Department of Disabilities, Aging & Independent Living

Developmental Disabilities Services Division

Legislative Report – SFY 2025

In accordance with:
18 V.S.A. §8725: Developmental Disabilities Services Act

Submitted to:	The House Committee on Human Services The Senate Committee on Health and Welfare
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Introduction

This Legislative Report is a summary of Developmental Disability Services provided to Vermonters with intellectual/developmental disabilities (IDD) in Fiscal Year 2025. These data represent compliance with the Developmental Disabilities Services Act, 18 V.S.A. § 8725, which states:

...the Department [of Disability, Aging and Independent Living] shall report to the Governor and the committees of jurisdiction regarding implementation of the [State System of Care] plan, the extent to which the principles of service … are achieved, and whether people with a developmental disability have any unmet service needs, including the number of people on waiting lists for developmental services.

The following report summarizes the met and unmet needs of Vermonters with IDD, consistent with the Principles of Service.

Principles of Service
Services provided to people with developmental disabilities and their families shall foster and adhere to principles that ensure that these Vermonters have equitable access to high quality of life. Those twelve principles are as follows:

1. Children's Services
Children with disabilities thrive in nurturing homes and lasting family relationships.

2. Independent Adulthood
Adults with disabilities will make decisions.

3. Informed Decisions
People and families need clear, complete information to make informed choices.

4. Individualized Supports
Services must reflect each person's unique needs, goals, and abilities.

5. Family-Centered Support
Supports should respect families' strengths, cultures, and expertise.

6. Meaningful Choice
People must have real options and be involved in decisions about their lives.

7. Community Inclusion
Communities are stronger when people with disabilities participate fully.

8. Employment First
The goal of supports is paid work in regular employment settings.

9. Local Access
Services should be available where people live, without forcing relocation.

10. Health & Safety
Protecting health and safety is essential.

11. Qualified Staff
Well-trained staff are critical to quality services.

12. Fiscal Integrity
Strong services require careful management and sustainable funding.

Federal Medicaid Compliance

DAIL is committed to providing high quality, cost-effective services to support Vermonters with developmental disabilities within the funding available, and to obtain value for every dollar appropriated by the Legislature. To do this, DAIL must balance the most person-centered, therapeutically appropriate, and cost-effective models with maximizing federal funds to capitalize on resources available. Home and Community Based Services (HCBS) accounts for 97% of all DDS appropriated funding. This means Vermont's DDS system leverages a notably high proportion of federal funds.

Guidance regarding the utilization of funding is provided through regulations, policies, and guidelines including:

Regulations Implementing the Developmental Disabilities Act of 1996

Vermont State System of Care Plan for Developmental Disabilities Services

Medicaid Manual for Developmental Disabilities Services

DDD Encounter Data Submission Guidance for Home and Community-Based Services

Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services Settings Rule

To maintain Vermont's Federal Medicaid Assistance Percentage (FMAP), which was 58.19% for Federal Fiscal Year 2025[1], the Department's Medicaid programs must be compliant with Centers for Medicare and Medicaid Services (CMS) regulations. Failure to meet CMS requirements would jeopardize more than 50% of the $325+ million used to support individualized services for Vermonters with Developmental Disabilities. To ensure compliance, the Department, with support from the Agency of Human Services, has undertaken significant system changes in the areas of payment model reform, conflict of interest mitigation, and direct care workforce training.

Conflict of Interest Mitigation

Under the prior Developmental Services Home- and Community-Based Services (DS HCBS) system, the Designated Agency (DA) performed initial intake, eligibility determination and options-counseling. For those individuals who are eligible for Home- and Community-Based Services, the DA then performed a Needs Assessment and developed a funding proposal. DAs also developed person-centered plans (Individual Support Agreements) and then provided the needed direct services. When an individual chose a Specialized Service Agency (SSA) or to self/family manage their services, the SSA or the independent Qualified Developmental Disabilities Professional assisted with the person-centered planning development, and the SSA provided the services.

[1] For every $1.00 of Medicaid program funding spent, $0.5819 is the federal share and $0.4181 is Vermont's share.

Under this approach, there were concerns about inherent conflicts of interest given that those providing services are also those selecting services and determining need/eligibility. By separating the entities responsible for intake, eligibility and referral, case management, and Needs Assessment administration from the entity providing paid services, these potential conflicts can be avoided. Separating the responsibility of case management from service delivery: increases choice, improves person-centered focus, establishes consistent processes and transparency within the system, and complies with federal requirements. These concerns were reflected in CMS requirements for conflict-free case management.

Federal requirements from CMS regarding conflict-free case management were finalized in 2014. Vermont's initial remediation plan was rejected by CMS. Vermont's current plan was approved by CMS in March 2023 and has a timeline for implementation of October 2025, with additional time (through May 2026) to allow for evaluation and adjustment as needed. At the end of FY25, transition meetings were beginning to move case management from being provided by DA/SSAs to Vermont's two new Case Management Organizations (CMOs): Benchmark Human Services and The Columbus Organization.

Intake, Eligibility, and Referral Changes

Vermont's Implementation Plan includes engaging with an independent entity to perform intake, eligibility, and referral; using an independently administered, validated Needs Assessment (the Supports Intensity Scale – Adult [SIS-A]); and contracting with external Case Management Organizations. With this shift to a standardized assessment, existing DA/SSAs continue to provide direct Home-and-Community-Based Services support to individuals based upon the SIS-A results. By separating out these roles, the conflict-of-interest in intake, eligibility and referral is mitigated and Vermont comes into compliance with CMS' conflict-of-interest requirements.

The SIS-A is the State's adopted needs assessment tool for everyone with IDD and a complete re-evaluation is required at a minimum of every three years or if a significant change in need occurs. In this model, case managers will administer a tool at least once a year to assess if there has been a change in need that may require a new assessment. SIS-A assessments indicate a level of support which corresponds to a budget range that is also based on the setting the person lives in (group residence, staffed living, unpaid caregiver, shared living provider, or own home). From initial rollout in September, 2022 to now, DDSD has seen 3,732 completed assessments. The SIS-A is now fully implemented and will remain the needs assessment tool for Vermonters with IDD. This assessment will continue to be administered by a third-party contractor (Public Consulting Group) to ensure no conflicts of interest to case management or service delivery.

Payment Reform

As Vermont works through this evolution of Developmental Disabilities Services to address conflicts of interest, a redesign of our payment system is also underway. The payment reform model balances flexibility with increased transparency. This model includes encounter data (service records) of each service provided, as well as an annual reconciliation of services delivered against authorized services. This payment approach increases clarity around what services

agencies are providing and offers newly available data on the individual, regional, and statewide level to allow increased quality improvement and planning.

The conflict-of-interest and payment reform projects align with the ***Developmental Disabilities Services Division Purpose and Core Values.*** Most notably, these initiatives support the Department's principles of person-centeredness, effectiveness, efficiency, and creativity. This work also preserves Vermont's compliance with CMS requirements, which ensures Vermont's continued ability to access available federal dollars that maximize the reach of Home-and-Community-Based Services that serve Vermonters.

The Department will provide a full report to the Legislature on the new payment model on February 15, 2026.

Key FY25 Areas of Work

Implementation of a Client Record Management Solution

During FY25, DDSD implemented a new client record management (CRM) solution built on the Salesforce platform. The CRM is designed to manage information essential to eligibility determination, needs assessment, and service planning, and serves an electronic "filing cabinet" to securely store and organize all supporting documentation.

The DDSD CRM provides shared, role-appropriate access for Service Providers, Case Managers, and DDSD staff, enabling teams to work from a common source of information to more efficiently and effectively support Vermonters. This modernization supports higher-quality, person-centered services by improving coordination among those who support Vermonters and ensuring decisions are informed by accurate, complete information, while maintaining accountability to policymakers and federal partners. This is an initial phase to the establishment of a more sophisticated database to effectively manage services within the Developmental Disabilities Services system.

Direct Care Workforce Development

In early FY24, Vermont took advantage of an opportunity made available through the Administration for Community Living (ACL). The ***Direct Caregiver Workforce Strategies Center State Peer Learning Collaborative*** offered Vermont technical assistance to develop a strategic workforce roadmap and identify our top three priorities related to this work. The Peer Learning Collaborative afforded Vermont's team access to 13 other states working on similar activities and the support of a nationally renowned expert. During this Peer Learning year, Vermont developed an inventory framework to identify and organize workforce development needs, which included three key focus areas: Integration and Partnership, Marketing and Recruitment, and Data. Vermont's Workforce Advancement Team now consists of representatives from the Adult Services Division, the Developmental Disabilities Services Division, the Agency of Human Services Office of Health Care Reform, and the Vermont Department of Labor.

At the end of FY25, Vermont's interagency Workforce Advancement Team started our second year working with ACL, this time as a part of the "State Advancement Lab." With continued access to peer states engaging in similar goals and a technical assistance group, Vermont has made significant progress towards our primary goal of strengthening and streamlining the Direct Care Workforce's professional development and learning infrastructure. This goal includes a key milestone of developing a task force of diverse stakeholders ranging from workers to educators to policy-makers. This work has continued into FY26 and is providing key data and action items to help Vermont standardize our care training program. Vermont is one of seven US states that does not have consistent training for Direct Care Workers, which puts us at a disadvantage to the 31 states that have fully standardized training and 12 states that have partially-standardized training.[2] Vermont's Workforce Advancement Team will produce a training standardization plan in FY26 that will propel our state's capacity to attract and maintain a quality Direct Care Workforce.

This work is especially important to address DDS' higher turnover rates. For FY25, the turnover rate for staff working in DDS was 32%,[3] with part-time workers demonstrating approximately half the turnover rate as full-time workers (27% and 52%, respectively).[4] While there have been fluctuations in this turnover rate in the past 10 years, the overall trend marks a steady state with an average turnover of 30%.[5]

Supported Employment

Vermont has a long-standing history as a leader in integrated, competitive employment for individuals with IDD. Also known as "Supportive Employment", Vermont began offering integrated, community-based employment opportunities for individuals receiving employment support in 1980. Prior to 1980, all supported employment opportunities were provided in "sheltered workshops." Vermont was the first state to close all segregated programs – the last one in 2002. As of SFY 2025, Section 14(c) of the Federal Fair Standard Labor Act of 1938 remains in place – which allows employers in the United States to request certification to pay individuals with disabilities less than federal minimum wage. The wage is set as a "commensurate" wage of the individual's capacity to perform the job, relative to a non-disabled colleague – a rate often below half of minimum wage and sometimes less than $1/hour.

In Vermont, employees with disabilities are paid prevailing wages in their supported, integrated employment, equal to their non-disabled co-workers. Vermont has secured gainful and competitive employment for all Vermonters by repealing statutory authority provisions in 21 V.S.A. § 385. Previously, the VT Commissioner of Labor could recommend a "suitable scale of rates" below minimum wage for those with disabilities. Act 40 (S. 117) of 2025 (signed into law in May, 2025) has ended this practice, ensuring that no employer will have the right to pay Vermonters with IDD less than the minimum wage they are expected to pay all employees.

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[2]PHI National: https://www.phinational.org/advocacy/personal-care-aide-training-requirements/

[3] This rate is inclusive of the over 80 staff who moved with their position from agencies to the new Case Management Entities: Benchmark and Columbus.

[4] Data collected from Vermont Care Partners'

[5] Across reported turnover data from 2016 – 2025, from NCI and VCP.

Vermonters with IDD who are employed earn at or above the minimum wage for all Vermonters. In 2022, Vermont was ranked #1 in the nation for number of people with developmental disabilities who receive supported employment to work per capita. National data shows that only 17% of working-age Americans with IDD are employed,[6] whereas 31% of working-age Vermonters with IDD who receive state services are employed through the supported employment model.

Family Support & Reimbursement

Vermont values the natural support that families provide to their family members with IDD. Vermont families comprise a significant amount of support within the IDD system, with 46% of individuals receiving HCBS living in their family home in FY25. Vermont has consistently ranked highest in New England in percentage of the IDD budget used to support individuals who reside with their family and has continually exceeded the national average.

Support provided by family members has been hallmark of our successful provision of services which is emphasized as family members adjust their employment, leave the workforce, and make difficult individual and professional decisions to safeguard their loved ones. The direct caregiver workforce has shifted in recent years, resulting in unprecedented challenges in meeting the support needs of individuals, with staffing shortages reducing available support.

In response to this need, the Developmental Disabilities Services Division developed a policy based on the approval of the Centers for Medicare and Medicaid through Vermont's Global Commitment to Health Agreement to allow ***Legally Responsible Individuals*** (parents, guardians, & spouses) to be paid for the some of the support they provide. Operationalization and implementation of this policy occurred in November, 2024.

In the eight months of this program being live in FY25, 81 Legally Responsible Individuals have been approved to be compensated for their support hours. Reimbursement of those who are already working to support Vermonters with IDD reflects respect and awareness of the direct care work. It serves to make this care model more feasible and long-standing. For individuals who needed to leave their jobs or change their housing to provide this support, payment for their hours spent providing care can ensure that they are more able to continue this level of support.

This system also helps Vermont to address the DDS staff vacancy rate of 19%, meaning approximately 1 in 5 positions to support Vermonters with IDD is not filled[7] across 14 reporting agencies. Compensation of Legally Responsible Individuals will ensure that the roles that those caring for loved ones remain filled and our care system is able to provide for all Vermonters with IDD.

[6] National Core Indicators, 2024. https://idd.nationalcoreindicators.org/wp-content/uploads/2025/07/NCI-IDD-IPS-2023-24-At-a-Glance.pdf

[7] Data from Vermont Care Partners

Appendix – Data Brief

The following Appendix provides data and statistics on: Flexible Family Funding, Residential Settings, Employment Rates, Waiting List, and Level-Based Data. The data shown in this appendix highlights the impact of services and, in particular, the extent to which the Principles of Service from the Developmental Disabilities Act is being met by the Developmental Disabilities Services system.

All data in this report is for FY25 unless otherwise noted. Please note that national datasets have a substantial gap between date of data collected and date of data publication, meaning that the most recent national reports have a two-to-four-year delay between collection and dissemination.

Key Data

4,731 – Total (unduplicated) Number of Vermonters (all ages) Served by DDSD

- **3,374** – Home- and Community-Based Services
- **863** – Flexible Family Funding
- **467** - Bridge
- **323** – Targeted Case Management
- **274** – Family-Managed Respite
- **36** – Pre-Admission Screening and Resident Review

$325,128,980 – Total HCBS Caseload Appropriated Funds

$83,483 – Average Appropriated Cost of HCBS funding per person

55% of new funding allocation was for new recipients, compared to 45% funding increases for existing caseload

Highlighted Funding Stream: Flexible Family Funding

Flexible Family Funding is an income-based discretionary support for those who are not receiving Home- and Community-Based Services but require support to allow themselves or their loved one to pay for things that meet their needs. This funding is requested due to needs for: respite, assistive technology, individual needs, household needs, and recreation. Data is collected on the outcomes that this funding supports. The maximum allocation per person is $1,000 per person per year.

For the **863** individuals who received Flexible Family Funding in FY25, 634 recipients were children (under 18 years old), 126 were transition-age adolescents (18-21) and 105 were adults (22 and older).

The $827k awarded Flexible Family Funding dollars[8] allowed…

539 Vermonters to improve the stability of their family unit.

472 Vermonters to improve their quality of life.

412 Vermonters to increase their independence in daily living.

367 Vermonters to maintain stable housing.

334 Vermonters to address their health and safety needs.

300 Vermonters to increase their ability to communicate.

66 Vermonters to avoid needing a crisis placement.

[8] The total cost to run this program includes the administrative cost for agencies and totals $1.25 million

Housing: Where do Vermonters with IDD live?

95% of Vermonters with IDD lived in homes of 1-2 people in FY25.

24% (497) of Vermonters with IDD own or rent their own home. Nationally, only 15% of adults in IDD services rent or own their home.[7]

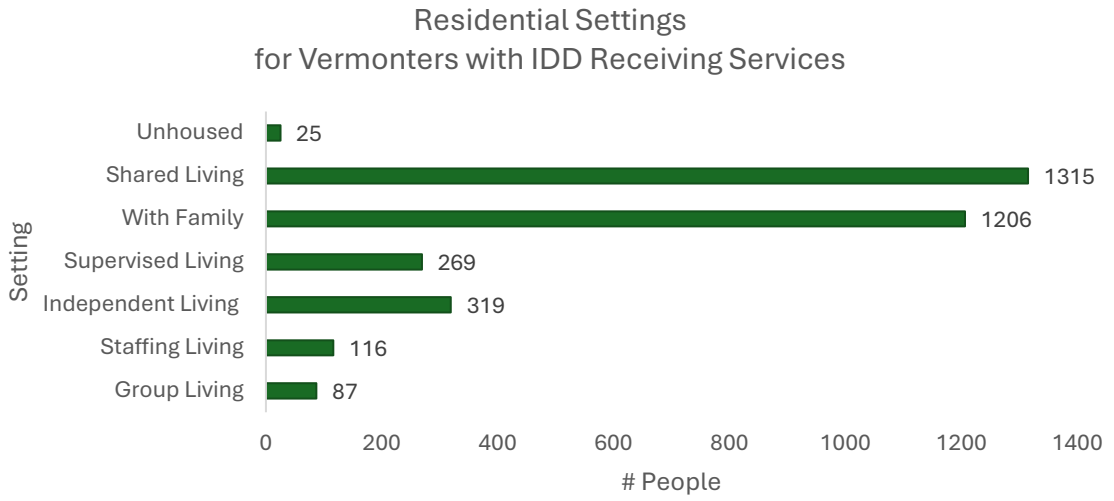
The average number of people per home support setting in FY25 was **1.16**. This is compared to the latest national average of 2.3 people per home.

75% of people receiving home supports are housed in a "Shared Living" model. Shared Living is funded through tax exempt stipends and is a more cost-effective option than the other home support options that are funded hourly. Nationally, **5%** of people receiving supports utilize this model.[7]

5% of Vermonters with IDD live in group homes, compared to a national average of 36%[9]. Vermont's 5% includes independent communities, which are notably different from traditional group homes in the structure of the housing agreement.

25 Vermonters with IDD receiving HCBS services were unhoused. Application of the Housing Need Factor multiplier created by the Corporation for Supportive Housing indicates that there could be up to **620** additional Vermonters with IDD whose housing is considered vulnerable.[10]

65% of supported parents with IDD received support to parent their child in their home.



[9]National Core Indicators, 2024. https://idd.nationalcoreindicators.org/wp-content/uploads/2025/07/NCI-IDD-IPS-2023-24-At-a-Glance.pdf

[10] Corporation for Supportive Housing (CSH) Factor previously utilized in California for housing estimate

Employment: How are Vermonters with IDD supported in their employment?

29.5% of disabled Vermonters (all disabilities) are employed

1,099 - Vermonters with IDD employed in a supported model

75 - under 22 years old

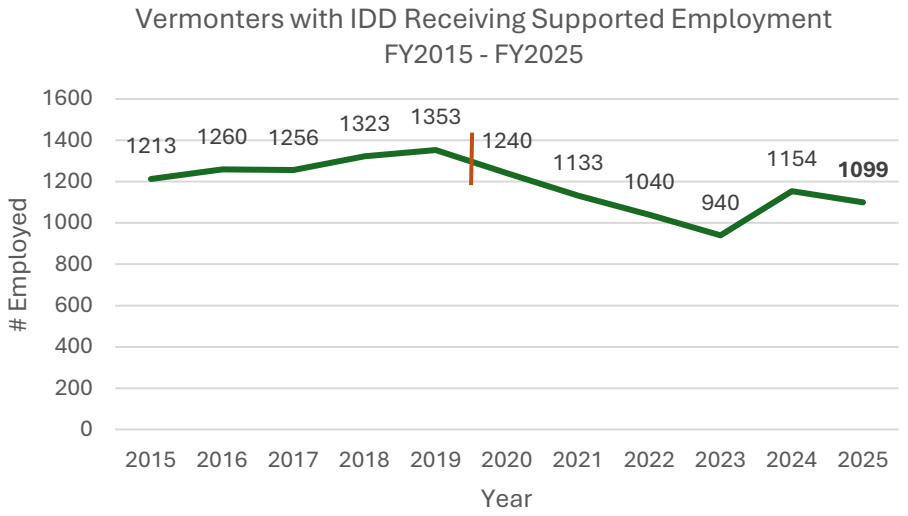
599 - between 22 - 35 years old

305 - between 36 - 50 years old

120 – over 50 years old

31% - Employment rate among Vermonters with IDD Receiving Services (between 16-64)

By comparison, the national employment rate among those with IDD is **17%**, which is approximately half of the VT rate**.**[11] Data from a recent national survey indicates that 42% of adults with IDD receiving services who are not employed expressed desire to be employed.[8] FY26 changes to the DDSD payment model will allow employment supports to start prior to job placement, removing a key access barrier and supporting higher employment participation among individuals who want to work.



The break line in the above chart represents the onset of the COVID-19 pandemic. The employment rate declined in the four years during and after this onset and is trending now towards recovery from this impact.

[11] National Core Indicators, 2024. https://idd.nationalcoreindicators.org/wp-content/uploads/2025/07/NCI-IDD-IPS-2023-24-At-a-Glance.pdf

Waiting List

There were no individuals who were waiting for Home and Community-Based Services (HCBS) at any point during the year who met a HCBS Funding Priority. The following chart shows the number of people who applied for services who did not meet a funding priority and were waiting for services in FY25. The data is broken out by type of support requested, in order of demand.

0 – Individuals waiting for services who **met a funding priority**
371 – Individuals waiting for services who **did not meet a funding priority**

Service Requested	Number
Service Coordination	248
Family Respite	189
Community Supports	113
Clinical services	69
Supportive Services	36
In-Home Family Support	32
Individual Crisis Services	16
Employment Services	8
Supervised Living	8
Vehicle Modification or Mileage	5
Shared Living	4
Home Modification or Remote Support	4
Shared Living Respite	2
Group Living	1
Staffed Living	0

Nationally, 88% of providers are experiencing staffing shortages, which has resulted in 62% of US providers turning away new referrals.[12] Vermont has lower ratios of those waiting for services compared to national averages, with fewer than 1 Vermonter waiting for every 10 Vermonter's receiving services, compared to a 1:5 ratio nationally.

An average of 21% of those with IDD are either currently served by their state agencies or waiting to receive services in the United States.[13] Applying this national statistic to Vermont's population (where 371 Vermonters are waiting for service and 4,731 Vermonters are receiving services) estimates that there are 19,193 Vermonters with IDD (age 16-64) who have not requested or received state agency services.

[12] The State of America's Direct Support Workforce Crisis 2025 - https://www.ancor.org/wp-content/uploads/2025/10/The-State-of-Americas-Direct-Support-Workforce-Crisis-2025.pdf
[13] Residential Information Systems Project (2022). Minneapolis: University of Minnesota, RISP, Research and Training Center on Community Living, Institute on Community Integration.

Visualization of Data by Support Level

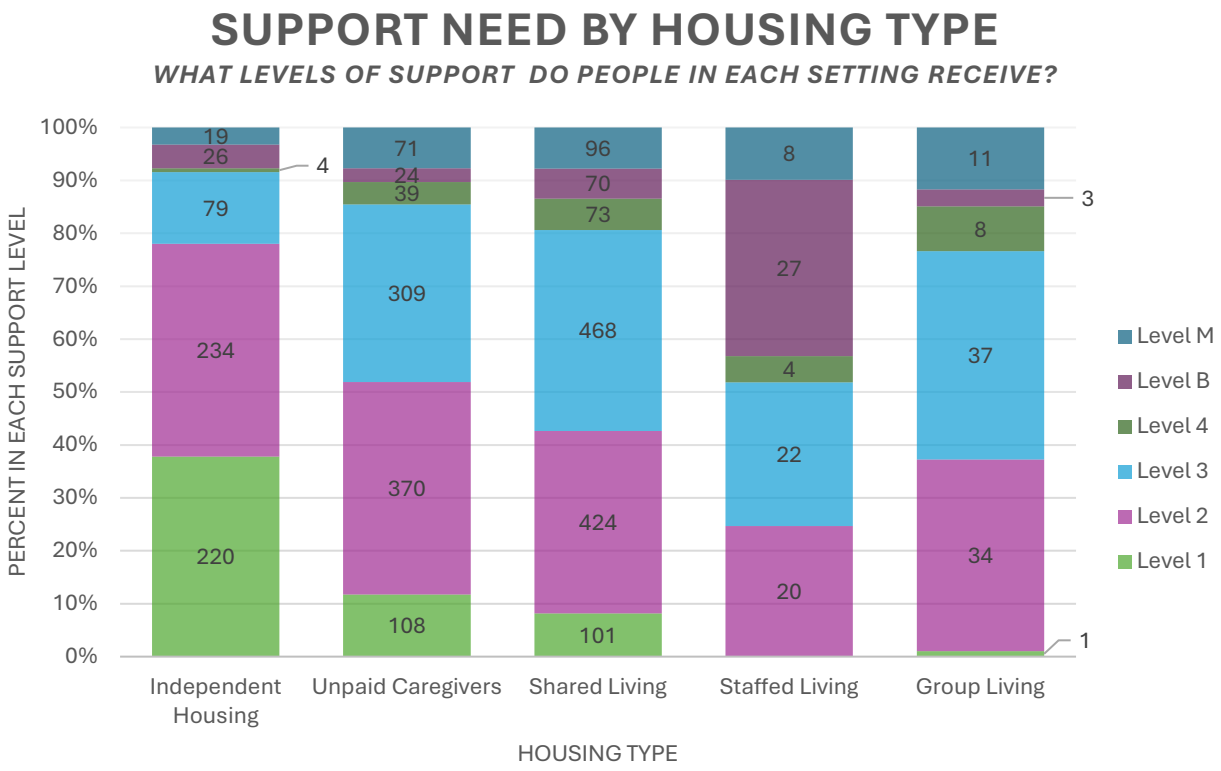
This section presents data grouped by support need level, as determined by the Supports Intensity Scale–Adult (SIS-A), Vermont's standardized assessment used to identify the intensity of support needs for adults with intellectual and developmental disabilities. As a part of FY24's defined need for data to be visualized by level of support, producing data in this increased granularity in this FY25 report is aimed at allowing data to be aligned with how services are delivered in practice. Individuals with higher support needs often rely on more intensive, specialized, or continuous supports, while those with lower support needs may require fewer or more intermittent services. Aggregating data by support need level can provide a more detailed picture of where resources are most heavily used, where gaps may exist, and how changes in policy or funding are likely to affect Vermonters differently depending on their level of need. This approach supports informed decision-making across the continuum of need.

Early datasets that have been delineated by support need level and can be reported for FY25 include: Residential Setting, Guardianship, Employment Support, and Community Support[14]. As Vermont's data systems modernize, the number of queryable data elements will increase.

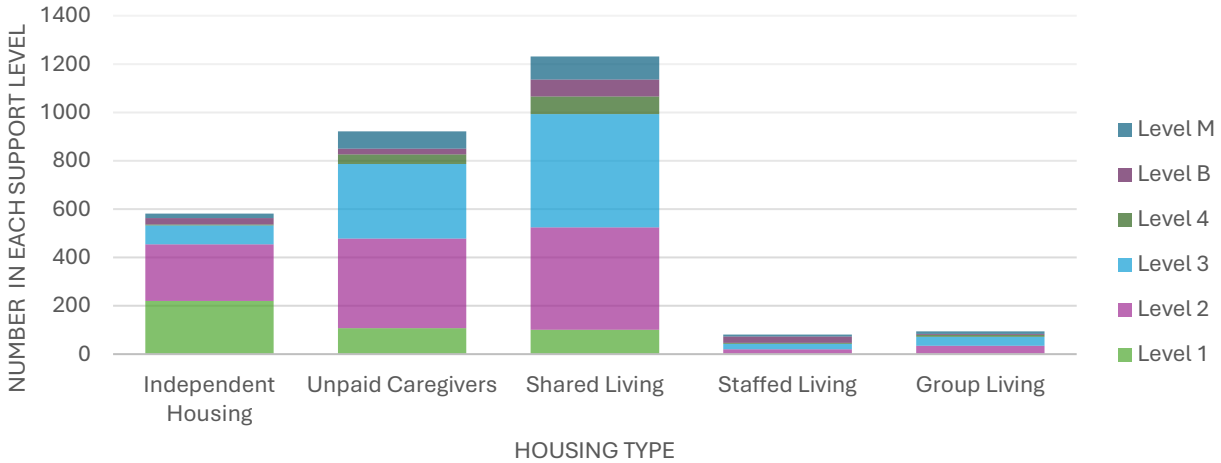
Validation of the SIS-A included creation of ***6 support levels***. There are four levels that represent low to high general support needs: 1 - low, 2 – moderate, 3 – high, and 4 – very high. These four levels are determined based upon the Support Needs Index calculated from the assessment. Two additional levels are for those who have extraordinary medical or behavioral support needs: M – extraordinary medical support needs and B – extraordinary behavioral support needs. These two levels are determined by review processes internal to the DDSD team for those whose medical and behavioral scores flag for further evaluation. It is important to note that these levels are "ordinal" which means that the difference between support needs in Level 1 and Level 2 does not necessarily equal the same difference between support needs in Level 3 and Level 4.

The following sets of data represent ***two ways of visualizing data***. The first is by service utilization, which answers the question "Who is using/receiving each type of support?" The second is by population, which answers the question, "What supports do people in X level use/receive?" Each answer targets a vital but disparate question regarding both who DDSD serves and how DDSD's services are utilized.

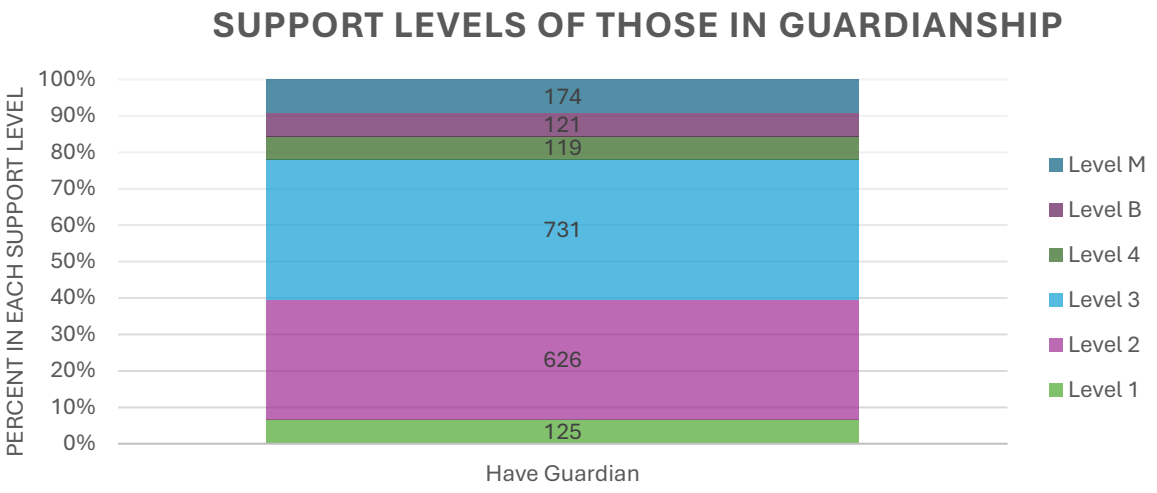
[14] Note: These data were pulled prior to all SIS-A Levels being assigned, as many individuals required verification for their assignment level. This means totals within each category may not match other data. However, data is sufficient for trend visualization and will continue to be iteratively updated.

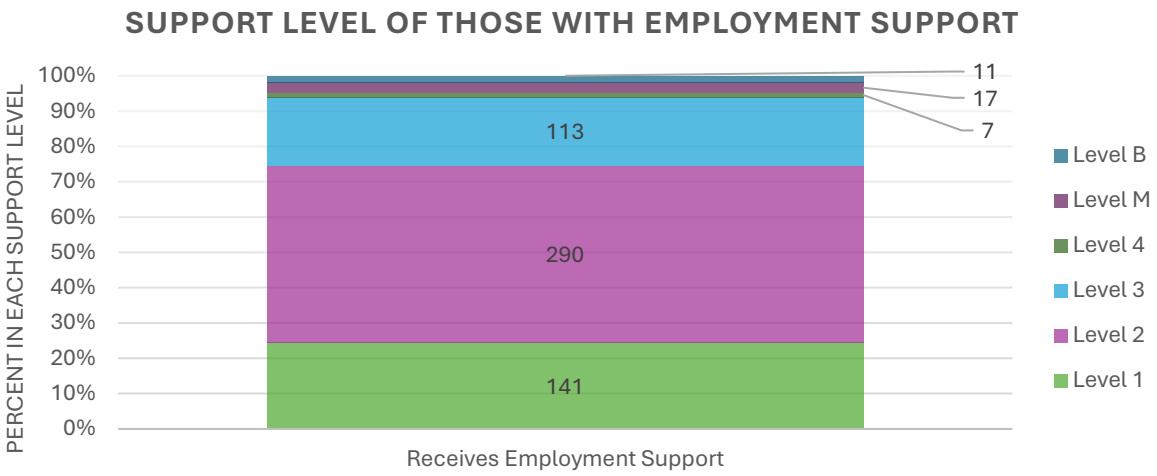


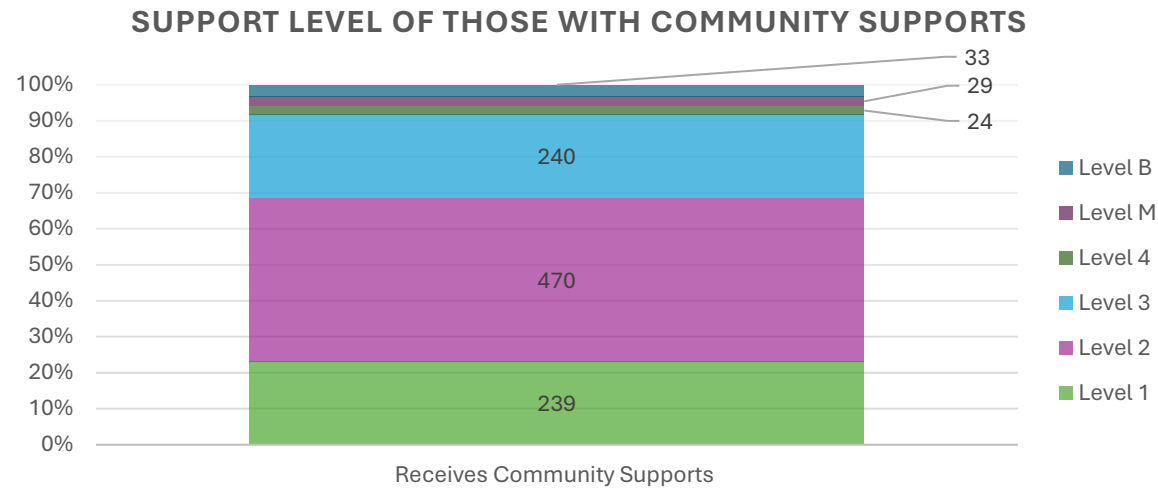
The above graph demonstrates the percentage of each residential setting that is occupied by those receiving each level of support (SIS-A Levels 1-4, M & B). The totals amongst each setting are not equal (e.g., 582 in Independent Housing vs 1,232 in Shared Living) and each bar demonstrates 100% of housing utilization, regardless of total. When these data bars are sized proportional to the population in each setting, the following graph shows how to conceptualize these percentages. (Data labels have been removed given size constraints and is meant as visualization only)

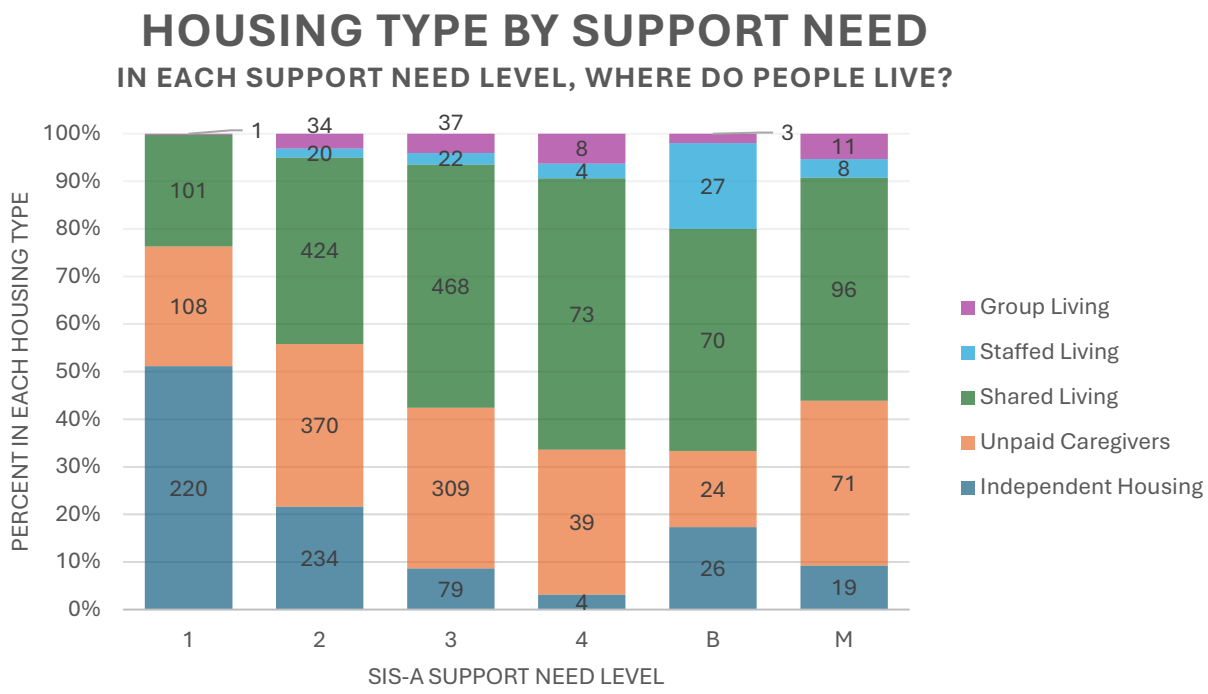


Support Level of those with Guardianship, Employment, & Community Support Services

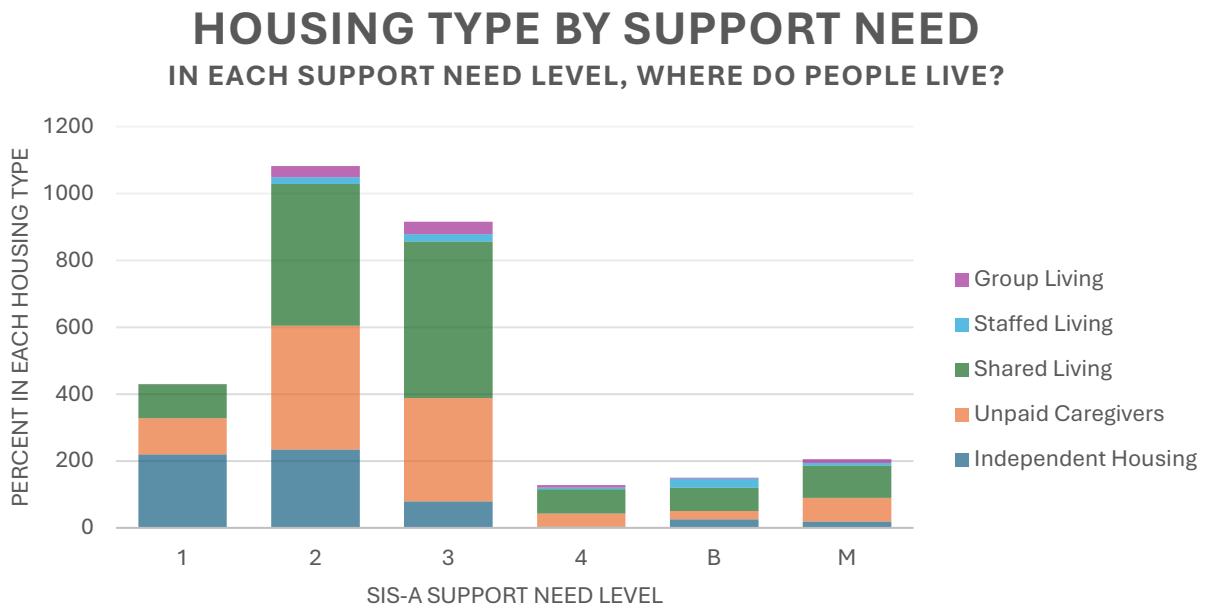








The above graph demonstrates the percentage of each support level that occupies each residential setting. Note that this presentation shows stacked bars that represent the total of those in each SIS-A level. As above, the totals amongst each level are not equal (e.g., 433 in Level 1 vs 1,101 in Level 2). When these data bars are scaled to the total people assigned to each support need level, the following graph shows how to conceptualize these percentages. (Data labels have been removed given size constraints and is meant as visualization only)



Guardianship, Employment, & Community Support Services by Support Level