

*Department of Disabilities, Aging and Independent Living
 Regulations Implementing the Developmental Disabilities Act of 1996: 2017 Revision
 Public Comments and Department Responses
 March 2, 2017*

Below is a summary of the comments received and the Department’s response to those comments.

A. Public Comments and Department Responses

#	Public Comment Received	Department Response
	General Comments	
1	<p>A parent indicated that more support is needed for families who have their children living at home with them. No support was provided when her child lived at home and then the care that her adult son received in a series of 5 shared living providers (SLP) was not of the best quality. People are isolated in stranger’s homes. The SLP sees her son as money and not valued as a person. The recommendation was to allow parents to be paid to provide care. The parent indicated that she was unable to keep working when having her son live at home.</p>	<p>No change recommended.</p> <p>The Department has previously considered changing its rules related to paying parents/guardian to care for their children. The Department researched how a policy allowing parents to be paid is implemented in other states and solicited stakeholder feedback on this issue. The Department heard support from some families interested in this option. We also heard input from adults with developmental disabilities (DD) and from self-advocacy groups that this option could limit choice and independence for adults with DD who wish to live separately from their families/guardians. This is a very complex topic with a variety of conflict of interest issues. At this point, the Department has decided not to pursue this option.</p>
2	<p>A parent expressed concern that the regulations are not sufficient to ensure that the system of services is seamless and responsive enough to meet the needs of her son. The range of options from community to crisis to institutional based services need to be readily available to ensure people get the care they need when they need it. The process of accessing crisis services should not be traumatizing to individuals and their families. The mental health system should build more on the ground alliances with community members, police, medical staff, each other. Agency staff should be well trained, supported</p>	<p>No change recommended.</p> <p>This comment is too general for a specific response.</p>

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	and given a livable pay rate to ensure that quality care is available.	
3	A handful of parents indicated that they received notification of the proposed rules just prior to the deadline for the comment period. They said this did not allow them sufficient time to review and comment. Several requested that the comment period be extended to allow people affected by the proposed changes an opportunity to provide input.	<p>The Department followed Vermont Statutes regarding posting information related to proposed changes to regulations. The Secretary of State’s Office posted the proposed rules and times for public hearings/public comment in newspapers of record on November 17, 2016. In addition, this information was posted on the DAIL website on November 8, 2016. DAIL also sent the information on November 8, 2016, to Developmental Disabilities Services Agency Directors, Designated Agency Executive Directors, the DDS State Program Standing Committee, Vermont Family Network, Green Mountain Self-Advocates, DAIL Advisory Board, Brain Injury Association of Vermont, Vermont Coalition of Disability Rights, VT DD Council, and Vermont Center for Independent Living. The Department does not have names and addresses of family members of people receiving DD services. Rather, the Department relies on the agencies and advocacy organizations that were sent the notification to disseminate the information to interested parties.</p> <p>Based upon the comments received during the public comment period, the Department will be amending the rules and filing them with the Legislative Committee on Administrative Rules (LCAR). The proposed final rule will be posted on DAIL’s website, as well. There will an opportunity for individuals and organizations to attend the public meeting before LCAR on the final proposed rule. The Department will request that agencies and advocacy organizations provide information to</p>

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4	<p>Several people noted that the proposed rules should be presented in a way that is accessible and understandable for consumers and families. They noted that the Federal Home and Community-based Services (HCBS) rules emphasize providing accessible materials.</p>	<p>individuals and families about this opportunity.</p> <p>No change recommended.</p> <p>HCBS rules emphasize providing accessible materials for consumers of HCBS services so they can make informed choices and participate in the development of their individual plans for service. The HCBS rules are not referencing the promulgation of regulations.</p> <p>The public posting of the rule directed people to a knowledgeable Department staff person who could explain the content of the rule. In addition, the Department met three times with a sub-committee of the Division’s State Program Standing Committee to explain the rule and thinking behind the proposed changes.</p>
5	<p>Several people commented that the regulations do not sufficiently incorporate the requirements of the Federal HCBS rules, such as choice, options and conflict-free case-management.</p> <p>“.. the proposed regulations do not address key elements of the Rule. The Rule also stressed that people need to have information and support to direct their own services and make choices among service options.”</p> <p>HCBS rules “say that person needs to lead their ISA process (Plan). How we are going to teach people to do this or how to ensure it will happen. More rigor that people have choice, presented with different options, presented with choice and that choices are honored (follow-up)”.</p>	<p>Prior to drafting the rules, the Department did a crosswalk between the HCBS rules and these regulations and added language to the proposed regulations to support compliance with the HCBS rules. See specific reference to compliance with HCBS proposed rules in 1.10, 1.21, 4.7(g)(2)(E) and 4.7(g)(2)(I)(vii). The HCBS rules are cited by reference rather than repeating the extensive language in the rule.</p> <p>4.11(a)(1) also includes added language emphasizing that people receive information regarding all their choices of management options and providers.</p> <p>9.3(a)(2)(B) adds language to training requirements for staff regarding supporting people to have valued roles in the community and the principles of person-centered thinking. The language in these sections was added to be consistent with the HCBS rules.</p>

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		<p>Provider agencies are subject to the HCBS rules, and the Department will be ensuring compliance with these rules through its Comprehensive Quality Strategy, which was submitted to the Federal Centers for Medicare and Medicaid, as well as through its ongoing Quality Management oversight.</p> <p>In addition, the Department is updating all Developmental Disabilities Services (DDS) guidelines to be consistent with HCBS rules.</p> <p>To further emphasize adherence to the HCBS rules, the Department agrees to strengthen the regulations by adding reference to the rules in several places as follows:</p> <p>In the 1.22, after the last sentence in the definition of home support, the following is added:</p> <p>“Home supports will be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.”</p> <p>This will also address removing 4.7(g)(2)(I)(vii) from the regulations (see response to comment #7).</p> <p>In 4.11(a)(1), the following is added after the second sentence”</p> <p>“The DA shall provide the choices in an unbiased manner to reduce the potential for conflict of interest.”</p>

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		<p>In 4.12(a), the following clause is added to the last sentence:</p> <p>“to support him/her in choosing services and supports and who provides them, determining a personalized decision-making process and/or in making decisions.</p> <p>Because we are recommending removing 4.7(g)(2)(E) from the regulations (see response to comment #7), the following is added to 1.37 after the final sentence:</p> <p>“The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.”</p>
6	<p>The proposed rules still reference the System of Care Plan (SOCP) in multiple locations. However, it is difficult to comment on those sections as the new SOCP is yet to be developed. It is unclear what will remain in the SOCP and its purpose.</p>	<p>No change is recommended.</p> <p>The new SOCP will continue to describe the nature, extent, allocation and timing of services that shall be provided to people with developmental disabilities and their families. It will incorporate those sections that are required by Act 140 to be adopted by rule. In addition, it will contain many of the same sections it currently contains, though the content will be updated. There will continue to be a separate public input process on the portions of the SOCP that are not being adopted by rule.</p>
7	<p>One commenter noted that key issues need to be addressed in regulations rather than in the SOCP. Some areas refer to the SOCP, instead of information being in the regulations.</p> <p>Another noted that significant portions of the SOCP are being moved into regulations and they were concerned that making minor changes would necessitate re-opening the rules. It was</p>	<p>The Department understands that there are different opinions regarding the level of detail that should go into regulation. Based upon feedback, the Department has decided to remove from the regulations the limitations described for each program listed in 4.7. These funding provisions will be included in the Division’s SOCP, Medicaid Manual for Developmental Disabilities Services or program specific</p>

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	<p>recommended that details such as funding rules be in the SOCP.</p> <p>Another commented that putting things into the regulations may help protect services from funding cuts as regulations require more effort to change than the SOCP.</p>	<p>guidelines. The Department concludes that limitations do not fit into any of the four categories that must be adopted by rule (18 V.S.A 8725 (a)):</p> <ol style="list-style-type: none"> 1) Priorities for continuation of existing programs or development of new programs; 2) Criteria for receiving services or funding; 3) Types of services provided and 4) Process for evaluating and assessing the success of programs. <p>Any limitation or rule related to the “nature, extent, allocation and timing of services” will be included in the SOCP as required by the Act.</p> <p>Where there are comments on the substance of a limitation in specific sections, they will be addressed later in this document.</p>
8	<p>One person noted a concern that is there is serious inconsistency in portions of what is proposed and what are our 10 Core Principals we stand by as the Department of Aging and Independent Living. Any proposed changes that limit or impede on our 10 Core Principals should not be recommended.</p>	<p>No change recommended.</p> <p>The Department agrees that proposed changes should not be inconsistent with Principles of Service outlined in the Developmental Disabilities Act. Without a specific reference to how a proposed change limits or impedes the Principles, the Department cannot provide a response.</p>
9	<p>It was noted that the <i>Medicaid Manual</i> is referenced in multiple places in the proposed rules. The current manual is dated July 1, 1995 with some information updated in January 1999. “This manual is out of date and our understanding is that DAAIL is working on updating it. We have not yet been provided a draft for review and feedback; and therefore, for clarity we recommend that all references to the Medicaid Manual state: <i>Division of Mental Retardation Medicaid Manual</i></p>	<p>The Department agrees that agencies can only be held accountable to a current version of the Medicaid Manual for Developmental Disabilities Services. While the documents are old, most of the requirements are still applicable.</p> <p>The Department agrees to add “current” before Medicaid Manual for Developmental Disabilities Services where it appears in the regulations. This</p>

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	<p><i>July 1, 1995 and Division of Developmental Services Medicaid Manual Updated Information –January 1999. We recognize that may necessitate updating these regulations again soon, but our feedback cannot be viewed as complete and accurate without knowledge of what requirements may be included in a Medicaid Manual update.”</i></p>	<p>avoids the need for an update to these regulations when the manual is updated. Providers and other stakeholders will have an opportunity to provide input and feedback on the revision of the Manual.</p>
10	<p>DAIL has included changes in the proposed regulations that we welcome philosophically. DAIL has also acknowledged the underfunding agencies are experiencing trying to meet current expectations. Therefore, we are anxious to learn the amount of new funding that has been requested to fund the expansion of services and cover new administrative requirements such as enhanced training.</p>	<p>No change recommended.</p> <p>The Department reviewed the potential financial impact of the proposed changes to the regulations. It is not anticipated that the changes in regulations will significantly increase the need for additional funding. The Department will continue to work with provider agencies on resources for addressing these important investments.</p>
11	<p>Act 140 required four specific categories to be addressed in regulations. The proposed regulations appear to add to the existing regulations without the necessary in-depth examination of what needed to be shifted from the System of Care Plan and policies to the regulatory scheme. Examples of items left out are the equity committee structure that impacts access to services and funding; regulations pertaining to shared living; training requirements for shared living providers and training/oversight of employees hired by shared living providers.</p>	<p>No change is recommended.</p> <p>The Department conducted a thorough review of the current SOCP to determine which portions needed to be adopted by rule. We believe those portions required by Act 140 were correctly moved, except as noted in the response to comment #7. The section of the SOCP that describes how the Equity funding committee operates is not one of the four areas noted in the Act. There are four references to shared living in the proposed regulations. Agencies are responsible for oversight of these contractors. Training requirements, as well as other DD policies and guidelines, apply to workers hired by shared living providers who are paid with DD funds. More specific policies and guidelines for shared living arrangements are outside the scope of the regulations.</p>
12	<p>One commenter noted that home providers need to be compensated fairly</p>	<p>No change recommended.</p>

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	and receive regular raises. They should also be more included as part of the consumer’s team and the development of consumers plans for support.	We agree that key team members, including shared living providers, should be included and participate in the development of consumer’s plans. Division guidelines address involvement of key team members in plan development. Section 4.12(a) currently references that a recipient may involve anyone they choose to be involved in the development of their service plan. Rates of compensation for home providers are outside the scope of the regulations.
13	One commenter thought he heard the Department say that these regulations will be VT's Transition Plan for the HCBS rules. We think the Transition Plan for the HCBS rules should be separate. We feel that the regulations do not talk about all the HCBS rules. For example, they do not explain how Vermont will do conflict-free case management. The regulations do not address the segregated day programs at some of the agencies. Vermont must keep its commitment to individualized services.	No change recommended. These rules are not the Transition Plan for compliance with HCBS rules for Vermont. Some language has been added to the proposed regulations to support compliance with the new HCBS rules (see response to comment #5), but they are not meant to be a plan. Vermont will be using the document called the Comprehensive Quality Strategy – or CQS – to describe how its system will meet the HCBS rules. The CQS is at the following web address. http://dvha.vermont.gov/global-commitment-to-health/1vt-gc-cqs-september-15-2015-cms-submission.pdf
14	One commenter indicated that proposed changes are at a minimum detrimental, with most extremely harmful to the health and well-being of our state's disabled population. “We also find the changes to be near-sighted cost savings that in the long run will cost Vermont exponentially more in hospitalization, criminal justice and employment for these individuals. But even more egregious is the irreparable harm they will do to their personal and social lives.”	No change recommended. Without a specific reference to how a proposed change impacts recipients and families, the Department cannot provide a response.
	Part 1. Definitions - General Comment	

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15	The proposed regulations do not define specialized services. The only mention of “nonpayroll services and supports” appears to be at Part 5, and the proposed regulations appear to limit choices rather than expand options for innovative non-payroll services and supports like Safety Connections.	<p>PASRR Specialized Services are defined in the PASRR regulations and, as such, are not defined here. The language regarding only submitting allowable expenses for non-payroll goods and services was added to enhance the prevention of abuse, fraud and waste in Medicaid programs. There has been increased emphasis from the Federal government on State’s responsibilities to ensure program integrity.</p> <p>The Department does want to support innovative non-payroll services and supports, such as Safety Connections, that are cost-effective and improve outcomes for recipients. The following is added to section 1.22:</p> <p>“including cost-effective technology that promotes safety and independence in lieu of paid direct support” to end of the third sentence.</p>
	Part 1. Definitions – comments by section	
16	1.1 It was recommended that the following be added to the definition of “Adult”. “People age 18 who attend school are a subcategory of “adult” whose services are provided in conjunction with VT IDEA Rules.”	<p>No change recommended.</p> <p>The Department does not believe this adds clarity to the proposed definition.</p>
17	1.2 The definition of <i>Agency</i> has been changed to read the DA <i>and</i> the SSA. We recommend the language be changed back to say the DA <i>or</i> SSA. As <i>agency</i> is used in the regulations, the tying of DA and SSA makes more than one agency responsible. This will create confusion and likely some management issues.	The Department agrees and changes “and” back to “or” in section 1.2 .
18	1.5 The definition of <i>Authorized Funding Limit (AFL)</i> includes a list of funding. We recommend this definition be simplified to state that it: <i>means all</i>	The suggested change does not provide enough clarity regarding what funds would be available to transfer to another agency. The intent of having an AFL is

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	<p><i>funding related to an individual’s HCBS budget that the person takes with them if they transfer to another agency.</i></p>	<p>so that consumers are aware of what funding is available to them to purchase services from any agency or to self- or share-manage their services.</p> <p>However, given a recent change regarding the amount of administration funding that is available when a person transfers, the Department adds the following language after “administration amount” to 1.5:</p> <p>“available to transfer (as specified in division policy)”.</p>
19	<p>1.8 Several people commented that the definition of <i>Clinical Services</i> in the last sentence that includes “that cannot be accessed through the Medicaid State Plan”, it should be changed to read “<i>that is not available</i> through the Medicaid State Plan”. Services must be available for people with I/DD from providers with the training and expertise to meet the person’s needs, which is not always possible to obtain through the Medicaid State Plan providers.</p> <p>Another commenter suggested the phrase should read “that cannot be accessed through the Medicaid State Plan including services not available due to coverage limitations or because they are not available at the Medicaid rate”. It was noted that coverage limitations in the State Plan can prevent access to needed services.</p>	<p>No change recommended.</p> <p>The Home- and Community-based Services funding mechanism in Medicaid is supposed to be accessed for services only after a determination that they cannot be accessed through State Plan Medicaid. It is expected that agencies explore all sources of funding, including Medicaid, Medicare and private insurance, before utilizing HCBS funding for clinical services. Medicaid has an exception process for getting additional services beyond coverage limitations. This should be exhausted, as well, prior to determining that a service cannot be accessed. Although the Department is not recommending changing the language in the regulations, in practice, the Department will fund needed clinical services when the agency requesting this service indicates it has exhausted all other resources and is unable to access a qualified Medicaid provider. The Department also intends to develop additional guidance on access and use of clinical services.</p> <p>Switching the term to “not available” would not be accurate, as these services</p>

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		are often available but the available providers may not have sufficient expertise to meet a person’s needs.
20	1.11 It was recommended that the definition of “Crisis Services” must include supports needed for individuals experiencing <i>unexpected loss of housing or a significant event</i> . Some clients have needed crisis services because of the unexpected loss of housing, through death of a family member or unexpected termination or resignation of a home provider.	No change recommended. Crisis Services are specifically for when a person is experiencing a psychological, emotional or behavioral crisis. An unexpected loss of housing does not always result in an emotional or behavioral crisis as alternative housing or emergency placements can be arranged. This would be part of housing and home supports, rather than crisis services. If a person is experiencing, or could be expected to experience, an emotional or behavioral crisis due to the loss of housing, crisis services would be available.
21	1.14, 1.40, 1.41 Role, responsibilities, reporting, training, confidentiality, relationships with the Division, need to be clarified and elaborated. This is also a need throughout Part 5, Self/Family-Managed Services.	No change recommended. These sections are references to the definitions of Designated Agency (DA), Specialized Service Agency (SSA) and Supportive Intermediary Service Organization (Supportive ISO). These sections reference the <i>Administrative Rules on Agency Designation for DA/SSAs</i> and the Department’s contract with the Supportive ISO, which outline roles, responsibilities, reporting, training, confidentiality, and relationships with the Division. When there is another regulation or document which specifies requirements, and which may change over time, the Department cites these by reference rather than repeating that content. This is to avoid redundancy and to ensure consistency should one document change. Additional details on requirements of DA/SSAs are also found in their Master Grant Agreements (MGA) with the State. By using the MGA and

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		the Supportive ISO contracts, which are renegotiated and updated annually, it allows more flexibility for making changes as needed in the areas identified. These details are more appropriate for contracts rather than regulations.
22	1.18 It was recommended that <i>and for maintaining employment</i> be added at the end of the first sentence of the definition of <i>Employment Supports</i> .	No change recommended. The second sentence in the definition includes “support to maintain a job”, so it is not necessary to repeat.
23	1.21 In the definition of <i>Home and Community-Based Services</i> , it was recommended that the addition of <i>congregate</i> so the definition reads: “an institutional <i>or congregate</i> setting...”	No change recommended. This would require a definition of “congregate”. Without a specific definition, it could be interpreted to limit some current options such as center-based day programs or other group-based services. The final clause in the definition of HCBS indicates that services must be consistent with HCBS rules which have very specific requirements for service settings to ensure individuals receiving support have choice, control and access to participate in the life of the community, as other citizens do. The HCBS rules offer significant protections to mitigate issues related to settings that have the effect of isolating people receiving services or discouraging integration of individuals from the broader community, or that people without disabilities in the community would associate with the provision of services to persons with disabilities. The addition of the term “congregate” will not add to those protections. State Program Standing Committee agreed in the past year that the HCBS rules would be the method for addressing the quality of group settings. In addition, as noted in the response to comment #5, additional references to

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		compliance with HCBS rules were added to the regulations.
24	<p>1.22 It was recommended that the definition of <i>Home Supports</i> end after home modifications in the third sentence. Home modifications should be available to create accessibility for all disabilities.</p> <p>The types of living situations should not be limited by the list identified in the last sentence, especially since those situations are not defined.</p>	<p>The Department agrees that home modifications should be available to create accessibility for all disabilities. The following phrase is stricken in the third sentence of 1.22 “for an individual with a physical disability” and replaced with “related to an individual’s disability... “(see comment #15 for additional change to this sentence). Specific details about allowable home modifications will be proposed for the SOCP.</p> <p>The Department agrees that the list of home support options can be left out of the regulations and be defined in more detail in the SOCP. This will provide greater flexibility as new options become available. The sentence listing home support options in 1.22 is stricken.</p>
25	<p>1.26 It was recommended that in the definition of <i>Network</i> adding “<i>or arrange</i>” between “to provide” and “developmental disabilities services” to be consistent with State Statutes.</p>	<p>The Department agrees with this recommendation. It is consistent with the <i>Administrative Rules on Agency Designation</i>. As such, “or arrange” will be added to 1.26 as suggested.</p>
26	<p>1.30 There was a question regarding whether this section should be included in the state’s regulations or whether the Qualified Developmental Disabilities Professionals (QDDP) definition is independent of the Department.</p>	<p>No change is recommended.</p> <p>Federal guidelines for HCBS require plans of care to be overseen by a QDDP. Vermont has some qualifications in addition to the Federal definition, so it is important to include this definition in VT regulations as well.</p>
27	<p>1.31 It was requested that DAIL inform DAs of the purpose of the Local System of Care Plans (LSCP) they are being asked to develop and submit to DAIL incorporating needs in their community, since the State System of Care Plan will no longer address how resources are utilized.</p>	<p>No change recommended.</p> <p>See response to comment #6. The information from the LSCPs will be incorporated into the SOCP.</p>

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28	<p>1.33 It was recommended that the definition of Respite Supports be amended to eliminate the provision limiting Respite Supports to individuals who "cannot be left unsupervised." This requirement unreasonably limits the availability of Respite Supports and fails to capture the legitimate need that family caregivers may have for respite regardless of the ability of the family member with a disability to manage their needs independently for limited periods of time.</p>	<p>The definition of respite supports in 1.33 is modified to substitute “cannot be left unsupervised” to “needs the support of another caregiver”.</p>
29	<p>1.36 There was a question regarding how the services defined in Part 1 correlate with the service definitions in the Global Commitment waiver and whether there are implications associated with differences. The concern is whether there would be conflicting definitions.</p>	<p>No change recommended.</p> <p>The Global Commitment waiver includes service descriptions in Attachment E that are worded slightly differently than the definitions proposed for these regulations. The GC waiver prefaces the service descriptions with this statement: “The attachment is for summary purposes only, complete service definitions, approved provider types, applicant rules, prior authorizations, limitations and exclusions can be found in Vermont statute, rule and policy.” The proposed service definitions in the regulations include more details, but are not inconsistent with the descriptions in the GC waiver.</p>
30	<p>1.42 DAIL defines a new service category of <i>Supportive Services</i>. It was recommended that the last sentence be revised after the semicolon to read <i>and other services provided by individuals qualified by training and expertise</i>.</p>	<p>The Department disagrees with this recommendation. The recommended language opens the option too widely as it does not specify the type of service or who determines who is a qualified provider. The proposed language limits the other services not specifically named to those provided by practitioners who are certified or licensed professionals.</p>

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	<p>1.42 The “Supportive services” definition should not be limited only to “medically appropriate” therapeutic services. “Therapeutic” should be added, so that the second sentence reads “<i>therapeutically</i> or medically appropriate services” Services like sexuality training for abuse victims or sex offender training are not necessary “medical” services but are therapeutically necessary and important.</p>	<p>The Department agrees with the recommendation and makes that change as follows: “Therapeutically or” will be added to second sentence before “medically” in 1.42.</p>
31	<p>1.44 It was recommended that the definition of Transportation Services include coverage for <i>transportation to access medical appointments, crisis services, clinical services and respite supports</i>. It was noted that limiting transportation to community and work supports and accessible vehicles arbitrarily limits how people can access a range of other services and their community.</p> <p>1.44 It was recommended that the definition of <i>Transportation Services</i> be changed to read: <i>means acquisition and maintenance of accessible transportation for an individual or reimbursement for mileage for community supports</i>.</p>	<p>The Department disagrees with this recommendation. A line item for transportation in a HCBS budget is limited to accessible transportation and mileage for community supports for several reasons. Reimbursement for transportation to medical appointments, including clinical services, is available through the Medicaid State Plan. Transportation for employment supports and crisis services are included in the cost of those services. The intent of respite is to provide a break for the primary caregiver and, although it may be provided in the community, the primary purpose is not for involvement or participation in the community. Therefore, mileage reimbursement is not offered for this service. There are not sufficient resources available to expand access to additional service categories.</p> <p>The definition of transportation services in 1.44 is replaced as follows: “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 Supports.”</p>

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32	<p>1.46 It was questioned why the definition section includes a definition of a <i>young child</i> and an <i>adult</i> but not a definition of a child? There is a need to clarify the difference between a young child and a child.</p>	<p>No change recommended.</p> <p>The definition of a school aged child is in 2.3 (a). It is included in this section because Part 2 is the only section where this term is used, whereas adult and young child are also used in other Parts.</p>
	<p>Part 2. Criteria for Determining Developmental Disability – general comments</p>	
33	<p>One person commented that there are different eligibility criteria for different people and this is unfair. IQ is considered for determining whether a person is eligible under a diagnosis of intellectual disability (ID), but it is not considered for people with an Autism Spectrum Disorder (ASD). The person suggested that the focus should be on person’s functioning as with Diagnostic and Statistical Manual of Mental Disorders (DSM) and that there should be one standard. It was questioned whether the office of civil rights would find it fair to have two standards.</p>	<p>No change recommended.</p> <p>The Developmental Disabilities Act, 18 V.S.A Chapter 204A, states who is eligible to receive services. It defines people with developmental disabilities as those with ID, ASD or pervasive developmental disorder (PDD), that manifested prior to age 18 and who have deficits in adaptive functioning. These are the regulations implementing the Act. Any change would require a change in statute. Under Medicaid rules, for state plan services, there cannot be different access standards for people based upon disability. However, the state has the authority to expand service options to special populations, including based upon a specific disability. Developmental Disabilities Services are specified in the Vermont’s Global Commitment to Health 1115 Medicaid demonstration as a special population.</p>
34	<p>One commenter asked whether the change in definition from Pervasive Developmental Disorder to Autism Spectrum Disorder changed who is eligible for services.</p>	<p>No change recommended.</p> <p>The definition of ASD is slightly narrower than PDD. The DSM-5 includes criteria that allows for the diagnosis of ASD for those who previously had well-established PDD diagnoses. Also, the proposed regulation will only apply to people newly applying for services. Current recipients previously found</p>

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		eligible under a diagnosis of PDD will continue to maintain their eligibility for services if they continue to display the same symptoms that led to their diagnosis. (See section 2.8.)
	Part 2. Criteria for Determining Developmental Disability – comments by section	
35	<p>2.6(h) It was noted that this is a new section and it has the potential to make Vermont's criteria for determining whether an individual has an intellectual disability more restrictive than the criteria set out in the DSM. The DSM correctly relies more on adaptive functioning than test scores when determining the level of services needed.</p> <p>Another person noted that the definition of developmental disability relies too much on test scores and numerical limits rather than how a person functions in life. The recommendation was to move to looking at how a person is functioning in life as a more person-centered approach to deciding who is eligible.</p>	<p>No change recommended.</p> <p>This section was added to provide clarity that the criteria for eligibility based on an intellectual disability (ID) is as stated in these regulations and not the criteria in the DSM. There was no actual change from the previous version of the regulations.</p> <p>The criteria in the regulations that are being proposed are more specific than the criteria in the DSM. The purpose is to set out clear criteria for making decisions regarding eligibility. For example, DSM indicates that individuals with ID have IQ scores <i>approximately</i> 2 standard deviations below average. DSM also notes that onset is during the developmental period which they note is childhood and adolescence. No age range is specified. Less specific criteria make it difficult to make clear decisions regarding eligibility. Using the DSM criteria has the potential to significantly increase those who could be found eligible for DD services. Similarly, using how a person functions in life rather than test scores or diagnosis would broaden the eligibility criteria beyond what is identified in statute regarding who the Department is responsible to serve.</p> <p>The Department has considered changes to the eligibility criteria and decided not</p>

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		to make changes now as an expansion would require additional resources be appropriated.
36	<p>2.10(g) There were several comments on the last sentence which was added to this Section which required clinicians to clearly articulate the rationale for their diagnosis when previously undiagnosed adults and older children. It was noted to be an unreasonable, impracticable, and possibly unethical requirement for clinicians. “This new requirement is unduly burdensome as it requires clinicians to disparage or second guess their colleagues and/or their own prior diagnosis.” It was also thought to be unnecessarily limiting of services to people diagnosed later in childhood or in adulthood. The recommendation was to strike this language.</p>	<p>The language was added to this section to address situations in which people with a long history of other diagnoses are being diagnosed later in life with ASD to access DD services. People who do not actually have DD but have other diagnoses are often better served in other systems that have the expertise to address their presenting problems. The Department has a responsibility to ensure that people who are served in DD services meet the criteria to receive those services and that funding is used for services for those for whom the Department is legislatively obligated to serve.</p> <p>To address the presenting issue and respond to the comments, the following changes to the proposed regulation were made:</p> <p>Replace language in 2.10 (a) with “Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history.”</p> <p>Replace 2.10 (c) with “Systematic observation with the individual to assess social interaction, social communication and presence of restricted interests and behaviors.</p> <p>Strike 2.10(d).</p> <p>2.10(e) becomes 2.10(d).</p> <p>2.10(f) becomes 2.10(e).</p>

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		<p>2.10(g) becomes 2.10(f) and replace current proposed language with:</p> <p>“Comprehensive clinical diagnostic formulation, in which the clinician weighs all the information from (a-e) above, integrates findings and provides a well-formulated differential diagnosis using the criteria in the current version of the DSM.”</p>
	Part 3. Recipient Criteria	
37	<p>3.1(a) It was recommended that the phrase that individuals must “meet the criteria for financial eligibility” to be a recipient should be stricken. Some recipients “private pay” for services, and those that do have many of the rights of recipients under the DD Act and these regulations.</p>	<p>The Department agrees with the recommendation. The language was changed to be consistent with the definition of “recipient” in Part 1. The proposed new language was replaced in 3.1(a) with “who has been authorized to receive funding or services, or a family that has been approved to receive services or funding or services under criteria specified in these regulations.”</p> <p>Section 4.5(c)(4) and 6 specify responsibilities of people who are required to pay for portions of their service.</p>
	Part 4. Application, Assessment, Funding Authorization, Programs and Funding sources, Notification, Support Planning and Periodic Review	
38	<p>4.3(b) It was recommended that the language be changed to read: <i>An application for a person who has never received services and...</i></p>	<p>The Department agrees that the section as written applies to new applicants, not those who were in DD services prior to placement. The following is added to 4.3(b):</p> <p>“who is new to services,” will be added after “person” in the first sentence.</p> <p>A second sentence is added:</p> <p>“For individuals who were receiving services prior to being in one of these</p>

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		facilities, an application shall be filed at the DA with whom the person was last associated.”
39	4.3(c) It was noted that “DA” was mistakenly left in the first line such that the sentence does not read correctly and should be removed.	The Department agrees this was an error and it was removed from section 4.3(c) . An additional clarification is added to this section: “Applications for children under 18 who are in the custody of their parents should be filed at the DA where a custodial parent lives.”
40	4.4(a) One commenter noted that there are extenuating circumstances that can impact the DA meeting this 5-day requirement. For example, a family applies and then goes on a vacation. It was recommended that the language be changed to read: “Within five...the DA shall <i>make a good faith effort to complete...</i> ”	The Department agrees that at times there are extenuating circumstances which prevent completion of the screening process in 5 days. The Department adds the following language after the first sentence in 4.4(a) : “If there are extenuating circumstances that prevent completion in 5 days, the agency shall document those in the individual’s record.”
41	4.4(a)(4) It was recommended that this section be changed to read: “ <i>Determining whether the person with a developmental disability or the person’s family is in need of immediate implementation of one or more services within 60 days. If the DA determines that the person or family mandates service implementation, the DA has the option of making a temporary decision on the application.</i> ”	No change recommended. Part of the screening process is to determine whether someone is in an immediate crisis requiring services prior to the allowable 45-day period for making a decision and then setting up services. It is expected that agencies respond and provide services in an emergency when there is an immediate threat to health and safety. The suggested language weakens the current language, by suggesting that responding to a crisis is optional.
42	4.4(b)(1) it was recommended the last clause that starts with the word “including” be removed. It is redundant since the regulations define DAs and SSAs as the only certified providers.	The Department agrees with this suggestion and makes that change.

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43	<p>4.4(c) It was recommended that the subjective descriptor “fully” be removed from the newly added last sentence of the clause.</p> <p>4.4(c)/ 4.11 The language here and elsewhere in the regulations that designated agencies must document that they provided recipients with their options is a positive strengthening of the choice of provider rules.</p> <p>Another person noted that families should get documentation from DAs so it is clear what has been discussed.</p>	<p>The Department agrees with this suggestion. This section is amended as follows:</p> <p>The Department agrees with this suggestion. In the first sentence of section 4.4(c) “a fully informed choice of service options is made” and is replaced with:</p> <p>“the applicant is informed of his or her choice of all the service options listed in 4.4(b).</p> <p>In the final sentence, “fully informed of his or her options” is replaced with:</p> <p>“informed of all of these options.”</p>
44	<p>4.5(c)(2) It was recommended that the language in the section be replaced with “This question is answered through a uniform <u>needs</u> assessment <u>and</u> process approved by the Department,…”</p> <p>4.5(c)(3) This clause eliminates the System of Care Plan in favor of these regulations so again raises questions about the role of any System of Care Plan.</p>	<p>The Department agrees with this recommendation and adds “needs” before assessment and “and” after.</p> <p>This change reflects the requirement to adopt certain parts of the SOCP through regulation (see comment #7). The funding priorities for receiving services do fall into one of the categories that must be adopted by rule - criteria for receiving services or funding. The ongoing role of the SOCP is explained above in the response to general comments (see comment #6).</p>
45	<p>4.6 The following comment was made several times. “This Section strikes the requirement that the funding amount authorized shall be equal to the amount needed to pay for the supports requested by the applicant or family that fit within the System of Care Plan funding priorities. This requirement is essential to ensure that there are sufficient funds to</p>	<p>No change recommended.</p> <p>The language that is being stricken is problematic in that it implies that if a need fits within the SOCP funding priorities, that the amount to be authorized would be based on what a family or applicant requested. This is not reflective of current practice in authorizing amounts of service</p>

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	<p>provide the services determined to be services provided under the DD Act. Without this sentence, funds could be cut, but the expectation that services continue will remain.”</p> <p>4.6 One commenter noted that this section indicates that the “procedures for authorizing funding or services” will be in the SOCP. However, since services and priorities are included in these rules, it is not clear what that statement means.</p> <p>The final sentence in this section reflects that the amount of services funded will no longer be tied to what is needed to fund supports the person requires and that fit within the System of Care plan funding priorities, but rather will be based on “the most cost effective method of meeting an individual’s assessed needs.” The commenter agreed that the system needs to continue to be a cost-effective system; however, recommended that language be changed to read: <i>“Services authorized shall be based upon a cost-effective method of meeting...”</i></p> <p>The final clause references that such authorizations will be guided by the System of Care Plan and the Medicaid</p>	<p>or funding. Agencies complete a needs assessment, determine what unmet needs fit within the funding priorities and follow the funding guidelines in the regulations, SOCP and Medicaid Manual for Developmental Disabilities Services. The SOCP states that services should be budgeted at the actual cost to deliver the service or the State set rate on file, whichever is lower.</p> <p>Neither the current nor the proposed language would prevent cuts in services if the legislatively appropriated amount of funds is less than projected needs.</p> <p>The “procedures for authorizing funding or services” is a reference to the procedures for local and state funding committees making recommendations to the Department for final decisions on authorizing funding.</p> <p>The Department does not agree that authorization of funding should be based upon “a” <i>cost-effective method of meeting</i> a person’s needs. It needs to be the most cost-effective alternative. To be clear, the term cost-effective means at the lowest cost that effectively meets the need. This is needed to ensure that there are sufficient funds available to meet the needs of those who meet the criteria to receive services, within funds available to the Department. This is consistent with current practice as described in the current SOCP. Consideration of cost-effectiveness is also a general requirement in Medicaid services.</p> <p>See response to comment #9.</p>

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	<p>Manual for Developmental Disabilities Services Division. As previously stated, the role of this plan is very unclear in the context of the proposed rules and the current Medicaid Manual should be referenced since it is the only currently available manual.</p> <p>One commenter suggested the following replacement language for 4.6. “The funding amount authorized shall fit within, be equal to the amount needed to pay for support needs requested, be approved within the System of Care Plan Funding Priority, and consistent with DDSD guidelines and criteria for the evaluation.”</p>	<p>The Department does not agree with the suggested change in language for the reasons noted above in this response.</p>
46	<p>4.7 The opening paragraph states that additional details and requirements are specified in the <i>Medicaid Manual</i>. It was recommended that the rules reference the manual currently in effect.</p> <p>This section identifies a list of services the Developmental Services Division will fund, criteria to access them and limitations of the services, including funding caps. It was noted that this entails much more detail than is necessary and may eliminate flexibility to meet individual’s needs. Such details would render funding appropriation changes undeliverable until regulations were changed. In addition, the section repeats things that are specified in DAIL Guidelines. It was recommended that the list of services be eliminated. It was also recommended that the funding limitations be eliminated and it was questioned whether the use of such limitations is consistent with mental health parity laws.</p>	<p>See response to comment #9.</p> <p>Act 140 specifies that the following areas must be adopted by rule:</p> <ol style="list-style-type: none"> 1) Priorities for continuation of existing programs or development of new programs; 2) Criteria for receiving services or funding; 3) Types of services provided. <p>The Department believes this requires the listing of programs that are priorities, a brief description of the type of service delivered by the program and eligibility criteria for those programs.</p> <p>As noted in the response to comment #7, the Department agrees to remove the limitation section under each program.</p> <p>The introduction section of 4.7 is replaced with the following:</p>

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		<p>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 SOCP, and additional details, limitations and requirements for each program are included in the System of Care Plan, 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.</p> <p>Funding limitations are moved out of the regulations, but will be included in other documents, including the SOCP. The Department will ensure that any limitations related to clinical services are not inconsistent with the State's mental health parity laws. Funding limitations are a necessary tool for managing resources within available funding. Act 140 provides the authority for the Commissioner to consider funds available to the Department in allocating resources. See 18 V.S.A §8725(b)(2).</p>
47	<p>4.7 Vermont needs to do a more in-depth look at innovative services and options being used nationally and provide room within the regulatory structure for them.</p>	<p>No change recommended.</p> <p>The Department is open to exploring innovations and options in services.</p>

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	<p>4.7 Programs listed should describe type/category of service, not specific program title, e.g. service coordination (including TCM and Bridge Care Coordination)</p> <p>Wherever listed, specific \$ amounts shall include the wording: “for \$ not below ___”</p>	<p>There is an opportunity, whenever the regulations are re-opened, to recommend new options. Some innovations may be feasible without requiring a change in regulations.</p> <p>The Department believes that each program should be listed separately as each has its own eligibility criteria.</p> <p>As noted in response to comment #46, funding limitations will be moved to other documents.</p>
48	<p>4.7(a) One commenter noted that this section references an Early Periodic Screening, Diagnosis and Treatment (EPSDT) service – Bridge Care Coordination. How does listing one EPSDT service in these regulations impact access to other EPSDT services?</p> <p>4.7(a)(1)(C) This Section limits the availability of the Bridge Program to families in areas of the State where there is not an Integrating Family Services (IFS) Program. The Bridge Program is an Early Periodic Screening Diagnosis and Treatment entitlement service and must therefore be available statewide and without waitlists.</p>	<p>EPSDT refers to requirements within the Medicaid State Plan to provide certain services to children under 21 regardless of whether the service is offered to adults through the State Plan. There is a wide variety of services that can be covered under EPSDT by a variety of Medicaid providers or through various departments of AHS. Listing one EPSDT service that is administered by the Department has no impact on access to other EPSDT services to which a child may be entitled.</p> <p>Service coordination for children is available in all regions of the state. It is funded through the Bridge Program through the Department where an IFS program is not operating. The Department of Mental Health (DMH) administers the IFS programs which include case management as a service. Any issue with waitlists in those regions would need to be addressed within DMH’s regulatory structure.</p>

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		<p>For clarity, the final sentence of 4.7(a)(1)(C) is replaced with the following:</p> <p>“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.”</p>
49	<p>4.7(b) It was recommended changing from “<i>This plan covers</i>” to “<i>This plan addresses</i>”.</p> <p>4.7(b)(2) Several commenters recommended that the dollar caps identified in (A) and (B) be removed.</p> <p>4.7(b)(2)(E) It was recommended that “covered” be removed from (E) and replaced with <i>otherwise reimbursed</i>.</p>	<p>The Department agrees to replace the word “covers” with “pays for” for clarity in 4.7(b). The term “covered” at the end of the sentence remains.</p> <p>As noted in the response to comment #7, these limitations will be moved to the SOCP. However, the Department intends to recommend these limits for the new SOCP. The caps need to remain in place as they provide equity and allow the Department to use the limited funds to provide a reasonable amount of assistance to a greater number of individuals.</p> <p>As noted in the response to comment #7, these limitations will be moved to the SOCP. The Department does not agree with that suggestion, but for consistency with 4.7(b), 4.7(b)(2)(E) will be proposed for the SOCP as follows: “The fund shall not pay for services covered by....”</p>
50	<p>4.7(d) Definitions of Family Managed Respite, Respite Supports (1.33), and Children’s Personal Care, need to be updated and included.</p>	<p>No change recommended.</p> <p>It is not clear what is being recommended in this comment. Children’s Personal Care is not a service administered by the Department. It is administered by the Department of Health, so it will not be included in these regulations. Respite is defined, and some recommended changes</p>

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		are being made (see response to comment #28).
51	4.7(d)(1)(C) Several commenters noted that the age limit for Family Managed Respite is currently 22 years. It was recommended that it should remain 22 and not be reduced to age 21.	No change recommended. The Department’s current Family-managed Respite Guidelines indicate that the age limit for Family-managed Respite is up to age 21. This has not changed since the start of this program.
52	4.7(d)(2)(D) Several commenters made the following comment. The maximum amount of Family Managed Respite cannot be delineated in the System of Care Plan. Amount of services are part of what must be included in the regulations. 18 V.S.A. §8724(a)(2).	As noted in the response to comment #7, the Limitations section will be moved to the SOCP rather than being included in regulations. However, the Department will propose that the maximum allocation per year will be \$6,000 plus the employer taxes, as it is currently.
53	4.7(e) Several commenters noted the following. This Section contains new restrictions for Flexible Family Funding that limit funding to services that enhance a family's <i>ability to live together</i> . This is a vague aspiration that should not be a requirement for funding and should be stricken. 4.7(e)(2)(D) It was recommended the cap of \$1,000 in be removed.	The Department agrees that the phrase is vague and is not needed. The phrase “enhance their ability to live together” is stricken and replaced with: “... help pay for any legal good or activity that the family chooses such as respite, assistive technology, home modification, or individual and household needs.” As noted in the response to comment #7, this limitation will be moved to the SOCP. When the SOCP is drafted, the Department will propose keeping the cap the same for the following reason. The amount of funding for this program is limited. The Department has considered increasing this cap, but opted instead to maintain this cap in favor of providing funding to more families. Eliminating the cap would require additional resources or serving fewer families.
54	4.7(f), 4.7(j) and 4.7(l) It was suggested that the descriptions of Global Campus, Post-Secondary Ed and Project Search	As noted in the response to comment #46, the Department believes that Act 140 requires the listing of programs that are

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	<p>programs do not belong in the regulations; the regulations are about <i>services</i>.</p> <p>4.7(f) It was recommended that these programs be listed under a category of service called Life-long Learning, rather than name the programs specifically.</p>	<p>priorities, a brief description of the type of service delivered by the program and eligibility criteria for those programs. Each of these programs provides a unique service, has different eligibility criteria and separate funding streams.</p> <p>However, the Department agrees that specific provider names should be removed from regulations. 4.7(f) is titled, Growth and Lifelong Learning. The program description in the first line, strikes, “The Global Campus program provides...” and replaces it with, “These Department-approved programs provide...”</p> <p>4.7(f)(1)(C) is replaced with “Access is limited to the geographic area where the approved program is provided.”</p> <p>See response to comment #74 for amendment to 4.7(j).</p> <p>4.7(l) is retitled, “Projects for Transition Support”. In the first line in the program description, “Project SEARCH prepares...” is replaced with, “These Department approved projects prepare...”</p> <p>4.7(l) In the second sentence, “this one year program” is replaced with “these projects”.</p>
55	<p>4.7(g) It was noted that this section states that the services listed comprise <u>all</u> services that may be provided to a person and paid for in the daily rate. Does this mean that other needed services could not be provided without a rule change? It does not specify that the daily rate may include administrative costs to provide the services. In addition, all services in the specified list are not identified in the current System of Care Plan or Medicaid</p>	<p>Based upon this feedback the section is revised as follows:</p> <p>“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</p>

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	<p>Manual; however, this section indicates that full definitions are included in the documents. We recommend that the first paragraph be re-written to read: <i>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 who have the most intensive needs. The budgets are based on an all-inclusive daily rate that combines all applicable services and supports provided to the individual in accordance with their needs plus associated administrative expenses. Services and supports may include service coordination, community and/or employment supports, respite, clinical and other supportive services, crisis services, home supports and transportation.</i></p>	<p>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.</p> <p>Abbreviated definitions of these services are included in Part 1. Full definitions are included in the most current <i>State System of Care Plan</i> and the <i>Medicaid Manual for the Developmental Disabilities Services.</i>”</p>
56	<p>4.7(g)(1)(C) One commenter noted that the limitations on services to children under 18 or 19 over the last 10 years have had a negative impact on Vermont families. “I see many families who are burnt out, overwhelmed with their child’s needs and unable to cope without the mandated EPSDT services they are entitled to. I have seen children in Residential Care and DCF custody who should not be, due to the lack of community based services by a DA. I have seen evidence over the years of the fact that unsupported (overburdened, over taxed, tired, exhausted) families do not teach new skills which produces more profoundly disabled adults unnecessarily.” Schools and families cannot meet all the needs of children with DD. Earlier intervention to support</p>	<p>No change recommended.</p> <p>Due to fiscal pressures, in 2001 the Department limited the funding priorities for access to HCBS services for children to prevention of institutionalization in a nursing home or psychiatric hospital. The reasoning for this limitation was that there were other services available to children with DD, that were not available to adults with DD, through education, Children’s Personal Care Services, High Technology Home Care, Department of Mental Health, Department for Children and Families early childhood programs, as well as other therapeutic services covered by the Medicaid State Plan.</p> <p>Since that time, the Department has added case management (Bridge Program) and</p>

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	<p>children and families is needed in order to comply with our values and principals, and support a stronger and more independent population of persons with special needs.</p>	<p>Family-managed Respite to its services offered to children and their families.</p> <p>Medicaid has also opened a new service for children with ASD/DD for Applied Behavior Analysis.</p> <p>At the same time, access to Children’s Personal Care has narrowed as the criteria for receiving that service has changed.</p> <p>Despite the availability of other state services, the Department acknowledges that there are gaps in services for children with DD and their families.</p> <p>Although the Department is not recommending changing the funding priorities for children at this time, we are continuing to work with the AHS Integrating Family Services initiative, DCF, DMH and DVHA in trying to address the gaps in services for children with DD.</p>
57	<p>4.7(g)(1)(C)(i)(1) A commenter noted that this section specifies that access to services is dependent upon the eligibility for ICF/DD level of care. They questioned whether the division still needed to apply the former Section 1915(c) criteria since the Global Commitment Waiver explicitly identifies that VT sought and received approval for “Removal of Institutional Bias” for developmental disabilities.</p> <p>4.7(g)(1)(C)(i)(3), It was noted that this section identifies that individuals must meet one of six funding priorities, which follow in (A) to (F). “If these criteria are</p>	<p>The term “removal of institutional bias” as used in the Global Commitment waiver refers to the choice a recipient has for care in either an institution or in a community-based setting, once he/she is determined to meet the eligibility for a program. The Specialized Programs, including DD services, retain meeting institutional level of care as part of their eligibility criteria. Institutional bias referred to the period before HCBS “waivers” when funding was only available for institutional care.</p> <p>See response to comment #6.</p> <p>For clarity, 4.7(g)(1)(C)(i)(3) is amended to read:</p>

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	<p>included in regulation, what would be included and the purpose of a System of Care Plan?"</p> <p>4.7(g)(1)(C)(i)(3)(A)(i) There was a recommendation that the criteria defining “imminent” as 45 days be removed.</p> <p>4.7(g)(1)(C)(i)(3)(F), A commenter noted that the funding level for parenting support is capped and asked if this meant that this level could not be increased without a change in the rules.</p>	<p>“The individual’s unmet need meets one of the following six funding priorities:”</p> <p>The 45-day timeframe is needed to prioritize who is in need of services. Without a timeframe, people who may need support very soon may be delayed or those who might not need it soon may be prioritized.</p> <p>As noted in the response to comment #7, the Department agrees that limitations in services, including funding amounts should be included in the SOCP. The Department agrees to strike:</p> <p>“maximum amount is \$7,800 per person per year” from 4.7(g)(1)(C)(i)(3)(F). The Department intends to propose the same limit in the SOCP.</p>
58	<p>4.7(g)(1)(C)(i)(3) One commenter noted that over time, the funding priorities have gotten increasingly narrow and more people are being left without services. The criteria to receive services is crisis oriented, resulting in fewer people receiving fewer services. The recommendation is to expand access to services especially in light of how these services can contribute to the broader healthcare reform efforts in the state.</p>	<p>No change recommended.</p> <p>Expanding funding priorities would require additional funds beyond the new caseload funding provided each year. The Department is unable to expand the funding priorities given current available funds.</p>
59	<p>4.7(g)(2)(A) A commenter noted that this section indicates that the services must be the “most cost effective option.” They also think a cost-effective system should continue to be maintained, but specifying that services must be the most cost effective may lead support options provided that are not the choice that is desired or best for the individual. It was recommended that this section be revised</p>	<p>As noted in the response to comment #7, this limitation will be moved to the SOCP. The Department intends to propose the same language in the SOCP. See response to comment #45 above regarding the rationale for cost effectiveness.</p>

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	to say <i>Services and supports must be cost effective and meet the individual's...</i>	
60	4.7(g)(2)(B) It was noted that this section specifies that all Medicaid State Plan and Medicare services must be accessed before using HCBS. It was recommended it be rewritten as follows to reflect the need for individuals to have access to qualified providers. <i>“All services that can be funded through Medicare, Medicaid State Plan and/or private insurance must be utilized prior to using developmental disabilities funding when qualified, competent providers are available in the individual’s community.”</i>	As noted in the response to comment #7, this limitation will be moved to the SOCP. The Department intends to propose this language in the SOCP. See response to comment #19 for rationale.
61	4.7(g)(2)(D) It was noted that this Section prohibits funding for services that duplicate or substitute for natural and/or unpaid support. The new federal Home and Community Based Services regulations define natural and unpaid supports as voluntary. Accordingly, this funding prohibition should be stricken. See, 41 CFR 441.301(c)(2)(5).	As noted in the response to comment #7, this limitation will be moved to the SOCP. However, the Department intends to propose this language in the SOCP. The language in the HCBS rule is about a person’s plan for services. It specifies that the plan should include who will provide the needed support including paid and voluntary unpaid providers. In the proposed regulations, it is specifying that when natural or unpaid supports are available, HCBS funds should not be used as they would not be needed. As noted in 4.7(g)(1)(C)(i)(2), the criteria for accessing HCBS funds is when there is an unmet need. The proposed language does not conflict with the Federal HCBS rule.
62	4.7(g)(2)(E) A commenter noted that this section specifies that funds must be utilized in accordance with the System of Care Plan and Medicaid Manual, which as previously noted is problematic.	As noted in the response to comment #7, this limitation will be moved to the SOCP. However, the Department intends to propose this language for the SOCP. See response to comment #6 related to the SOCP and #9 related to the Medicaid

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	<p>It also specifies that they must be utilized in accordance with the Federal HCBS Rules, including provision for conflict-free case-management. They noted that Vermont has yet to submit a plan to the Centers for Medicaid Services (CMS) specifying how they will meet the Federal HCBS rules, including provisions related to case-management. They think this very specific statement is premature in the absence of a plan having been submitted. There should be clear requirements and meaning to a statement such as “provisions for conflict-free case-management” before it is incorporated into regulation.</p> <p>Another commenter noted that guidelines are needed to assure there is not conflict of interest for getting information, referral and assistance regarding services and options.</p>	<p>Manual for Developmental Disabilities Services.</p> <p>See response to comment #13 related to the plan that was submitted to CMS regarding compliance with HCBS rules. The provisions for conflict-free case management are not relevant to this plan as they are currently required by the rule.</p> <p>See response to comment #5 for language added to 4.11(a)(1) to address conflict of interest.</p>
63	<p>4.7(g)(2)(F) It was recommended to modify the third sentence of this section as follows: “For up to one calendar year...fund (Equity and Public Safety) <i>except in situations where there has been a budget reduction instituted during the year.</i>”</p>	<p>As noted in the response to comment #7, this limitation will be moved to the SOCP. However, the Department intends to propose the same language in the SOCP.</p> <p>The Department does not agree with this addition. The Equity and Public Safety funds rely on returned caseload dollars to fund anticipated needs of new and existing consumers who meet funding priorities.</p>
64	<p>4.7(g)(2)(D)(i) It was recommended that this section be rewritten as follows: “<i>Residential settings are defined as individual addresses owned and operated by a single person or entity, not as an intended community.</i>”</p>	<p>As noted in the response to comment #7, these limitations will be moved to the SOCP. The Department intends to propose the same limitation in the SOCP.</p> <p>The Department wishes to keep options open, while still meeting the setting</p>

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	<p>4.7(g)(2)(I)(i)&(ii) It was recommended that the sentence providing authority for the Division to allow exceptions to the requirements be removed.</p>	<p>requirements in HCBS rules. See comment #23.</p> <p>There are occasionally unique circumstances that warrant an alternative setting that is not consistent with the limitations. The Division needs to retain the flexibility to grant exceptions in those cases when it is appropriate. Considerations regarding affordable and accessible housing options may require exceptions. Any exceptions granted would still need to comply with the HCBS rules.</p>
65	<p>4.7(g)(2)(J) Several commenters objected to the limitation of 25 hours of work and community support, indicating the limit is arbitrary. In general, program parameters such as these may be more appropriately contained within the System of Care Plan and not codified in Regulations. Regardless of where it is located, the 25-hour limit should be stricken as it restricts opportunities for community integration and work, two essential activities which are known to greatly enhance one's quality of life and health. Furthermore, the limit will reduce access to home providers who typically work 40 hours a week.</p> <p>It was recommended that 4.7(g)(2)(J)(iii) be re-written as follows: "Community support hours shall be based on individual needs, based on assessment process."</p>	<p>As noted in the response to comment #7, these limitations will be moved to the SOCP.</p> <p>However, the Department intends to recommend this limit in the new SOCP. The limit of 25 hours a week for work supports and community supports was established in previous SOCPs as a method of managing limited resources. The Department appreciates the desire to expand access to these services; however, the Department cannot increase this limit without a significant increase in resources.</p> <p>25 hours a week provides a fair amount of time for support to participate in one's community. With regards to employment support, there is an expectation that the agency support a person to expand their ability to work more independently rather than expand the hours they receive staff support to work.</p> <p>Home providers are expected to be available to support individuals for whom they provide a home, and most do not</p>

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66	<p>4.7(g)(2)(K) It was recommended that this be removed as housing safety and accessibility standards are defined in Department Guidelines.</p> <p>It was recommended that service caps should not be included.</p> <p>Also, only “physical accessibility” is addressed. The question was posed regarding whether this precludes resources being used for some accessibility needs such as auditory or visual.</p>	<p>typically work 40 hours a week in addition to being a home provider.</p> <p>As noted in the response to comment #7, these limitations will be moved to the SOCP. However, the Department intends to propose these limits in the draft of new SOCP.</p> <p>Although the standards are defined in Department guidelines, a limitation of funding for home supports is that they must only be used in homes that meet these standards. Funding caps are needed to allow equitable distribution of limited funds.</p> <p>The Department agrees to make a change to include other disabilities. See response to comment #24. The change will be included in the proposed SOCP.</p>
67	<p>4.7(g)(2)(L) One commenter requested a rationale for the 8 hour per day limit on self/family managing home supports and indicated that it contradicts self/family management section where it says they must manage all supports.</p> <p>Several comments noted that this limits the option for self/family management when a person needs more than 8 hours of home supports. Families indicated that it forces them to receive agency managed services, sometimes outside their family home. They felt this limited choice which is required by HCBS rules.</p>	<p>As noted in the response to comment #7, this limitation will be moved to the SOCP. However, the Department intends to propose this limit in the draft of new SOCP.</p> <p>The Department believes that people living in 24-hour care settings need the oversight of an agency to ensure compliance with these regulations, as well as all state and federal rules, guidelines and policies and to ensure the health and safety of recipients. Individuals and families can manage other additional categories of service, such as respite, community or work supports, to provide needed support beyond the 8 hours per day of home support.</p> <p>The definition (1.34) of self/family management indicates that self/family management is when a person or their family manages all the services a person</p>

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		is funded to receive <i>within federal and state guidelines</i> . HCBS rules do not mandate unlimited choice, but rather that people are informed of all their available options.
68	<p>4.7(g)(2)(M) Places a cap on the amount of funding a person can receive. It was recommended that the caps be removed. DAIL funds individuals with lesser budgetary requirements in accordance with their support needs. It was recommended that funding for all individuals be established according to their needs. Further, agencies are being required to serve these individuals without adequate funding provided and at a great loss to the agencies.</p> <p>Another commenter recommended that the funding limits that are articulated in the System of Care Plan be increased to at least \$350,000. In addition, the funding limits and funding decisions must explicitly recognize that, in order to meet the needs of Vermonters, that there are situations where a particular Vermonter's needs require financial support above specified limits. A formal process to determine when and by how much any limit is exceeded must be explicitly described in the System of Care Plan.</p>	<p>As noted in the response to comment #7, this limitation will be moved to the SOCP. However, the Department intends to propose this limit in the draft of new SOCP.</p> <p>Caps are one of the methods available to the system to manage limited resources and to help ensure equitable distribution of resources across those in need of DD services.</p> <p>In recognition of the challenges faced by agencies related to the exceptions cap of \$250,000, the Department had proposed an increase to \$300,000. In addition, as noted in 7.B of the General Provisions of the FY17 Master Grant Agreements (MGA) between an agency and AHS, an agency may approach the AHS to resolve funding shortfalls when a person has extraordinary needs beyond the funding limit. The MGA outlines the formal resolution process.</p>
69	<p>4.7(g)(2)(O) Several commenters noted that this section contains new caps on therapeutic visits and recommended it be stricken as the limits will potentially increase rates of institutionalization and/or serious mental health issues for individuals with disabilities.</p> <p>Another commenter noted that 96 hours of clinical services is below standard of care for these services.</p>	<p>As noted in the response to comment #7, limitations will be moved to the SOCP. The Department will ensure that any limitations related to clinical services are not inconsistent with the State's mental health parity laws.</p> <p>The "supportive services" described do not fall under mental health services, and as such, would not be subject to the mental health parity laws.</p>

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	<p>4.7(g)(2)(O) It was questioned whether the caps on clinical services are consistent with mental health parity laws. The commenter also did not think clinical decisions should be made in this way, which may leave vulnerable people with inadequate care. The psychiatric care caps are not sufficient to meet the care needs of individuals experiencing periods of instability. Additionally, the regulations should not be a substitute for a physician determining medically necessary care.</p>	<p>The Department intends to propose the limitation in 4.7(g)(2)(O)(iii) in the draft SOCP, but increase the number of visits to 96 in 4.7(g)(2)(O)(iv).</p> <p>It should also be noted that this section included the option for increasing visits if needed beyond the limits using funds available internally at agencies. The Department intends to propose similar language for the SOCP.</p>
70	<p>4.7(g)(2)(P) There was a recommendation to revise the language as follows: “Funding for Facilitated Communication (FC) shall be approved only when its use...”</p> <p>A parent noted that her son deserves the right to communicate. Since he is not able to express himself through the use of speech, he needs access to technology that will give him the opportunity to express himself for that on the fly communication as well as his expression. The regulations should not make it more difficult to acquire assistive communication devices through Medicaid. The regulations need to support access to FC to allow people to communicate.</p>	<p>As noted in the response to comment #7, these limitations will be moved to the SOCP. However, the Department intends to propose this limitation in the draft of new SOCP.</p> <p>Moving the word “only” does not change the meaning of the sentence.</p> <p>The proposed regulation allows for HCBS funding to support training and consultation in the use of Facilitated Communication that follows the Department’s newly developed guidelines for its use.</p> <p>The issue of payment through Medicaid for assistive technology devices that are used by people who use FC is outside these regulations as the authorization comes through the Department of Vermont Health Access.</p>
71	<p>4.7(h) It was recommended that this specific service option, ICF/DD, should not be in regulation but if included should simply be identified as one of</p>	<p>The Department disagrees with this recommendation. ICF/DD services are one of the types of service offered through funding by the Department. Act 140 requires the programs and services</p>

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	<p>many service options that an agency may utilize.</p>	<p>funded in DD services to be included in regulation.</p> <p>As noted in the response to comment #7, the limitation section will be moved to the SOCP, if it is needed there.</p>
72	<p>4.7(i) This Section makes the use and distribution of One Time Funds subject to the discretion of the Department. Unless an alternative source of funding for unanticipated, short-term, and unusual needs is identified, this section should be stricken. The annual distribution of One Time Funds to Vermont's Designated and Specialized Services Agencies cannot be discretionary. As is widely acknowledged, these funds are essential to Vermont's Designated and Specialized Services Agencies financial viability and their ability to deliver quality care in a cost-effective manner. One Time funds are typically used to address needs that are difficult to fund through other mechanisms within Medicaid and which if left unaddressed, have a high potential for triggering more costly services in the future. Therefore, these funds are essential to the health and safety of the Vermonters who receive services from a Designated or Specialized Services Agency.</p> <p>4.7(i) Another commenter indicated that one-time funds must continue at their current level and suggested the following language: "These funds may <i>shall</i> be distributed to agencies at the discretion of the Department and are not guaranteed. The amount and timing of distribution is at the discretion of the Department."</p>	<p>No change recommended.</p> <p>The current SOCP indicates that One-Time Funding <i>may</i> be distributed to the DA/SSA/Supportive ISOs and that "the Division determines how one-time funding is used by the DA/SSAs and Supportive ISO, including the timing and allocation of these funds to agencies." The proposed language in the regulations restates what has been in the SOCP, but states more specifically that the distribution of the funds is at the discretion of the Department.</p>

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	<p>4.7(i) Another commenter recommended the following replacement language:</p> <p>“50% of these funds, at a minimum, shall be distributed to agencies. The amount and timing of distribution is at the discretion of the Department.”</p>	
73	<p>4.7(i) It was noted that the Division apparently has more than one source of funding from which one-time funds are generated. Consequently, if this section is retained, we recommend it be separated into two sections: (1) One-Time Funds Generated from DS Caseload (New Appropriations and funds returned to Equity and Public Safety funding pools) and (2) One-Time Funds Generated from Various Sources other than DS Caseload. It was recommended that the following replacement language be used in this section:</p> <p><i>“1) <u>One time Funds Generated from DS Caseload.</u> These are funds that result from providing agencies with only the amount of funds required to cover the number of days of service that will be provided during the fiscal year in which the funds are distributed. The funds that remain but are required to continue services for the individual in the following fiscal year are identified as “one-time.” These one-time funds from caseload appropriated for the fiscal year and funds returned to Equity and Public Safety shall be distributed to agencies.</i></p> <p><i>(2) <u>One-time Funds Generated from Various Sources other than DS Caseload.</u> One time funds are used to address short term needs and cannot be used for long term needs. These funds may be distributed to agencies at the discretion of the Department. The amount and</i></p>	<p>The Department agrees that using the term “various sources” is not clear. The first sentence in section 4.7(i) is replaced with:</p> <p>“One-time funds are generated from the new and returned caseload dollars for the Equity and Public Safety funding pools.”</p> <p>These are the only sources of one-time funds. As noted in the response to comment #72, the amount and timing of the distribution of funds will remain at the discretion of the Department.</p> <p>The Legislature appropriates the funds to meet the DS caseload needs for those who meet a funding priority. The Department is meeting the needs of those who meet a funding priority during the FY and into the future fiscal years. The portion of funding not needed during the fiscal year for individual’s services are discretionary funds for the Department to utilize. The one-time funds which may be distributed to agencies are a subset of those discretionary funds. The discretionary funds have been used for a variety of activities including post-secondary programs, transition projects and other investments in the DS system.</p>

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	<p><i>timing of distribution is at the discretion of the Department.</i></p> <p><i>The Division shall provide a report on how all one-time funds were utilized to the Developmental Disability Services State Standing Committee within 120 days of the close of a fiscal year.”</i></p> <p>It was recommended that the “Allowable Uses for One-Time Funding by Agencies and the Supportive ISO” be broadened to include things such as training.</p> <p>It was recommended that the caps for funding and the clauses related to allowable uses be removed from regulations and defined in Department Guideline.</p>	<p>The use of one-time funds distributed to the agencies is provided in the Division’s Annual Report, so a separate report is not necessary.</p> <p>The allowable uses are directed to short term needs of recipients. Training is a requirement of agencies and costs should be included in their service rates.</p> <p>As noted in the response to comment #7, limitations will be moved to the SOCP. However, the Department intends to recommend the limits remain the same in the proposed SOCP. Caps are included to allow for fair and equitable distribution of limited funds to as many people as possible. Act 140 requires including the criteria for receiving services or funding. The Department believes including the clauses regarding allowable uses for One-Time Funding are part of that requirement.</p>
74	<p>4.7(j) It was recommended that references to specific programs, SUCCEED, Think College and College Steps, be removed and the section simply reference Post-Secondary Initiatives.</p>	<p>The Department agrees with this recommendation and the language in 4.7(j) is changed as follows:</p> <p>The sentence starting with “the PSEI is founded...” is stricken. The last sentence is replaced with:</p> <p>“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.”</p>
75	<p>4.7(k) It was recommended that the limitations on hours be removed.</p>	<p>As noted in the response to comment #7, limitations will be moved to the SOCP. However, the Department intends to</p>

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		<p>recommend the limit remain the same in the proposed SOCP. The proposed limit is a significant increase from the current limit of 5 hours per week for people who did not previously have HCBS funding. 25 hours per week of Specialized Services is a significant additional service for a person who is already funded for 24-hour care in a nursing facility.</p>
76	<p>4.7(n) Two commenters indicated that they did not understand why coverage for one State Medicaid Plan service in DD services would be included but not others. Will other State Plan coverages continue to be available and if so, should they all be included?</p>	<p>The Department agrees that all programs and funding sources that are prioritized should be included the regulations. The following changes are made:</p> <p>4.7(n) becomes 4.7(o) with a new title: <u>Targeted Case Management for persons with Developmental Disabilities.</u></p> <p>New language for 4.7(n) is:</p> <p><u>“Special Populations Clinic and Rehabilitation Services</u> 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:</p> <ul style="list-style-type: none"> • diagnosis and evaluation (D & E) • individual psychotherapy • group therapy • emergency care • Medication Evaluation, Management and Consulting Services (Chemotherapy, med-Check) <p>1. <u>Eligibility</u> (A) Clinical: Individuals who meet the criteria for developmental disabilities as defined in these regulations. (B) Financial:</p>

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		<p>Vermont Medicaid eligible as determined by DCF/Economic Services Division. (C) Access Criteria: Access to these services is determined by the agency, based upon need and available resources.</p>
77	<p>4.8 It was noted that this section allows the Division to invest funds in initiatives. It was recommended that the funding stream for this should be identified. The process for the Division to secure stakeholder input and concurrence with proposed initiatives and the process for reporting back to stakeholders on the outcomes should be included in the clause. It was recommended that if the other existing programs have eligibility criteria and limitations, this section should also.</p>	<p>Act 140 requires priorities for the development of new “programs” to be adopted by rule. This section refers to special initiatives which would be short term investments. These would be likely be investments to address issues identified in Local SOCPs. The process for the Division to secure stakeholder input for initiatives would be through the public input process required for the adoption of the System of Care Plan. The Department agrees that a process for reporting back to stakeholders on outcomes should be included in this section. Because the initiatives will be adopted through the SOCP process, the funding stream, eligibility criteria and any limitations would be identified in the SOCP.</p> <p>A final sentence is added to this section: “For all special initiatives, specific outcome measures will be required and results will be reported by DDSD.”</p>
78	<p>4.9 It was recommended that the “Approaches to Managing Within Funds Available” section be cut. In the event of fiscal pressures the Division must go through the Legislative Committee on Administrative Rules prior to reducing or eliminating any services. 18 V.S.A. § 8725.</p>	<p>The Department agrees that this section should be stricken from the rules.</p> <p>If appropriated funds are less than projected need, the Commissioner has the authority to allocate resources considering funds available to the Department. (18 V.S.A § 8725 (b)(2).</p> <p>As noted above, the Department will remove this language from the rules, but</p>

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	<p>4.9 Another commenter recommended that this section be removed from the proposed regulations for another reason. DAIL has consistently verbalized their recognition of the underfunding of the DS system. Approaches identified in this section will further jeopardize people supported by the system and the capacity of agencies to maintain supports. If adequate funding is not available DAIL should seek support from the legislature.</p>	<p>not for the reason expressed. When appropriate, the Department does return to the Legislature for additional funds. When there are fiscal pressures requiring management within funds available, it is because the Legislature has decided to appropriate less funding, so it does not then make sense to return to the Legislature to request additional funding.</p> <p>Note: Because 4.9 will be removed, the subsequent sections 4.10-4.19 in the proposed rules are renumbered in the revised version as 4.9-4.18. The sections referred to in comments #79-85 refer to the sections as they were originally proposed.</p>
79	<p>4.10 It was noted that since the 45 day criteria was established the funding process for individuals has been extended. Funding decisions used to be made by centralized Equity and Public Safety Committees and notifications of those decisions were usually made within two working days. Those committees now make recommendations to the Division. The Division has no timeframes for making and distributing their decisions which impacts the capacity of agencies to meet the 45-day time frame.</p>	<p>No change recommended for the language in this section.</p> <p>The Division typically sends the Equity decisions within 3-4 working days after the state committee meeting. The timing of sending out the Public Safety decisions has changed and likely is impacting agencies' abilities to meet the 45-day criteria. The Department will change its practice to sending the Public Safety decisions within a few days after the meeting to allow for more timely notifications.</p>
80	<p>4.11 It was recommended that this section be clarified throughout where it refers to another "agency" or another "provider", to make it clear that a recipient may choose to receive services with a non-agency provider regardless of whether the non-agency provider is</p>	<p>This recommendation is accepted. The following is added as 4.11(a)(4): "The recipient or family may receive services from any willing agency in the state."</p>

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	<p>within the geographic region of a particular DA. This clarification will reflect the current reality that some providers currently contract with multiple DAs from around the State.</p> <p>4.11(a) It was recommended the following language be added to this section. <u>Families have the option of choosing service options/providers outside of their geographic area but within the state system of care.</u></p>	<p>4.11(a)(5) “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.”</p> <p>As is noted in 10.6 (a), any non-designated entity or organization must be a sub-contractor of an agency to provide DD services funded through the Department. It is at the discretion of the agency whether to sub-contract with a provider. Non-designated organizations may apply to become agencies. (See 10.2(c))</p> <p>The Department reviewed when the term “agency” vs. “provider” is used in all of 4.11 and adjusted the intended term. The revisions appear in the responses to comments below. (See comments #82, #84)</p>
81	<p>4.11(a)(1) It was recommended that “full” be removed as it is not defined to allow for consistent interpretation.</p> <p>4.11(a)(1) A commenter was pleased to see the proposed amendments to this section (Choice of Provider), in particular the affirmative obligation for Designated Agencies to provide service recipients with full information so that the recipient</p>	<p>The Department agrees with this recommendation and revised the language in 4.11(a)(1) as follows:</p> <p>“It is the DA’s responsibility to ensure the individual is informed of his or her choice of all services options listed in 4.4(b) in order to make an informed decision when making the choice of management options/service providers. The DA shall document options discussed and information shared as part of this process.” See additional language added to this section in response to comment #5.</p>

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	and his or her family are made aware of the choices of service options and providers, and the requirement for documentation to be made of the options discussed and the information shared with the service recipient.	
82	4.11(a)(2) It was recommended that this section be revised to read: “If the recipient...that at least one agency within the geographic area offers the needed services at <i>the amount the DA requires to provide the service.</i> ” Funding must be provided at an amount that will allow the person’s needs to be met.	The Department does not agree with this recommendation. The regulations contain language regarding the process for how the amount of funding is authorized. However, the language for 4.11(a) (2) is changed as follows to add clarity: “... that at least one provider within the geographic area offers the authorized services at or below the amount of funding authorized at the DA.”
83	4.11(a)(3) It was noted that this section does not mention shared management. Recipients and families need as many options explained by agencies and need to have real options. Self/family management has not been maximized in Vermont.	As noted above in response to comment #81, the Department agrees with this recommendation and, as noted previously, the language in 4.11(a)(1) l adds a reference to 4.4(b) which includes shared-management.
84	4.11(a)(3) It was recommended that this section be revised to read: “If no other agency...the DA shall provide the needed services <i>at the amount the DA requires to provide the service and</i> in accordance with its Master Grant Agreement.” 4.11(c) It was suggested that this section should not be included in regulations;	The Department does not agree with this recommendation. The regulations contain language regarding the process for how the amount of funding is authorized. However, the language in 4.11(a) (3) is changed as follows to add clarity: “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 provide the authorized services in accordance with its Master Grant Agreement.” 4.11(b) replaces the term “agency” with “provider”.

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	<p>however, if included, it should be modified as follow: “The recipient may...services at or below the <i>amount required for the DA to provide the services.</i>”</p> <p>4.11(c)(1), There is one specific instance where the "agency" - "provider" language needs to be clarified in this section where it states: "If an alternative agency is not able to provide the services at the lower approved budget, the DA must do so at that lower rate." The word "agency" should be replaced with "provider." The last sentence should be modified to read: “If an alternative agency...the DA must <i>be funded and provide the services at the DA rate.</i>”</p> <p>4.11(c)(2) – Agencies receive 5% administrative funding rather than their administrative rates for new funding. When they are required to transfer their full administrative rate, they are required to further add to their underfunding by sending more administration than they received. DAIL recently implemented a change so that agencies transfer the 5% administration that they received and not the additional amount they were required to internally fund. This change is not reflected in this section and needs to be incorporated.</p> <p>4.11(c)(3) – The system provides funding to meet identified needs, however this clause implies that a person can shop for an agency that can provide the needed services at less cost; and consequently, receive more services than they were identified to need by taking their funding to the lower cost agency.</p>	<p>4.11(c) is changed to read: “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 at the DA.”</p> <p>The Department agrees that the term “agency” in 4.11(c)(1) should be replaced with “provider” in the final sentence. The Department agrees to change the final clause in that section to ...” the DA must do so at the amount of funding authorized at the DA.”</p> <p>The first sentence in 4.11(c)(1) is changed to read: “When requesting new funding, if an individual chooses to receive services from an agency other than the DA, or an agency agrees to sub-contract with a provider, ...”</p> <p>4.11(c)(2) The Department agrees that the change in procedure is not reflected in the rule. This section is replaced with: “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 promptly transfer the individual’s authorized funding limit to the agency selected according to the procedures outlined in Division guidelines.”</p> <p>4.11(c)(2) indicates that when a person chooses to transfer to another agency, the authorized funding limit is transferred to the new agency. The current SOCP outlines how Individuals can move funds around within their budget to address their</p>

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	This seems inconsistent with the intent of the system and efforts to be cost effective. It seems the excess funds should instead go to serve someone else as the person’s needs could be met for less.	needs. If services cost less to meet a person’s needs, those funds should be re-allocated by the receiving agency through internal adjustments. This guidance will be included in the next SOCP.
85	4.13(a) This section requires the use of the level of care assessment. Providers had been working collaboratively with DAIL to finalize this document; however, DAIL has not yet scheduled a meeting to complete this work. The tool should be finalized prior to inclusion in regulatory requirements.	The Department agrees that the tool should be finalized prior to inclusion in the regulations. The phrase “and level of care assessment” is stricken from this section.
	Part 5. Self/Family-Managed Services general comments	
86	There were several general comments on the introductory section of Part 5 indicating that the changes would further reduce choice and limit options within self/family-management. Examples were that there would be nothing to manage except direct services and that the family would lose independent case management. One person noted, “People choose self/family management or shared management for compelling reasons. It allows people to maximize funding by providing an alternative to agency rates that include overhead. It also allows services to be provided more flexibly, when and where people need them rather than on an agency schedule. Following the federal Rule, Vermont needs to expand these options rather than roll them back.”	No change recommended. The language in this section was added to clarify the intent of self/family-management. The purpose of self/family management is for the individual or family to oversee their services, not purchase services from a non-certified provider who is out of the network. This is to ensure accountability and oversight by the Division. Recipients and families may still hire all workers to provide support, as well as independent case managers. They may also purchase clinical and supportive services or pay for camps as respite. They may not, however, hire a non-certified provider to manage their services. This is a new limit on the self/family management option. However, the Department feels it is necessary, as contracting with a non-certified provider circumvents the regulatory process that has been set up to ensure accountability and quality services.

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87	Part 5. One person commented that part 5 has comprehensive requirements for recipients and families who self/family manage, but that there are no regulations for home providers who hire workers to provide services.	No change recommended. The situations where home providers are hiring workers are agency-managed services. Through their contracts with home providers, agencies have the responsibility to ensure all regulations and guidelines are being followed.
88	Part 5. One commenter noted that there is also no provision for administrative expenses for families that share-manage their services as there are through self and family management. It was recommended that they be allowed.	No change recommended. This is a general comment that does not relate to a specific regulation. The Department will consider this recommendation outside the regulations.
89	Part 5. One commenter noted that the roles, responsibilities, informed ISA development, training, confidentiality, and reporting requirements of the Department, DA, SSA, Supportive ISO need to be reconsidered.	No change recommended. This comment is not specific enough for the Department to respond. See response to comment #21.
	Part 5. Self/Family-Managed Services – comments by section	
90	5.2(b) It was recommended that the following change be made: “The plan must specify what each service is supposed to be and how much the service shall cost on a monthly basis.” In this sentence, recommend replacing “a monthly” with “an annual”.	The Department agrees to make this change. In 5.2(b) , “a monthly” is replaced with “an annual”.
91	5.2(d) Add “for a minimum of 7 years” to the end of the sentence “Maintain a complete and up-to-date case record that reflect details regarding the delivery of services.” The records may be needed in the event of an audit.	The Department adds to this section the following: In 5.2(d) , “Retain case records in accordance with the record retention schedule adopted by the Department”.
92	5.3 includes a significant new requirement for requests for increased services and funding for existing recipients for the Supportive ISO to have to work with the DA on completing the new needs assessment, developing and	Based upon the feedback provided, the Department agrees to strike the second sentence and replace it with the following: “For existing recipients who are self/family managing who have a new

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	<p>reviewing proposals at the local DA funding committee and having the DA submit those proposals to state funding committees. The current process is that requests and reviews are completed by the Supportive ISO rather than the DA. All the comments received were strongly opposed to this change. Comments from several families indicated that they had not had good experiences working with their DA and did not want to have to return there if they needed additional services. Many indicated their appreciation of the independence and freedom to make services work for their family member as a key benefit of self/family management and that the change was a move in the wrong direction.</p> <p>Several advocacy organizations echoed their opposition to this change. There was a recommendation that additional support or training be offered to Supportive ISO and their funding committee when there were complex situations to review.</p>	<p>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 the local Designated Agency or an independent evaluator 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.”</p>
93	<p>5.4(b) There were several comments indicating that the language is causing confusion about what is required. Several people thought the language was limiting the ability of families to hire an independent QDDP. Another person noted that if the QDDP works for an agency, then it would be a shared vs and self/family managed option.</p> <p>One person recommended changing second sentence to “Before a person uses a QDDP, the Department’s endorsement is required to ensure that they have the knowledge and skills to perform the duties of a QDDP”.</p>	<p>To enhance the clarity of this section it is re-written as follows:</p> <p>“All QDDP’s must meet the criteria specified the Division’s <i>Qualified Developmental Disabilities: Definitions, Qualifications and Roles</i>. For QDDPs employed by an agency, the agency is responsible for ensuring that the QDDP meets those criteria. For those not employed by an agency, including those working for the Supportive ISO, the person must be endorsed by the Department as an independent QDDP, before being paid in that role.”</p>

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94	<p>5.5(d) It was recommended to change the language as follows: “Help the person 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 with the person’s AFL.”</p>	<p>The Department agrees with this recommendation and replaces the proposed language with the following for 5.5(d):</p> <p>“Help the person 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 with the person’s AFL.”</p>
95	<p>5.5(e) One commenter recommended changing language to be consistent with current billing practice of the Supportive ISO.</p>	<p>The Department agrees with the recommended change and replaces 5.5(e) with the following:</p> <p>“Bill Medicaid according to the procedures outlined in the provider agreement between the Supportive ISO and the Department.”</p>
96	<p>5.5(i) It was recommended adding “Records must be retained for a minimum of 7 years.”</p> <p>The records may be needed in the event of an audit.</p>	<p>The Department adds the following:</p> <p>In 5.5(i), “Retain case records in accordance with the record retention schedule adopted by the Department.”</p>
97	<p>5.5(n) Recommend replacing “board” with “committee.”</p>	<p>The Department agrees to make that change.</p>
98	<p>5.7 There was a question regarding whether there is clarity in the proposed regulations that shared managed services do not involve the Supportive ISO.</p>	<p>The Department agrees that this is not specifically addressed in the regulations. The following is added to the introductory section of 5.7:</p> <p>“The agency is responsible for providing information and guidance to the recipient or family in their responsibilities for share-management.”</p>
	<p>Part 6. Recipient financial Requirements</p>	
	<p>No comments</p>	

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	Part 7. Special Care Procedures – General comments	
99	It was noted that the language in this section, especially regarding nursing (RN vs LPN), appears to be inconsistent. It was suggested that the Department ask the Office of Professional Regulation (OPR/Board of Nursing) to review staffing in this section.	<p>The Board of Nursing has reviewed the Department’s regulations and has found they meet all necessary requirements.</p> <p>For clarity, the Department agrees to add a second sentence in 7.2(a) that says: “These regulations follow the Vermont State Board of Nursing Position Statement – The role of the nurse in delegating nursing interventions.”</p>
	Part 7. Special Care Procedures - comments by section	
100	7.7 and 7.8 Several commenters noted that this Section permits certain training and competence determinations for Specialized Care procedures to be provided by LPNs rather than by Registered Nurses (RN). Commenters felt that these tasks should be done by RNs rather than LPNs. The training received by a Registered Nurse is essential to ensure that the persons authorized to provide special care procedures have the requisite professional competence.	<p>The regulations require a RN to assess the person and then develop the special care plan. Training and oversight then can be implemented by LPNs. The position statement from the Vermont Board of Nursing states that an LPN may delegate specific tasks to LNAs, other LPNs, and unlicensed personnel only after the RN has assessed the client. VT RNs and LPNs have the authority to delegate nursing interventions that may be performed by non-nurses. (26 VSA. §§1572(2)(G) and (3)(A)(vi). Decision making regarding the delegation of nursing care must be focused on the protection of health safety, and well-being of patient/client.</p> <p>The Department is operating within the authority of the Board of Nursing, which has determined that LPN’s can delegate and oversee certain procedures safely.</p> <p>For the purposes of clarity, the following sentence is added to the beginning of 7.7 (b):</p> <p>“A registered nurse shall complete an assessment of the person prior to developing the special care plan.”</p>

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101	<p>7.7, 7.8, 7.9 and 7.10 It was noted that registered is removed before nurse in all these clauses. Nurse is not defined in Part 7 or in the definitions in Part 1, and a definition needs to be added to the regulations. Required nursing qualifications are unclear. The inference is that a Licensed Practical Nurse may now do these tasks rather than a registered nurse. There was confusion with that inference as it is known that the State secured additional funding to support the hire and retention of registered nurses in State government, in particular at the Vermont Psychiatric Hospital. Do the tasks of training and delegating the special care procedures outlined in Part 7 require lesser nursing training than that required by nurses working for the State?</p>	<p>No change recommended.</p> <p>The proposed language follows the rules set forth by the Board of Nursing. See response to comment #100. The definition of a nurse and nursing qualifications is governed by OPR/Board of Nursing and is not needed in these regulations.</p> <p>Please refer to 7.3 (c) which notes that these regulations do not apply to care provided in hospitals or nursing homes, which are under different regulatory requirements. This would include the Vermont Psychiatric Hospital.</p>
	<p>Part 8. Grievance, Internal Appeal and Fair Hearing – general comments</p>	
102	<p>It was recommended that Part 8 - Grievance, Internal Appeal and Fair Hearing be removed from the regulations and the requirements be conveyed through Guidelines. It was thought that the Agency of Human Services will soon have to update this policy to comply with changes made when the 1115 Waiver recently renewed. As such, by retaining this policy within these regulations, the DD Act Regulations will likely need to be updated within a few months of approval. It was recommended that these guidelines also be formatted to make them more accessible and usable to constituents, particularly those with cognitive impairments.</p>	<p>Vermont’s Global Commitment to Health Section 1115 Demonstration requires compliance with 42 C.F.R. Part 438, the federal regulations governing grievances and appeals. As those federal regulations are subject to change, the Department agrees that it is prudent to strike the content of Part 8 from its regulations and incorporate by reference the federal grievance and appeals regulations.</p> <p>The Department, however, cannot delete Part 8 in its entirety. 33 V.S.A. §8726 requires the Department to include in its rules provisions regarding “complaints and appeals.” The incorporation of the federal regulations by reference satisfies this requirement yet provides the needed flexibility to respond to changes in federal law. The Department, in consultation with stakeholders, will develop for the</p>

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		public a user-friendly guide to grievances, appeals and fair hearings, which will explain the rights as they apply to developmental disabilities services.
	Part 8. Grievance, Internal Appeal and Fair Hearing – comments by section	
103	8.4(a) A commenter noted that the explicit extension of the timeline for extension of an appeal is a good addition. Based upon the commenter’s experience, agencies are not uniformly and consistently providing proper notice of adverse actions.	No change recommended.
	Part 9. Training – general comments	
104	It was recommended to include throughout this section the wording: <u>“best and promising practices and the priorities of the System of Care Plan.”</u>	The Department agrees with this recommendation for section 9.1 and makes that change. The term “and promising was already added to section 9.2(a)(4) and 9.3(a)(2)(A) where it previously only said best practices. The addition of “and Priorities of the System of Care Plan” is not relevant to those sections.
105	One commenter noted that the terms “values” and “respect” in this section need objective criteria to make sure a person’s rights are actually respected. People are often in a situation where their rights are curtailed.	No change recommended. The purpose of the regulations is to specify the requirements for service delivery. The Department then uses its quality oversight functions to assess the quality of the implementation of the rules. The Quality Management team assesses whether a person’s rights are being respected as required by the DD Act, the regulations, the Behavior Support Guidelines, Health and Wellness Guidelines.
	Part 9. Training – comments by section	

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106	<p>9.3 A handful of comments were received expressing appreciation for the person-centered values list.</p> <p>It was noted that this section is identified as “Agency Responsibilities;” however, it was recommended that it be identified as <i>Agency and Supportive ISO Responsibilities</i>.</p> <p>A commenter noted that several new training requirements are added to the regulations. The commenter appreciated the support of positive philosophical approaches, however, suggested that the addition of new requirements must have funding attached to support implementation. Agencies cannot be expected to comply with new requirements without additional resources.</p>	<p>The Department agrees to add “and Supportive ISO” to the title of section 9.3.</p> <p>See responses to comments #10 and #73. The Department will continue to work collaboratively with agencies to direct adequate resources to support this important training to personnel.</p>
107	<p>9.4 It was noted that the first sentence of this section adds “and demonstrate knowledge” as new criteria. The commenter indicated that it was not clear what this means and recommended definition as follow: “and demonstrate knowledge <i>through post training testing</i> in all the following areas:”</p>	<p>No change recommended.</p> <p>The Department disagrees with this recommendation. Section 9.3(d)(1) requires that agencies and the Supportive ISO have a system to verify that workers have received pre-service and in-service training. This is not a new requirement.</p> <p>The Department expects that as part of QDDP monitoring the services provided to the person, monitoring the ISA, monitoring homes, that assurances are taking place that the staff providing services are trained and demonstrate the necessary knowledge.</p> <p>The agency and Supportive ISO can determine the best method for verification.</p>
108	<p>9.4(c) and 9.5(a)(2) These sections add a requirement that the agency ensure “that</p>	<p>The Department disagrees with the recommendations and interpretations of</p>

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	<p>the employer of record has provided training and the worker demonstrates knowledge” in specified areas. The agencies do not have a relationship with these workers who are employed by others. This is a decision the system made and has continued to preserve as a cost saving method of providing services. The responsible employers are families or home providers. As such, agencies cannot take on this role. If this is a practice that DAIL wants to implement, we recommend that the State look to take on these responsibilities through their relationship under the home care worker union agreement. However, for consistency, we recommend DAIL approach this as they do for people who self/family manage. In those situations, the Supportive ISO is not responsible, the employer of record, the individual or their family, is simply responsible for providing the training.</p>	<p>agency responsibilities related to training. (See response to comment #107.) To clarify employer and agency responsibilities these sections are modified as follows:</p> <p>9.4(c) The last two sentences are stricken. They are revised and moved to after the introductory sentence in 9.4 as follows:</p> <p>“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.”</p> <p>9.5(a) “or” is replaced with “and”. Deleted “Including” and added “in (a)(1) through (4) of this section”. A second sentence is added that states: “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.”</p>
109	<p>9.6(b) Several comments were received that this section provides too many exceptions to essential quality protections in the event of an emergency, including that 4 days (96 hours) is too long a period in which to allow certain quality and safety requirements to be suspended.</p> <p>Several comments also stated that “Emergencies” and “Unavailability of a trained worker” are unfortunately becoming code for insufficient direct</p>	<p>No change recommended.</p> <p>The Department recognizes the staff turnover and vacancies issues both statewide and nationally. Section 9.6 (b) is not intended to become code for this situation and the Department agrees that it requires a separate remedy. Section 9.6 (b) is meant to ensure the health and safety of individuals and allow flexibility in emergencies when the person cannot be</p>

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	<p>care staff from turn-over and vacancies in staff positions.</p> <p>The root causes of staff turnover and vacancies, including the lack of livable wages, must be addressed at the systems level.</p>	<p>left alone and yet their caregivers are unavailable due to emergencies.</p>
	Part 10. Certification of Providers	
110	<p>10.2(a), 10.2(b) and 10.2(c) It was noted that Certification equals designation as contained in 10.2a. It was questioned whether sections 10.2 (b) & (c) were needed or whether just 10.2a was needed.</p>	<p>No change recommended.</p> <p>(b) and (c) are needed to distinguish current and newly applying providers. The process for applying is described in (c).</p>
111	<p>10.2(f) It was noted that the approaches in this section are not currently in place if indeed the intent of this Part is to address recertification as well as initial certification. Written determinations are not available within 30 days and Master Grant Agreement execution has not guaranteed that a grant agreement is timely in place.</p>	<p>No change recommended.</p> <p>While there have been circumstances in which the Department has not been able to adhere to the timelines for the Master Grant Agreements with agencies, the 30-day time frame is for making a determination after receiving an application for certification. The Department expects to be able meet that timeframe.</p> <p>Once a provider is certified, they can then enter into a Master Grant Agreement with AHS to receive funds from the Department. That is a separate process.</p>
112	<p>10.5 Several commenters noted the following: The new quality standards are weaker than the current language and they objected to the new language. Several people suggested that the current standards should either be strengthened or maintained. If the Quality Standards for Services are weakened, it would work against the legislative intent of revisions to 18 V.S.A. chapter 204A §8725 under Act 140 (2014).</p>	<p>No change recommended.</p> <p>There has been no change in the standards being used by the Department to evaluate quality. The quality standards listed in this section are the DDSD Consumer Outcomes developed by a quality work group consisting of individuals receiving services, advocates, family members and professionals in 2009. More specific indicators, which are used during Department's Quality Review process, are</p>

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		consistent with the standards in the current regulations.
113	<p>10.5 One commenter felt the evaluation process should not rely on subjective “feelings”, but must look at objective findings to determine whether people’s civil rights are protected and respected, and whether services and supports are benefit people.</p>	<p>No change recommended.</p> <p>The Quality Services Review process takes several factors into account in ensuring that a person’s civil rights are protected and respected and does not rely solely on the feelings of the person. (See response to comment #105.) A person’s feelings about their services, their lives and how they are treated is a very important part of the process.</p>
114	<p>10.5 One commenter recommended a Case Manager Certification noting the following: Certification of Agencies is very important to assure that agencies are serving the needs of clients most effectively and with the least amount of administrative cost.</p> <p>A Case Manager Certification would assure that ISAs/Plans are developed with client/consumer and their significant others, would benefit our system by decreasing the amount of cost associated with Administrative and Management within agencies, would have increased autonomy and the ethical duty to provide Client Centered Plans with less need for supervisory functions, develop a more streamlined process of reporting to DAIL the outcomes of Plans, CCMs would be required to do Peer Supervision for no cost and it would be a requirement for re certification. Re certification can be done at perhaps every 5 years.</p> <p>Certification process can be adopted either through existing Case Management Certification entities such as the CRCC: Commission for Rehabilitation Counselor Certification or can be developed here in</p>	<p>No change recommended.</p> <p>The Department will take this under consideration for the future but has decided not to make changes to case management at the current time.</p>

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	<p>Vermont. Training and coursework could be accessed through local college systems or through existing training entities already utilized by agencies. This has been discussed with a provider agency and DAIL, which was met with open mindedness. If a Certified Case Manager role is valued, we will find a way to get it done with persistence.</p>	
115	<p>10.6 One commenter was pleased to see the addition of new Section 10.6 which formally recognizes that there are non-designated developmental disability service providers. Perhaps the Section should be renamed to "Services by non-designated providers." Beyond the semantics of the section name, they were greatly concerned about the inclusion of the following sentence in Section 10.6(a): "The decision to subcontract with an entity or organization is at the discretion of the agency." They feel the language is not consistent with the Developmental Disabilities Act which says in Section 8724(6) that the Department is supposed to provide service recipients with "meaningful choices about how they live and the kinds of services they receive." The proposed language of Section 10.6(a) is also in conflict the proposed changes to Section 4.11 of the Rules (Choice of Providers).</p>	<p>No change recommended.</p> <p>People receiving services in Vermont have a variety of choices of providers including Designated Agencies, SSA's and to self-manage services. To ensure the quality and oversight required of Vermont, the decision to subcontract with an entity or organization is at the discretion of the designated agency. Because an agency has the responsibility to ensure that the provision of services is in "accordance with all applicable state and federal policies, rules, guidelines and regulations that are required of agencies" (10.6(c)) and "that all activities and standards under their Master Grant Agreements with AHS are carried out by their subcontractors (10.6(e)), an agency must have the discretion to determine whether a subcontractor has the capacity to adhere to requirements. In addition, a contract is a legal agreement to which both parties agree, so the contractor cannot be compelled to subcontract with an entity.</p> <p>Entities who wish to become certified providers have the option to do so. (See also response to comment #86 regarding non-certified providers)</p>
116	<p>10.6(a) This section should be revised to make it clear that as long as the non-designated entity or organization is</p>	<p>No change recommended.</p> <p>See response to Comment #115.</p>

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	operating in compliance with all applicable state and federal law, rules and policies, and that non-designated service provider can provide the "needed services at or below the authorized funding limit" (as required under Section 4.11(c)(1)), then decision to subcontract with a non-designated provider should be at the discretion of the recipient , and not the agency.	
117	10.6 While the proposed regulations added some additional language here and there about options, in reality, the proposals eviscerate both the self/individual management AND shared management options by injecting an agency throughout. (See Part 5 and 10.6). The agency would control just about every aspect, from needs assessments to subcontracts with all providers except direct support workers. Under the proposed scheme independent service coordination will cease to exist since service coordinators will be agency subcontractors – in direct conflict with the federal Rule that requires conflict-free case management.	The Department had decided to make changes related to the involvement of DA’s for people who self/family manage based upon the feedback provided. See responses to comments #86 and #92. System of Care Plan
	Part 11. Evaluation and Assessment of the Success of Programs	
	No comments	