession regarding practicing within their area of expertise and referring to other professionals when needed. When a single clinician is conducting the assessment, he or she should determine whether other professionals need to evaluate the person to gain additional information before rendering a diagnosis. Additional evaluators may include psychologists, speech language pathologists, medical sub-specialists, developmental-behavioral or neurodevelopmental disabilities pediatricians, occupational therapists, psychiatrists, and neurologists.

(6) In the event a shortage of qualified assessors prevents timely evaluations, the state will assist agencies to identify available qualified assessors or may, in its discretion, waive the provision of rule(i)(4).

(j) Essential components of an assessment to determine autism spectrum disorder.

New applicants must be assessed using the DSM criteria in effect at the time of application. An assessment to determine whether an individual has an autism spectrum disorder must include all of the following components:

(1) Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history;

(2) Systematic autism spectrum disorder diagnostic interview with primary caregivers;

(3) A systematic observation with the individual to assess social interaction, social communication, and presence of restricted interests and behaviors;

(4) For older children and adults who can report symptoms, a systematic clinical interview;

(5) Referral for multidisciplinary assessment, as indicated;

(6) Comprehensive clinical diagnostic formulation, in which the clinician weighs all the information from (7.100.3(j)(1) through (5), integrates findings and provides a well-formulated differential diagnosis using the criteria in the current version of the DSM; and

(7) Current assessments based upon the individual's typical functioning.

(A) A determination of autism spectrum disorder for the purpose of these regulations must be based upon current assessment. It is the responsibility of the clinician or team performing the assessment to decide whether new observations or assessments are needed. In general, for school-age children, "current" means a comprehensive assessment conducted within the past three years. However, for school-age children applying for limited services such as Flexible Family Funding, Targeted Case Management, the Bridge Program, or Family Managed Respite, "current" means a comprehensive assessment conducted any time prior to age 18; for such children, a new assessment is required if the DA believes the child may not have autism spectrum disorder or when applying for HCBS.

(B) The initial diagnosis of autism spectrum disorder must not be based upon assessments and observations conducted when the individual is experiencing a psychiatric, medical or emotional crisis or when a person is in the midst of a hospital stay. Further assessment should be completed when the person stabilizes and/or returns to the community.

(C) For adults, "current" means a comprehensive assessment conducted in late adolescence or adulthood and adaptive testing within the past three years. Situations where new testing may be indicated include the following:

(i)The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

(ii)New information indicates that an alternate diagnosis better explains the individual's functioning and behavior.

(k) Significant deficits in adaptive behavior defined.

Significant deficits in adaptive behavior means deficits in adaptive functioning which result in an overall composite score on a standardized adaptive behavior scale at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by an overall composite score of 70 or below, taking into account the standard error of measurement for the assessment tool used.

(l) Criteria for assessing adaptive behavior in a school-age child or adult.

(1) Adaptive functioning must be measured by the current version of a standardized norm-referenced assessment instrument. The assessment tool must be standardized with reference to people of similar age in the general population. Adaptive functioning must not be measured with an instrument that is norm-referenced only to people in institutions or people with intellectual disability or autism spectrum disorder.

(2) The assessment instrument must be completed by a person qualified to administer, score, and interpret the results as specified in the assessment tool's manual. The administration of the tool must follow the protocol for administration specified in the assessment tool's manual.

(3) The assessment must be current. A current assessment is one which was completed within the past three years, unless there is reason to think the individual's adaptive functioning has changed.

(4) Based upon the assessment, the evaluator must determine whether the person is performing two or more standard deviations below the mean with respect to adaptive functioning, compared to a national sample of similar-aged people.

(5) Ordinarily, assessments must be based upon the person's usual level of adaptive functioning. Assessments should not ordinarily be performed when the individual is in the midst of an emotional, behavioral or health crisis, or must be repeated once the individual stabilizes. An assessment performed while the individual was in a nursing facility or residential facility must be repeated when the individual is in a community setting.

(6) It is the responsibility of the psychologist to ensure that the adaptive behavior assessment is based upon information from the most accurate and knowledgeable informant available. It may be necessary to integrate information on adaptive functioning from more than one informant.

(m) Manifested before age 18

Manifested before age 18 means that the impairment and resulting significant deficits in adaptive behavior were observed before age 18. Evidence that the impairment and resulting significant deficits in adaptive behavior occurred before the age 18 may be based upon records, information provided by the individual, and/or information provided by people who knew the individual in the past.

(n) Nondiscrimination in assessment

Assessment tools and methods must be selected to meet the individual needs and abilities of the person being assessed.

(1) People whose background or culture differs from the general population must be assessed with methods and instruments that take account of the person's background.

(2) A person must be assessed in the language with which he or she communicates most comfortably.

(3) People with language, motor, and hearing disabilities must be assessed with tests which do not rely upon language, motor ability, or hearing.

(4) If a person uses hearing aids, glasses, or other adaptive equipment to see, hear, or communicate, the evaluator must ensure that the individual has access to the aids or adaptive equipment during the evaluation.

(5) If a person uses a language interpreter or a method of augmentative and alternative communication and or needs a personal assistant for communication, the evaluator (e.g., the psychologist) is responsible for deciding how best to conduct the overall assessment in order to achieve the most authentic and valid results. However, scores for standardized tests are valid only if testing was performed in accordance with the criteria set forth in the test manual.

(o) Missing information to document developmental disability

There may be circumstances in which considerable effort is made to obtain all the required history and documentation to determine whether a person has a developmental disability, but the required information cannot be obtained. This may include situations in which there are no available informants to document a person's functioning prior to age 18, previous records cannot be obtained, or do not exist. In these circumstances, the determination of whether the person meets the criteria for having a developmental disability should be based upon the current assessment and all available information, including other life factors that occurred after age 18 that could potentially impact cognitive, adaptive, or other functioning.

7.100.4 Recipient Criteria

(a) Who can be a recipient

(1) A recipient is an individual with a developmental disability, as defined in 7.100.2 (o) and (ee), who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

(2) Services or supports to a family member of a recipient must be in the context of supporting the recipient and are for the purpose of assisting the family to provide care and support for their family member with a developmental disability.

(b) Recipients must be Vermont residents

(1) A recipient must be a resident of Vermont as defined in 7.100.2(ff). In the case of a minor child, at least one custodial parent of the child must be a resident of Vermont.

(2) A person or family who leaves Vermont for a vacation, visit, temporary move, or trial move may continue to be a recipient for a period not to exceed six months.

(c) Exceptions

The Commissioner may make exceptions to the requirements of the program access criteria in 7.100.4(a), in order to promote the purposes of the Developmental Disabilities Act, if the exception will not deprive other people who meet the criteria for being recipients of needed services or benefits (e.g., when funds are provided by another state, or by another Vermont state agency or department).

(d) People receiving services on July 1, 1996

People with developmental disabilities who were receiving services on July 1, 1996, may continue to receive services consistent with their needs and the System of Care Plan and these regulations.

(e) Eligibility after leave of service

Any person who leaves services for one year or longer for any reason and later reapplies for services must be assessed based upon the eligibility criteria in effect on the date of the person's reapplication.

7.100.5 Application, Assessment, Funding Authorization, Programs and Funding Sources, Notification, Support Planning and Periodic Review

(a) Who may apply

(1) Any person who believes he or she has a developmental disability or is the family member or authorized representative of such a person may apply for services, supports, or benefits. In addition, the guardian of the person may apply.

(2) Any other person may refer a person who may need services, supports, or benefits.

(3) An agency or a family member may initiate an application for a person with a developmental disability or a family member but must obtain the consent of the person or guardian to proceed with the application.

(b) Application form

(1) Department will adopt an application form to be completed by or on behalf of all applicants. The DA must provide a copy of the application to all people who contact the DA saying they wish to apply for services.

(2) Copies of the application form will be available from the Department, on the Department's website, and from every office of a DA. A person may request an application form in person, by mail, by electronic format, by facsimile (FAX), or by telephone.

(3) The DA must provide assistance to an applicant who needs or wants help to complete the application form.

(c) Where to apply

(1) An application must be filed at an office of the DA for the geographic area where the person with a developmental disability lives.

(2) An application for a person, who is new to services, who is incarcerated or living in a residential school, facility or hospital must be filed at an office of the DA for the geographic area where the person was living before going to the school, facility or hospital. For individuals who were receiving services just prior to being in one of these facilities, an application must be filed at the DA which

was last responsible prior to the individual entering the facility.

(3) An application for a person who is in the custody of the Department for Children and Families (DCF) must be filed at an office of the DA for the region in which the individual was placed in DCF custody. Applications for children under 18 who are in the custody of their parents should be filed at the DA where a custodial parent lives.

(4) An application may be submitted by mail, facsimile (FAX), secure electronic format, or in person.

(d) Screening

(1) Within five (5) business days of receiving an application, the DA must complete the application screening process. If there are extenuating circumstances that prevent completion in five (5) business days, the agency must document those in the individual's record. The screening process includes all of these steps:

(A) Explaining to the applicant the application process, potential service options, how long the process takes, how and when the applicant is notified of the decision, and the rights of applicants, including the right to appeal decisions made in the application process;

(B) Notifying the applicant of the rights of recipients in plain language, including the procedures for filing a grievance or appeal and their rights as outlined in the federal CMS HCBS rules;

(C) Discussing options for information and referral; and

(D) Determining whether the person with a developmental disability or the person's family is in crisis or will be in crisis within 60 days. If the DA determines that the person or family is facing an immediate crisis, the DA must make a temporary or expedited decision on the application.

(2) At the point of initial contact with an applicant, the DA must inform the applicant of all certified providers in the region and the options to:

(A) Receive services and supports through any certified provider in the region,

(B) Share the management of those services with the DA or SSA, or

(C) Self/family-manage their services through the Supportive ISO.

(3) Contact and referral information for options for services outside of the DA must be provided to each applicant and referral assistance provided to ensure the applicant is informed of his or her choice of all the service options listed in 7.100.5(d)(2). The DA must have documentation that the applicant was informed of all of these options.

(4) If the applicant wants more information about options or chooses to pursue services outside the DA, then the DA must contact the SSA or Supportive ISO on behalf of the applicant.

(e) Assessment

(1) The DA is responsible for conducting the assessment or assuring that it is conducted. The

assessment process must involve consultation with the applicant, and, with the consent of the applicant, other organizations which support the applicant.

(2) The DA must offer information and referral to the applicant at any time that it may be helpful.

(3) Assessment consists of in-depth information-gathering to answer the four following questions:

(A) Is this a person with a developmental disability, as defined in 7.100.2(o) of these regulations, and a person eligible to be a recipient, as defined in 7.100.4? If so,

(B) What does the person or his or her family need? This question is answered through a uniform needs assessment and process approved by the Department, which determines with each person or family their service or support needs, including identification of existing supports and family and community resources.

(C) Does the situation of the person or family meet the criteria for receiving any services or funding defined as a funding priority in the *System of Care Plan*? If so,

(D) What are the financial resources of the person with a developmental disability and his or her family to pay for some or all of the services?

(f) Authorization of funding for services

Based on the answers to the questions in 7.100.5 (e), the DA will seek or authorize funding for services to meet identified needs or will determine that the individual is not eligible for the requested funding for services. The procedures for authorizing funding or services are described in the *System of Care Plan.* Services and the funding amount authorized must be based upon the most cost-effective method of meeting an individual's assessed needs, the eligibility criteria listed in the *System of Care Plan,* as well as guidance in the *System of Care Plan* and current *Medicaid Manual for Developmental Disabilities Services.* When determining cost effectiveness, consideration will be given to circumstances in which less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful.

(g) Available Programs and Funding Sources

The Department's programs reflect its current priorities for providing services for Vermont residents with developmental disabilities. The availability of the Department's current programs is subject to the limits of the funding appropriated by the Legislature on an annual basis. The nature, extent, allocation and timing of services are addressed in the *System of Care Plan (*SOCP) as specified in the DD Act. Additional details, eligibility criteria, limitations and requirements for each program are included in the SOCP, the current *Medicaid Manual for Developmental Disabilities Services,* and in specific Division guidelines. Programs will be continued, and new programs will be developed, based on annual demographic data obtained regarding Vermont residents with developmental disabilities, the use of existing services and programs, the identification of the unmet needs in Vermont communities and for individual residents of Vermont, and the reasons for any gaps in service.

(h) Special Initiatives

The Division may invest in initiatives that enhance the overall system of support for people with developmental disabilities and their families. The Division may use funding to support initiatives that will enhance choice and control and increase opportunities for individuals receiving developmental disabilities services and their families. The timing and amount of funding for any initiative will be identified in the *System of Care Plan*. For all special initiatives, specific outcome measures will be required, and results will be reported by DDSD.

(i) Notification of decision on application

(1) Timing of the notices

(A) Within 45 days of the date of the application, the DA must notify the applicant in writing of the results of the assessment and the amount of funding, if any, which the applicant will receive.

(B) If the assessment and authorization of funding is not going to be completed within 45 days of the date of application, the DA must notify the applicant in writing of the estimated date of completion of the assessment and authorization of services or funding. A pattern of failure to complete the process within 45 days will be considered in determining whether to continue the designation of an agency.

(2) Content of notices

(A) If some or all of the services requested by the applicant are denied, or the applicant is found not eligible, the written notice must include the right to appeal the decision, the procedures for doing so, and the content of notices as specified in 7.100.9 and 8.100). Denials of eligibility must follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 must be followed regarding the timing and content of those notices.

(B) If the assessment determines the applicant has a developmental disability and has needs that fit within the funding priorities outlined in the *System of Care Plan*, the notice must state the amount of funding and services the applicant will receive. The notice must also state what costs, if any, the recipient is responsible to pay (7.100.7).

(C) If the assessment determines the applicant does not have a developmental disability, the notice must state that the DA will continue to offer information and referral services to the applicant.

(D) If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based Services funding, the notice must state that the DA will continue to offer information and referral services and will place the person's name on a waiting list (7.100.5 (q)).

(j) Choice of provider

(1) The DA must help a recipient learn about service options, including the option of self/family-managed services.

(A) It is the DA's responsibility to ensure the individual is informed of his or her choice of all services options listed in 7.100.5(d)(2), so that the individual can make an informed decision when choosing between and among management options/service providers. The DA must document options discussed and information shared as part of this process. The DA must provide the choices in an unbiased manner to reduce the potential for conflict of interest.

(B) If the recipient is not self/family-managing services, the DA will ensure that at least one provider within the geographic area offers the authorized services at or below the amount of funding authorized at the DA.

(C) If no other provider is available to provide the authorized services and the recipient or family does not wish to self/family-manage services, the DA must provide the authorized services in accordance with its Provider Agreement.

(D) The recipient or family may receive services from any willing agency in the state.

(E) A recipient or family may request that an agency sub-contract with a non-agency provider to provide some or all of the authorized services; however, the decision to do so is at the discretion of the agency.

(2) If the recipient's needs are so specialized that no provider in the geographic area can provide the authorized services, the DA may, with the consent of the recipient, contract with a provider outside the geographic region to provide some or all of the authorized services.

(3) The recipient may choose to receive services from an agency other than the DA if the agency agrees to provide the authorized services at or below the amount of funding authorized for the DA to provide services.

(A) When requesting new funding, if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider will submit a budget to the DA and the DA will determine its costs to serve the individual and must submit the lower of the two budgets to the funding committee. If an alternative provider is not able to provide the services at the lower approved budget, the DA must do so at the amount of funding authorized for the DA to provide services.

(B) If at any time a recipient chooses or consents to receive some or all authorized services or supports from a different agency, the agency currently serving the recipient must promptly transfer the individual's authorized funding limit to the agency selected according to the procedures outlined in Division guidelines.

(C) When an individual chooses to transfer to another agency or to self/family-manage, the receiving agency or Supportive ISO must fully inform the recipient and the individual's authorized representative, if applicable, prior to the transfer, of the impact on the amount of services that can be provided within the approved budget based upon the agency or Supportive ISO's costs for services.

(D) Any disputes about the amount of funding to be transferred will be resolved by the director of the Division.

(4) The recipient may choose to self/family-manage services (See 7.100.6).

(k) Individual support agreement (ISA)

(1) Once a recipient has received written authorization of services or funding (7.100.5 (f)), the recipient, together with the agency or Supportive ISO, writes an ISA that defines the services and

supports to be provided. The recipient may ask any person to support him or her in establishing a person-centered process, making decisions, and choosing services, supports and/or providers.

(2) The agency or, in the case of self/family-managed services, the Supportive ISO, has ultimate responsibility to ensure that an initial ISA is developed within thirty (30) days of the first day of billable services/supports or authorized start date for HCBS. This timeline may be extended at the request of the recipient, as specified in the *ISA Guidelines*.

(3) Initial and ongoing ISAs must be written and reviewed in accordance with the Department's *ISA Guidelines*. A written ISA is required even if the recipient chooses to self/family-manage services.

(4) The ISA is a contract between the recipient and provider(s) who provides the service or support.

(5) An ISA may be revised at any time.

(l) Periodic review of needs

(1) The needs of each individual currently receiving services must be re-assessed annually by the agency or Supportive ISO, together with the individual and his or her team, using the needs assessment to assure the individual's budget reflects current needs, strengths and progress toward personal goals. An Annual Periodic Review will take place as part of the planning for the individual's next ISA or ISA review. This will include an examination of the utilization of services in the past year as compared to the authorized funding limit. The individual's budget must be adjusted to reflect current needs.

(2) The agency or Supportive ISO must make adjustments in a recipient's budget and/or services, if indicated, based upon the following:

(A) Changes in the recipient's needs;

(B) Changes in use of funded services;

(C) Changes in the cost of services to meet the needs;

(D) Changes in the *System of Care Plan* or these regulations; or

(E) Changes in funds available due to insufficient or reduced appropriation or an administrative arithmetic error.

(3) As part of the periodic review, the agency or Supportive ISO must ask each recipient about his or her satisfaction with services and provide each recipient and individual's authorized representative with an explanation of the rights of recipients, including those outlined in the federal CMS HCBS rules, and how to initiate a grievance or appeal (See 7.100.9 and 8.100).

(4) If a periodic review results in a determination that services or funding should be reduced, changed, suspended or terminated, the agency or Supportive ISO must notify the recipient as provided in Section 7.100.5 (p)and Part 7.100.9 and 8.100.

(m) Full reassessment of a young child

(1) The agency or Supportive ISO must conduct or arrange for a full clinical reassessment of a child at the time he or she turns six to determine whether the child is a person with a developmental disability. Assessments conducted by schools or other organizations should be used whenever

possible to avoid duplication.

(2) *Exception:* A child receiving limited services as the result of a diagnosis of autism spectrum disorder does not need to be reassessed to confirm the diagnosis of ASD at the time he or she turns six. An adaptive behavior assessment is required at this time to confirm the child continues to have significant deficits in adaptive behavior as defined in 7.100.3.

(3) If the reassessment determines that the child is no longer a person with a developmental disability, benefits for the child and family must be phased out as provided in 7.100.5 (o)(2) of these regulations.

(n) Full reassessment (transition from high school to adulthood)

(1) The agency or Supportive ISO must conduct or arrange for a full clinical reassessment and a reassessment of needs of a recipient one year prior to his or her last month of high school. If the agency or Supportive ISO has less than one year's prior notice of the person's leaving high school, it must conduct the reassessment as soon as it learns that the person is going to leave high school or has left high school. The reassessment must consider: (A) whether the young adult is a person with a developmental disability; and (B) the future service and support needs of the person and his or her family. The needs assessment should be reviewed and updated prior to requesting funding if there have been significant changes in circumstances that impact services and supports needed. Any assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

(2) If the reassessment determines that the young adult is no longer a person with a developmental disability, services to the young adult and his or her family must be phased out as provided in 7.100.5(o)(2) of these regulations.

(3) If the reassessment determines that the support needs of the person or family will change or increase when the young adult is no longer in school, the ISA and budget must be reviewed in accordance with this section.

(o) Full reassessment

(1) The agency or Supportive ISO must conduct or arrange for full clinical reassessment of an adult or child if there is reason to believe the person may no longer have substantial deficits in adaptive behavior or may no longer have a developmental disability.

(2) If the reassessment determines that the individual is no longer a person with a developmental disability, services to the person must be phased out within twelve months or less, unless the individual is eligible to continue to receive services based on 7.100.4 (d). Upon the determination of ineligibility, the agency or Supportive ISO must provide timely notice of the decision to the recipient and the individual's authorized representative, if applicable, and as provided for in 7.100.5 (p), 7.100.9, and 8.100.

(p) Notification of results of reassessment or periodic review

If a reassessment or review results in a determination that the recipient is no longer eligible, or services should be reduced, suspended, or terminated, the agency or Supportive ISO must notify the recipient and individual's authorized representative, if applicable, in writing of the results of the review or reassessment, and of the right to appeal the decision and the procedures for doing so. The notice will include the content as specified in 7.100.9 and 8.100. Denials of eligibility should follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 would be followed regarding the timing and content of those notices.

(q) Waiting list

A person with a developmental disability whose application for Home and Community-Based Services, Flexible Family Funding or Family Managed Respite is denied must be added to a waiting list maintained by the Designated Agency. The Designated Agency must notify an applicant that his or her name has been added to the waiting list and explain the rules for periodic review of the needs of people on the waiting list.

(1) The Division will provide instructions to the Designated Agency for reporting waiting list information to the Division.

(2) Each Designated Agency must notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list must occur:

(A) When there are changes in the funding priorities or funds available; or

(B) When notified of significant changes in the individual's life situation.

(3) Waiting list information will be included the DDS Annual Report and will be reviewed annually by the DDS State Program Standing Committee.

7.100.6 Self/Family-Managed Services

Many individuals receiving services, or a family member of an individual receiving services, may be eligible to manage the services instead of having the services managed by an agency. Individuals may manage their services either independently or with the help of their families. An individual or a family member may manage up to 12 hours a day of In-home Family Supports or Supervised Living, but may not self/family manage Staffed Living, Group Living or Shared Living.

Self/family-management is a service option that is designed to provide choice and control to an individual or family. Self/family-management requires individuals or their family members to hire and oversee their own employees and function as the employer of record. Except for supportive services, clinical services provided by licensed professionals, or camps that provide respite, individuals and families may not purchase services from a non-certified entity or organization.

In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in 7.100.6(b). A Supportive ISO, in making this determination, must consider the reasons set forth in 7.100.6(f)(2), as well as any and all criteria established by the Department. An individual or a family member also has the option of managing *some, but not all,* of the services and have an agency manage some of them. This arrangement is called shared-managing. 7.100.6(g) explains how shared-managing works.

(a) Self/Family-Management Agreement

An individual or family member who is allowed to manage services must sign an agreement with a Supportive ISO. The Department will provide an approval form for agreements. The agreement must set out the responsibilities of the individual or family member and the responsibilities of the Supportive ISO.

(b) Responsibilities of an individual or family member who manages services

An individual or family member who manages services must be capable of and carry out the following functions:

(1) Maintain Medicaid eligibility for the individual receiving services. Immediately notify the Supportive ISO of any circumstances that affect Medicaid eligibility.

(2) Develop an ISA that reflects what services the individual needs and how much money the individual has been provided in their budget to spend for those services. Follow the Department's *ISA Guidelines* to ensure that all required information is included and completed according to specified timelines. The plan must specify what each service is supposed to be and how much each service will cost on an annual basis. The ISA must also identify the individual's service provider(s) and explain how the services received must be documented.

(3) Ensure that services and supports are provided to the individual in accordance with the ISA and the budget.

(4) Maintain a complete and up-to-date case record that reflects details regarding the delivery of services. Follow the *Guide to Self/Family Management* regarding what needs to be included in the case record. Retain case records in accordance with the record retention schedule adopted by the Department.

(5) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are set forth in 7.100.11(e).

(6) Understand the individual's ISA and their budget. Make necessary changes based on the individual's needs. Follow these regulations and the Department's *ISA Guidelines* regarding what to do when there is a change.

(7) Follow the Department's *Health and Wellness Guidelines* to take care of the individual's health and safety.

(8) Follow the rules about reporting critical incidents to the Supportive ISO. Make sure the reports are filed in accordance with the specific timeline required by the Department's *Critical Incident Reporting Guidelines*.

(9) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

(10) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

(11) Prepare written back-up plans for when the plan cannot be followed (e.g., a worker gets sick and/or does not show up for work). Include in the plan who will come and work and what will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

(12) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.

(13) Take the following steps when hiring workers:

(A) Write a job description. Complete reference checks before allowing the worker to start work;

(B) Interview and hire workers that meet the requirements of the Department's Background Check Policy, or who receive a variance when there is an issue with the background check;

(C) Sign up with the state contracted F/EA. Give the F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

(D) Train or have someone else train all workers in accordance with these regulations. The rules are in the Department's pre-service and in-service standards in 7.100.10;

(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets to verify they reflect the actual hours worked. Sign and send accurate timesheets to the F/EA;

(F) Suspend or fire workers as necessary; and

(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

(14) Manage services in accordance with the Department's *Guide to Self/Family Management*.

(15) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the Supportive ISO for assistance in determining what expenses are reimbursable. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

(c) Role of the Designated Agency

For existing recipients who are self/family managing who have a new need as determined by a new needs assessment and need an increase in services and funding, the Supportive ISO develops and submits proposals to the Supportive ISO funding committee and then to the appropriate statewide funding committee. For complex situations, the Supportive ISO may consult with an independent evaluator, the Division or the local DA to determine strategies regarding how an individual's needs may best be met. This may include a collaborative effort between the Supportive ISO and DA regarding assessments and funding proposals as needed.

(d) Role of Qualified Developmental Disability Professional (QDDP)

(1) An individual or family member who manages services must choose someone to be his or her independent QDDP or must ask the Supportive ISO to find a QDDP for him or her.

(2) All QDDP's must meet the criteria specified in the Division's *Vermont Qualified Developmental Disabilities Professional Protocol.* For QDDPs employed by an agency, the agency is responsible for ensuring that the QDDP meets those criteria. QDDPs not employed by an agency, including those working for the Supportive ISO, must be endorsed by the Department as an independent QDDP, before being paid as a QDDP.

(3) The QDDP must:

(A) Approve the individual's ISA and ensure that it is signed by the individual and guardian, if there is one;

(B) Confirm that the ISA is being carried out the way it is supposed to be and that it meets the needs of the individual;

(C) Confirm that services and supports are delivered the way the Department and Medicaid regulations and guidelines require;

(D) Contribute to the periodic review of the individual's needs conducted by the Supportive ISO;

(E) Confirm the ISA is updated to show the changes in the individual's needs and goals;

(F) Approve any changes to the ISA;

(G) Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996 and the rights outlined in the federal CMS HCBS rules; and

(H) Review and sign off on all critical incident reports according to the *Critical Incident Reporting Guidelines.*

(e) Responsibilities of a Supportive ISO when an individual or family member manages services

When an individual or family member manages services, the Supportive ISO must:

(1) Provide support and assistance to the individual or family member to ensure he or she understands the responsibilities of managed services including following all policies and guidelines for the Division. Explain managed services and the individual's or family member's employer role and responsibilities;

(2) Conduct periodic reviews with contributions from the QDDP, make adjustments to budgets as needed and notify the individual of his or her rights under these regulations;

(3) Confirm the individual's Medicaid eligibility on an annual basis;

(4) Help the individual or family member to develop an authorized funding limit (AFL), provide guidance in self-managing the AFL, ensure the AFL is not managed by a third party, as well as provide assistance in determining whether a service is reimbursable under Department rules. Provide the F/EA with the individual's AFL;

(5) Bill Medicaid according to the procedures outlined in the provider agreement between the Supportive ISO and the Department;

(6) Review requests for more money and seek funding according to the process outlined in 7.100.5 of these regulations and the *System of Care Plan*. Requests for short term increases in funding will be addressed internally by the Supportive ISO. Requests for long term increases will be sent to the appropriate statewide funding committee;

(7) Confirm that the individual has a current ISA that reflects the areas of support funded in the budget and identifies and addresses any known health and safety concerns; Nofify the individual/family that funding may need to be suspended if there is not a current signed ISA, according to the timelines outlined in the ISA guidelines;

(8) Provide QDDP services when requested. QDDP services are a separately purchased service;

(9) Maintain a minimum case record in accordance with the requirements outlined in the *Guide to Self/Family Management*. Make sure that the individual or family member responsible for managing services understands that the individual must have a complete case record in accordance with the requirements outlined in the *Guide to Self/Family Management*. Retain case records in accordance with the record retention schedule adopted by the Department;

(10) Review and appropriately manage all reported critical incidents. If applicable, report the critical incidents to the Department in accordance with requirements in the *Critical Incident Reporting Guidelines*;

(11) Provide information about the Division's crisis network to the individual or family member responsible for managing services;

(12) Determine that the individual or family member who is managing the services is capable of carrying out the duties by conducting an initial assessment and providing ongoing monitoring;

(13) Provide required pre-service and in-service training to the individual's support workers if the individual or family member does not provide that training. The training requirements are located in Part 7.100.10 of these regulations; and

(14) Form and consult with an advisory committee.

(f) Determination that the individual or family member is unable to manage services

(1) The Supportive ISO may deny a request to self- or family-manage, or may terminate the management agreement, if it decides that the individual or family member is not capable of carrying out the functions listed in 7.100.6(b). If the individual's or family member's request is denied, or a management agreement is terminated, then the individual's services must be provided by the individual's DA or from a SSA willing to provide services. Unless it is an emergency, the Supportive ISO has to inform the individual or family member at least thirty (30) days before terminating the agreement.

(2) The Supportive ISO may decide that the individual or family member is not capable of carrying out the functions listed in 7.100.6(b) for reasons which include the following:

(A) The managed services put the individual's health or safety at risk (the agreement can be terminated immediately if the individual is in imminent danger);

(B) The individual or family member is not able to consistently arrange or provide the necessary services;

(C) The individual or family member refuses to participate in the Division's quality assurance reviews; or

(D) Even after receiving training and support, the individual or family member is not substantially or consistently performing his or her responsibilities for self/family-management as outlined in Section 7.100.6 (b). This includes not following policies, regulations, guidelines, or funding requirements or not maintaining and/or ensuring proper documentation for developmental disabilities services. The Supportive ISO must document substantial non-performance as follows:

(i) When the Supportive ISO discovers an issue, they must notify the individual or family member in writing of the issue and what is needed to correct the issue along with a timeline to do so; and offer support and training to the individual or family member as needed;

(ii) If the individual or family member has not corrected the issue according to the required timeframe, the Supportive ISO must send written notice to the individual or family member indicating that if the issues are not corrected in 30 days, the agreement for self/family-management may be terminated.

(iii) Repeated documented failures to follow requirements will be evidence to justify termination of the self/family-management agreement.

(3) If the Supportive ISO decides an individual or family member is not able to manage services, the individual or family member may file a request for a fair hearing with the Human Services Board, as provided in 3 V.S.A. § 3091. The Supportive ISO must provide written notice to the individual or family member at least 30 days prior to terminating a self/family-management agreement and the Supportive ISO's notice must include the individual or family member's right to request a fair hearing within 30 days of the date of the notice.

(g) Responsibilities of an individual or family member who share-manages services

An individual or family member may manage some services and let an agency manage some services. That is called shared-managing. The agency is responsible for providing information and guidance to the individual or family member regarding his or her responsibilities for share-management. An individual or family member who share-manages with an agency must do all of the following:

(1) Ensure services and supports are provided to the individual in accordance with the ISA and his or her budget.

(2) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are in 7.100.11(e).

(3) Make and keep all papers and records as required by the agency.

(4) Report critical incidents to the agency. Make sure the reports are filed in accordance with the specific timelines required by the Department's *Critical Incident Reporting Guidelines*.

(5) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is

suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

(6) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

(7) Prepare written back-up plans for when the plan cannot be followed (e.g., the worker gets sick and/or does not show up for work). Include in the plan who will come and work and what will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

(8) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.

(9) Take the following steps when hiring workers:

(A) Write a job description. Complete reference checks before allowing the worker to start work;

(B) Interview and hire workers that meet the requirement of the Department's Background Check Policy, or upon receipt of a variance when there is an issue with the background check;

(C) Sign up with the state contracted F/EA. Give the F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

(D) Train or have someone else train all workers in accordance with these regulations. See the Department's pre-service and in-service standards in 7.100.10;

(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets. Sign and send accurate timesheets to the F/EA;

(F) Suspend or fire workers as necessary; and

(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

(10) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the agency for assistance in determining what are reimbursable expenses. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

7.100.7 Recipient Financial Requirements

(a) Income and resources; Medicaid-funded programs

For all supports and services funded by Medicaid, the income and resource rules of Department of Vermont Health Access (DVHA) governing eligibility for Medicaid programs apply and are incorporated here by reference.

(b) Room and board; personal spending money

Medicaid developmental disabilities funding does not cover room and board, clothing, or personal effects.

(1) At least annually, the Commissioner or the Commissioner's designee will publish a schedule of rates for room and board and rates for personal spending allowances for recipients. The personal spending allowance will not be less, and may be more, than the personal spending allowance for nursing home residents. The sum of the room and board rates and the personal spending allowance will be equal to the current Supplemental Security Income (SSI) rates, including state supplement.

(2) Payment of the rate set by the Commissioner's schedule will be considered payment in full for the recipient's room and board if the recipient receives residential services funded by the Department. Recipients who receive income from a source other than SSI will be charged the same rate for room and board as SSI recipients.

(3) In unusual circumstances the Division Director may permit non-Medicaid funds of the Department to be used to subsidize the excess costs of a recipient's room and board.

(4) Recipients who rent or own their own home or apartment and have room and board costs in excess of the Commissioner's schedule will receive assistance in accessing rent subsidy, low interest loans, fuel assistance, and other sources of housing assistance for low-income Vermonters. To the extent authorized by the *System of Care Plan*, the Commissioner may provide non-Medicaid funds to subsidize the excess costs of a recipient's rent or house payment, if the recipient is unable to afford the cost.

(5) Recipients who rent or own their own home or apartment and who work may elect to use their earnings to pay rent or mortgage or room and board costs in excess of the Commissioner's schedule.

(6) The recipient, in consultation with his or her representative payee, if any, will determine how to spend the personal spending allowance.

(c) Financial responsibility of parents

The parents of a child under age 18 with a developmental disability are financially responsible for costs not covered by any Medicaid program or funded by the Department, specifically: housing; food; clothing; non-medical transportation; personal items; and childcare necessary for a parent to work.

7.100.8 Special Care Procedures

(a) Purpose

The purpose of these regulations is to ensure that people with developmental disabilities who have specialized health care needs receive safe and competent care while living in home and community settings funded by the Department.

(b) Special Care Procedure

(1) The purpose of classifying a procedure as a "special care procedure" is to provide a system for ensuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for. These regulations follow the Vermont State Board of Nursing Position Statement – The role of the nurse in delegating nursing interventions.

(2) Examples of special care procedures are as follows:

(A) Enteral care procedures. Procedures that involve giving medications, hydration, and/or nutrition through a gastrostomy or jejunostomy tube. Special care procedures include replacement of G and J tubes, trouble-shooting a blocked tube, care of site, checking for placement, checking for residuals, use, care and maintenance of equipment; follow up regarding dietitians' recommendations, obtaining and following up lab work, mouth care, and care of formula.

(B) Procedures to administer oxygen therapy. Use of O2 tanks, regulators, humidification, concentrators, and compressed gas. This may include need for O2 assistance through use of SaO2 monitor, use of cannulas, tubing, and masks.

(C) Procedures that require suctioning techniques. Oropharyngeal (using Yankeur), nasopharyngeal (soft flexi tube) and tracheal components, which may include suctioning; clean versus sterile suctioning, care and maintenance of equipment, including stationary and portable systems.

(D) Administration of respiratory treatments. Using nebulizer set-up, care and maintenance of equipment.

(E) Tracheotomy care. Including cleaning of site and replacement of trach.

(F) Procedures that include placement of suprapubic and urethral catheters, intermittent catheterization, use and care of leg bags, drainage bags, when and how to flush, clean versus sterile catheterization.

(G) Procedures that include care of colostomy or ileostomy. Care of the stoma and maintenance of equipment.

(H) Diabetes care, including medications, use of insulin, monitoring.

(c) Application and limitations

(1) These sections (7.100.8) apply to DAs and SSAs (including their staff and contractors).

(2) These sections (7.100.8) apply to managed services, but they do not apply to care provided by natural or adoptive family members unless the family member is compensated for providing the care with funds administered or paid by the Department.

(3) These regulations do not apply to care provided by hospital or nursing home staff.

(d) Determining that a procedure is a special care procedure

The determination that a care procedure is a "special care procedure" has three components:

(1) The procedure requires specialized nursing skill or training not typically possessed by a lay individual;

(2) The procedure can be performed safely by a lay individual with appropriate training and supervision; and

(3) The individual needing the procedure is stable in the sense that outcomes are predictable.

(e) Who determines special care procedures

(1) The initial identification of the possible need for a special care procedure may be made by the agency that serves the individual, by nursing staff of the Department, or by any other health providers.

(2) A registered nurse must determine whether a procedure is a special care procedure.

(f) Who may perform a special care procedure

(1) A special care procedure may be performed only by a person over the age of 18 who receives training, demonstrates competence, and receives monitoring in accordance with these regulations.

(2) Competence in performing a special care procedure is individualized to the particular needs, risks, and characteristics of an individual. The fact that an employee or contractor may have been approved to perform a special care procedure for one individual does not create or imply approval for that person to perform a similar procedure for another individual.

(3) The agency responsible for the health needs of the individual must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or by a qualified health professional.

(4) The agency is responsible for having a back-up plan for situations where the person or people trained to perform a special care procedure for an individual are unavailable. If a trained lay person is not available, the procedures must be performed by a qualified health professional. In the case of managed services, the services coordinator bears responsibility for having a back-up plan.

(g) Specialized care plan

(1) If a nurse has determined that an individual needs a special care procedure, the agency is responsible for ensuring that a specialized care plan is attached to the ISA and that every person who is authorized to perform a special care procedure has a copy of the specialized care plan.

(2) A registered nurse must complete an assessment of the person prior to developing the specialized care plan. The specialized care plan must be developed by the registered nurse and must identify the specialized care procedures and the nurse responsible for providing training, determining competence, and reviewing competence. The specialized care plan must also include a schedule for the nurse to monitor the performance of specialized care procedures. (7.100.8(j)).

(h) Training

(1) Qualifications of trainer. Training must be provided by a nurse. The nurse must have a valid

State of Vermont nursing license.

(2) Timeliness. Training must be provided before any caregiver who is not a health professional provides a special care procedure without supervision. Training must be provided in a timely manner so as not to impede services for an individual.

(3) Best practice. Training in special care procedures must conform to established best practice for performance of the procedure.

(4) Individual accommodations. Individuals with developmental disabilities have had unique experiences that may enhance or obstruct the ability to provide care. Within the framework of special care procedures, a combination of best practice and accommodation of individual characteristics will define the procedures to be used with a particular individual.

(5) Documentation of training. The agency responsible for the health needs of the individual is responsible for ensuring that the nurse provides a record of training for any person who is carrying out a special care procedure. The records must include information about who provided the training, when the training was provided, who received training, what information was provided during the training, and the conditions under which reassessment and retraining need to occur.

(6) Emergencies. The nurse must be notified of any changes in an individual's condition or care providers. The agency responsible for the health needs of the individual must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or else by nursing personnel. If the nurse determines that, as a result of the emergency, a trained lay person cannot safely perform the procedure, the procedure must be performed by a qualified health professional.

(i) Competence

The determination of competence is a determination that a person demonstrates adequate knowledge to perform a task, including use of equipment and basic problem-solving skills. Competence includes capability, and adequate understanding.

(1) Determination of competence. Determination of competence must be made by a nurse. The specialized care plan must identify the nurse responsible for making this determination.

(2) Supervised practice. An individual who is working toward but has not yet achieved status of a competent special care provider must provide specialized care under the supervision of a nurse.

(3) Competence defined. Competence involves demonstrating safe performance of each step of the special care procedure and proper use and maintenance of equipment, basic problem-solving skills, consistency of performance, and sufficient theoretical understanding.

(4) Documentation of competence. The record must document which people are determined competent to perform a special care procedure.

(5) Review of competence. A specialized care provider's competence must be reviewed by a nurse at least annually and also when that worker's competence is in question, or at any time when there is change in the condition of the individual.

(j) Monitoring

Ongoing monitoring by a nurse ensures that a special care provider's skills and knowledge continue to be current. The individual's specialized care plan must include monitoring requirements, including expectations for monitoring the performance of special care procedures and patient outcomes at least annually.

7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings

Medicaid-funded services for eligible individuals with developmental disabilities are part of the Global Commitment to Health 1115(a) Medicaid Waiver, which is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. As set forth in the Demonstration, the Agency of Human Services (AHS), as the state, and the Department of Vermont Health Access (DVHA), as if it were a non-risk prepaid in-patient health plan (PIHP), must comply with all aspects of 42 C.F.R. Part 438, Subpart F, regarding a grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Medicaid services, including developmental disabilities services.

AHS has adopted Health Care Administrative Rule (HCAR) 8.100, which fully sets forth the responsibilities of the Vermont Medicaid Program, as required by 42 CFR Part 438, Subpart F. This rule details, among other things, the content and timing of notices of an Adverse Benefit Determination, the circumstances relating to continuing services pending appeal and potential beneficiary liability, and the State fair hearing and grievance processes.

For provisions that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical, and clinical eligibility for developmental disabilities services, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

The Division will develop a plain language guide to the Internal Appeals, Grievances, Notices, and State Fair Hearings, in collaboration with stakeholders. The guide will be made available to all applicants and authorized representatives during the initial screening and all recipients during the annual periodic review, as well as whenever an applicant or recipient is notified of a decision regarding eligibility or service authorization. The plain language guide will include specifics related to how to file a grievance or appeal, to whom it should be directed, timelines and where to get assistance in filing.

7.100.10 Training

(a) Purpose

Training is an ongoing process that helps ensure safety and quality services and reflects the principles of services of the Developmental Disabilities Act of 1996, generally accepted best practices, and promising practices and the priorities of the *System of Care Plan* and these regulations.

(b) Standards

(1) The Division will develop training standards and periodically update them to ensure that workers:

(A) Understand the values and philosophy underlying services and supports;

(B) Acquire skills necessary to address the individual needs of the recipient for whom they provide services and support;

(C) Acquire skills to implement the principles and purposes of the Developmental Disabilities Act of 1996; and

(D) Are exposed to best and promising practices in supporting individuals with developmental disabilities.

(2) In developing the standards, the Division will endeavor to involve individuals with developmental disabilities and their families in the design, delivery, and evaluation of training.

(3) The minimum standards for training are outlined in (c) – (f).

(c) Agency and Supportive Intermediary Support Organization responsibilities

(1) Each agency must adopt and implement a training plan which ensures adherence to the following minimum standards:

(A) Workers compensated with funds paid or administered by the agency must receive pre-service and in-service training or have knowledge and skills in the areas addressed by pre-service and in-service training consistent with Department and Division standards and these regulations.

(B) Workers, on an ongoing basis, must have opportunities to broaden and develop their skills and knowledge in the following areas:

(i) Best and promising practices;

(ii)Values including:

The principles of supporting people to have valued roles in their community including:

(1) The dignity of valued roles
(2) Sharing ordinary places
(3) Making choices and the dignity of risk
(4) Relationships in living a full life
(5) Making contributions to others

The principles of person-centered thinking including:

(1) How to respectfully address significant issues of health or safety while supporting choice

(2) How to sort what is important for people from what is important to the people we support

(3) How rituals and routines play a role in what is important to the people we support

(4) The importance of having power with rather than power over the people we support;

(iii) Current and emerging worker responsibilities; and

(iv) Current and emerging needs of the individual.

(2) The training plan must be written and based on the agency's assessment of its ability and capacity to meet the needs of the people it serves, the local *System of Care Plan*, and the training needs of its staff and board members.

(3) The training plan must be updated as needed but at least every three years.

(4) Each agency, and Supportive ISO must:

(A) Have a system to verify that all workers compensated with funds administered or paid by the organization have received pre-service and in-service training in accordance with these regulations or have knowledge and skills in the areas addressed by pre-service and in-service training.

(B) Make pre-service and in-service training available to all workers at no cost to the family or recipient.

(C) Involve people with disabilities and their families in the design, delivery, and evaluation of training and invite them to participate in training.

(D) Have a system to verify that all workers have been told about and understand the requirement to report abuse and neglect of children to the DCF, and abuse, neglect and exploitation of vulnerable adults to APS.

(5) Each agency and Supportive ISO must:

(A) Inform each person that self/family-manages services or share-manages services about the recipients or family's responsibility for ensuring that all workers receive pre-service and in-service training in accordance with these regulations.

(B) Inform each person that self/family-manages or share-manages services about the availability of pre-service and in-service training at no cost to the family.

(d) Pre-service training

Before working alone with an individual who receives support funded by the Department, each worker must be trained and demonstrate knowledge in (1) through (5) of this section. The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(1) Abuse reporting requirements:

(A) The requirements of Vermont law to report suspected abuse or neglect of children; and

(B) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

(2) Health and Safety:

(A) Emergency procedures, including where to locate the emergency fact sheet;

(B) What to do if the individual is ill or injured;

(C) Critical incident reporting procedures; and

(D) How to contact a supervisor or emergency on-call staff.

(3) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)

(A) Whether the individual has a guardian, and how to contact the guardian;

(B) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;

(C) Health and safety needs of the individual;

(D) Methods of communication used by the individual including tools, technology and effective partner support strategies; and

(E) The individual's ISA, including the amount of supervision the individual requires.

(4) Values:

(A) Individual rights, as specified in 18 V.S.A. § 8728 and as outlined in the federal CMS HCBS rules;

(B) Confidentiality;

(C) Respectful interactions with individuals and their families; and

(D)Principles of service contained in the Developmental Disabilities Act of 1996.

(E) Respecting that people can make decisions for themselves, with support when needed.

(F) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand.

(5) How to access additional support, training, or information.

(e) In-service training

(1) Within three months of being hired or entering into a contract, workers must be trained in and demonstrate the knowledge and skills necessary to support individuals in 7.100.10(e)(1)(A) and (B). Workers must be trained in or demonstrate knowledge and skills necessary to support individuals, in 7.100.10(e)(1)(C) and (D). The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(A) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;

(B) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support methods of communication used by the recipient, and supporting decision making). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite, the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

(C) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and

(D) Basic first aid.

(2) Workers must be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

(f) Exception for emergencies

(1) For the purposes of this section, "emergency" means an extraordinary and unanticipated situation of fewer than 72 consecutive hours.

(2) In an emergency, if the unavailability of a trained worker creates a health or safety risk for the individual, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 72 hours after the worker first begins to work with the individual in response to the emergency, as long as essential information about the individual is communicated to the worker and he or she has immediate access to all the documents and information covering all areas of Pre-service training (see 7.100.10 (d)).

(3) This exception does not apply to workers performing special care procedures. All requirements in 7.100.8 of these regulations must be met prior to staff performing special care procedures.

7.100.11Certification of Providers

(a) Purpose of certification

In order to receive funds administered by the Department to provide services or supports to people with developmental disabilities, providers must be certified to enable the Department to ensure that an agency can meet certain standards of quality and practice.

(b) Certification status

(1) To meet certification standards, an agency must:

(A) Meet the standards for designation as a DA or SSA (see *Administrative Rules on Agency Designation*);

(B) Meet the Department's *Quality Standards for Services* (7.100.11(e)); and

(C) Provide services and supports that foster and adhere to the Principles of Service (See 18

V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728) and the rights outlined in the federal CMS HCBS rules.

(2) Current providers. Any agency receiving Department funds on the effective date of these regulations is presumed to be certified.

(3) New provider. A new provider that wishes to be certified by the Department must first establish that it meets the standards for designation. Upon being designated, an organization must apply in writing to the Department for certification. The application must include policies, procedures, and other documentation demonstrating that the organization is able to meet the quality standards for certification contained in 7.100.11(e) and provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728).

(4) Providers that are not designated will not be certified.

(5) If a certified provider loses its designation status, the provider is automatically de-certified.

(6) The Department will send the applicant a written determination within 30 days after receiving an application for certification. In order to receive funds administered by the Department, an organization must be certified and have a Provider Agreement with the Department.

(c) Monitoring of certification

The Department will monitor certified providers through a variety of methods including quality reviews, other on-site visits, review of critical incident reports and mortality reviews, investigation of complaints from recipients and the public, input from Department staff and staff or employees of other departments of AHS.

(d) Services available regardless of funding source

(1) Any services or supports which are provided to people who are eligible for Medicaid must be made available on the same basis to people who are able to pay for the services or who have other sources of payment.

(2) The rate charged to recipients who are able to pay for services or who have payment sources other than Medicaid must be the same as the rate charged to Medicaid-eligible recipients, *except that* the rate may be discounted to reflect lower administrative or implementation costs, if any, for non-Medicaid recipients. If a provider establishes a sliding fee scale for such services, the provider must have a source of funding (such as United Way, state funds, donated services) for the difference between the cost of providing the service and the fee charged.

(3) Any services not funded by Medicaid may be made available in accordance with a sliding fee schedule.

(e) Quality standards for services

To be certified, an agency must provide or arrange for services that achieve the following outcomes as specified in *Guidelines for the Quality Review Process of Developmental Disabilities Services:*

(1) Respect: Individuals feel that they are treated with dignity and respect.

(2) Self Determination: Individuals direct their own lives and receive support in decision making when needed.

(3) Person Centered: Individuals' needs are met, and their strengths and preferences are honored.

(4) Independent Living: Individuals live and work as independently and interdependently as they choose.

(5) Relationships: Individuals experience positive relationships, including connections with family and their natural supports.

(6) Participation: Individuals participate in their local communities.

(7) Well-being: Individuals experience optimal health and well-being.

(8) Communication: Individuals communicate effectively with others.

(9) System Outcomes.

(f) Status of non-designated providers

(1) Any non-designated entity or organization that provides services or supports to individuals with funds administered by the Department must be a subcontractor of an agency. This requirement does not apply to persons employed as independent direct support providers. The decision to subcontract with an entity or organization is at the discretion of the agency.

(2) The Department quality service reviews will be responsible for including people served by subcontracted providers to verify that they meet quality review standards.

(3) Any subcontract must contain provision for operations in accordance with all applicable state and federal policies, rules, guidelines, and regulations that are required of agencies.

(4) Agencies must require the following through all of its subcontracts: reserve the right to conduct inquiries or investigations without prior notification in response to incidents, events or conditions that come to its attention that raise concerns as to person-specific allegations regarding safety, quality of supports, the well-being of people who receive services or any criminal action. Further, the Department may conduct audits without advanced notice.

(5) Having a subcontract does not terminate an agency receiving funds under Vermont's Medicaid program from its responsibility to ensure that all activities and standards under their Provider Agreement with the Department are carried out by their subcontractors.

7.100.12 Evaluation and Assessment of the Success of Programs

The Department will evaluate and assess the success of programs using the following processes:

(1) The review of services provision, as outlined in the *Guidelines for Quality Review of Developmental Disabilities Services,* as well as those processes outlined in Appendix B of the quality review guidelines *Sources of Quality Assurance and Protection for Citizens with Developmental Disabilities;*

(2) The designation process for DA and SSAs as outlined in the *Administrative Rules on Agency*

Designation;

(3) Review of the data reported by agencies on required performance measures and monitoring of programs, as described in the agencies' Provider Agreements with the Department; and

(4) Review of performance measures submitted to AHS as required by Act 186.

The information gathered will be used for informing the continuation of programs, quality improvement, innovations in service delivery and policy development.

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 204A : Development Disabilities Act

(Cite as: 18 V.S.A. § 8726)

§ 8726. Application for services; rules

(a) No later than January 1, 1997, the department shall adopt rules that include the following:

(1) Criteria for determining whether an applicant is a person with a developmental disability.

(2) A format and procedures, for processing applications for services, including time frames, emergency procedures, and notice of determination.

(3) Procedures and time frames for periodic reviews of a person's eligibility and continuing need for services.

(4) Standards and procedures for billing.

(5) Complaints and appeals, including notice as required in section 8727 of this title.

(b) No later than July 1, 1997, the department shall adopt rules that include the following:

(1) Certification standards and procedures for programs for people with developmental disabilities.

(2) Training standards for staff.

(3) Standards for training and supervision of personnel who perform special care procedures.

(c) Any person with a developmental disability or a family of a person with a disability shall be provided with:

(1) Timely information and referral to community and governmental resources.

(2) An opportunity to request services.

(3) Upon request, an assessment of the most appropriate supports and resources for their needs and choices.

(4) Services and funding within the department's available resources in accordance with both the system of care plan and the person's or family's written plan of service.

(d) Any person with a developmental disability or a family who is receiving services on July 1, 1996, shall continue to receive services consistent with their needs and the system of care plan. (Added 1995, No. 174 (Adj. Sess.), § 1.)

VERMONT

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Deadline For Public Comment

Deadline: Oct 28, 2022

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	22P023
Title:	Disability Services-Developmental Services
Type:	Standard
Status:	Proposed
Agency:	Department of Disabilities, Aging and Independent Living; Agency of Human Services
Legal Authority:	18 V.S.A. § 8726
Summary:	The purpose of this rule is to fulfill the requirements of the Developmental Disabilities Act (DD Act), to include specific details for its implementation. The effective date of the last adopted rule was October 1, 2017. Since then, 2022 Acts and Resolves No. 186

	eliminated the requirement in 18 V.S.A. § 8725 that certain categories of the Developmental Services System of Care Plan be adopted by rule. Further, the federal rules relating to Medicaid grievances and appeals have been amended. Finally, the Vermont Supreme Court's decision in In re: R.R., 2019 VT 31, requires that the Standard Error of Measurement (SEM) for IQ tests, including IQ scores of 75 or below, be considered when determining eligibility for services. The proposed language includes IQ scores of 75 or below when accounting for the SEM. Other amendments to the rule include formatting, as well as updates to align with current practice in the administration of the Developmental Services program.
Persons Affected:	Individuals with developmental disabilities, their family members and guardians; Vermont Legal Aid-Disability Law Project; Green Mountain Self-Advocates; advocates representing the interests of people with autism; providers, including Vermont Care Partners, designated agencies, and specialized service agencies; the VT Developmental Disabilities Council; the Developmental Disabilities Services (DDS) State Program Standing Committee; Vermont Family Network; Federation for Children and Families; University of Vermont Center for Disability and Community Inclusion; AHS; and DAIL
Economic Impact:	The proposed changes to the eligibility criteria for people ages six and up have the potential for increasing the number of people who are eligible for DDS, placing increased pressure on the DAIL/DDSD budget to serve additional people. In response to In re: R.R., 2019 VT 31, DDSD has adjusted its threshold for eligibility from an IQ score of 70 to 75 when accounting for the SEM. Since then, an average of one additional person per month has received Home and Community-Based Services (HCBS) based upon this change, for an average annual cost of $472,727 as of February 2022. This increase has already been factored into the budgeting process for DAIL. The Office of Public Guardian (OPG), within DDSD, may experience increased referrals for people in need of guardianship, which, over time, could require additional OPG staff. Finally, access to services may have a positive financial impact on some family caregivers by enabling them to enter the workforce or increase their work hours.

Posting date:	Sep 07,2022

Hearing Information

Information for Hearing # 1

Hearing date:	10-11-2022 10:00 AM ADD TO YOUR CALENDAR
Location:	Virtual Hearing via Zoom
Address:	https://www.zoomgov.com/meeting/register/vJItf-mvpjIuHkQi1R3K44n26EDzvQpJP8Q
City:	online
State:	VT
Zip:	n/a
Hearing Notes:	

Information for Hearing # 2

Hearing date:	10-19-2022 4:00 PM ADD TO YOUR CALENDAR
Location:	Virtual Hearing via Zoom
Address:	https://www.zoomgov.com/meeting/register/vJIscO2rrjooGGcXJNaEeThhmXRcRF6yjEc
City:	online
State:	VT
Zip:	n/a
Hearing Notes:	

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

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Keyword Information

Keywords:

system of care plan
developmental disabilities
developmental services
eligibility
Department of Disabilities, Aging, and Independent Living

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	Herald of Randolph (ads@ourherald.com)	Tel: 728-3232 FAX: 728-9275 Attn: Brandi Comette
	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
	News & Citizen (mike@stowereporter.com) Irene Nuzzo (irene@newsandcitizen.com and ads@stowereporter .com removed from distribution list per Lisa Stearns.	Tel: 888-2212 FAX: 888-2173 Attn: Bryan
	St. Albans Messenger Ben Letourneau (ben.letourneau@samessenger.com)	Tel: 524-9771 ext. 117 FAX: 527-1948 Attn: Ben Letourneau
	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** September 6, 2022
RE: The "Proposed State Rules " ad copy to run on **September 15, 2022**
PAGES INCLUDING THIS COVER MEMO: **2**

***NOTE* 8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

Disability Services-Developmental Services

Vermont Proposed Rule: 22P023

AGENCY: Agency of Human Services, Department of Disabilities, Aging and Independent Living (DAIL)

CONCISE SUMMARY: The purpose of this rule is to fulfill the requirements of the Developmental Disabilities Act (DD Act), to include specific details for its implementation. The effective date of the last adopted rule was October 1, 2017. Since then, 2022 Acts and Resolves No. 186 eliminated the requirement in 18 V.S.A. § 8725 that certain categories of the Developmental Services System of Care Plan be adopted by rule. Further, the federal rules relating to Medicaid grievances and appeals have been amended. Finally, the Vermont Supreme Court's decision in In re: R.R., 2019 VT 31, requires that the Standard Error of Measurement (SEM) for IQ tests, including IQ scores of 75 or below, be considered when determining eligibility for services. The proposed language includes IQ scores of 75 or below when accounting for the SEM. Other amendments to the rule include formatting, as well as updates to align with current practice in the administration of the Developmental Services program.

FOR FURTHER INFORMATION, CONTACT: Clare McFadden Department of Disabilities, Aging and Independent Living / Developmental Disabilities Services Division (DAIL/DDSD), 280 State Drive, Waterbury, VT 05671-2030 Tel: 802-585-5396 Fax: 802-241-0410 Email: clare.mcfadden@vermont.gov URL: https://www.dail.vermont.gov.

FOR COPIES: Stuart Schurr, General Counsel, Department of Disabilities, Aging and Independent Living, 280 State Drive, HC2 South Waterbury, VT 05671-2020 Tel: 802-241-0353 Fax: 802-241-0386 Email: stuart.schurr@vermont.gov.