#	Public Comment Received	Department Response
118	**1.47** This section, which is the definition of a subcontractor, refers to subcontractors of DVHA. Section 10.6 refers to subcontractors of agencies. This could lead to confusion. The recommendation is to add that this definition does not apply to subcontractors of agencies.	The Department added this definition, as it was to be used in the revised Grievance and Appeals section. Since the Department has now elected to restore, until a later date, the currently-adopted Grievance and Appeals section, this definition is not currently needed, and the Department agrees to remove it. (See comment and response #133) When these Regulations are amended to incorporate new Grievance and Appeals provisions, if this term is used, the Department will clarify the definition and to whom it applies.
119	**1.49** Stakeholders found the last clause in the definition of "supportive services" confusing. They recommended ending the first sentence after "sexuality groups", and adding a second sentence: "This includes other therapeutic or medically appropriate services not covered by under State Plan Medicaid when provided by licensed or certified individuals (such as therapeutic horseback riding)."	The Department agrees with this recommendation and amends the definition of "Supportive Services" to read as follows: "**Supportive Services"** means therapeutic services that cannot be accessed through State Plan Medicaid. These are therapeutically or medically appropriate services that include behavior support and consultation; assessment, consultation and training for communication supports; skills-based training such as dialectical behavior therapy skills groups or sexuality groups. This includes other therapeutic or medically appropriate services not covered under State Plan Medicaid when provided by licensed or

		certified individuals (such as therapeutic horseback riding).
120	**4.3(b)** There was a recommendation for further clarification of language of responsible DA in this section. The current language is not clear enough because the last DA someone was associated with could have been a DA who is the provider, but not the person's responsible DA.	The Department agrees to change the language as follows: "For individuals who were receiving services just prior to being in one of these facilities, an application shall be filed at the DA which was last responsible prior to the individual entering the facility."
121	**4.4(a)(4)** It was recommended to add "The DA shall be reimbursed by DAIL for all costs associated with supporting the immediate crisis." The concern is that agencies are responsible to respond to crises, and expend resources to do so, but with no assurance that their costs will be covered.	The Department does not agree that this is necessary. Agencies have resources built into their budgets to respond to crises. These include individual and local crisis funds, one-time funds and internal base funding from unutilized services that can be shifted from one person to another. This is a contract issue rather than a regulatory issue.
122	**4.6** There were several comments related to striking the sentence in 4.6, "The funding amount authorized shall be equal to the amount needed to pay for any support need requested by the applicant or family that fit within the System of Care Plan funding priorities" and replacing it with language requiring the authorized services to be *the* most cost-effective method of meeting the person's needs. One stakeholder noted that by striking the first sentence, it would allow the department to fund services below the cost needed to pay for the service. That could result in agencies being unable to deliver the needed services. They suggested alternative language "The funding amount authorized shall be equal to the amount needed to pay for any support needs that are approved and that fit within the System of Care Plan funding priority."	The Department agrees to modify the language in this section as follows: "Services and the funding amount authorized shall be based upon the most cost-effective method of meeting an individual's assessed needs, the eligibility criteria listed in Section 4.7, as well as guidance in the *System of Care Plan* and current *Medicaid Manual for Developmental Disabilities Services*. When determining cost effectiveness, consideration shall be given to circumstances in which

	It is very important that this sentence stay in the rule. The deleted language is essential. Once the Department has determined that the person is eligible and priority services are needed, sufficient funds must be given to meet that need. The deletion of this language runs contrary to the Department's responsibility to "develop, *maintain*, and monitor an equitably and efficiently allocated statewide system of community-based services *that reflect* the choices and *needs of people with developmental disabilities and their families*." 18 V.S.A. §8723(2) (emphasis added). We have not heard the Department articulate a reason for deleting this sentence. Our concern is the underfunding of approved services. The deleted language should be put back in. Another stakeholder objected to the requirement that the authorized service be *the* most cost-effective method of meeting the need. They recommended it be *a* cost-effective method of meeting the need. Individuals should not have to be unsuccessful in a series of presumed cost-effective options before being funded for what an agency has assessed would be an effective method of serving a person.	less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful." The Department revised the existing language as it implied that once an individual met a funding priority, the Department would pay for *any* support need *requested* by the family. This was never the intent and is not current practice. The revised language reflects the current method of authorizing services.
123	**4.7** The initial proposed rules that were filed for public comment included funding limitations for each program. Based upon public comment on the initially filed rules, the Department removed these sections and has proposed their inclusion in the State System of Care Plan (SOCP). There was mixed feedback from stakeholders on whether the limitations belong in the rules or in the SOCP. Some stakeholders believe the limitations are part of the criteria for receiving services or funding which must be included in the regulations. When there are proposed reductions to services or funding allocations to agencies, they want the Department to return to the legislature to make those decisions. Putting all limitations on **funding** into the System of Care Plan, and out of the LCAR process runs contrary to the plain-meaning and intent of 18 V.S.A. §1825(a).	The Department agrees that any limitation that meets the definition of "criteria for receiving funding" is required to be adopted by rule. The Department believes that the criteria for receiving services are appropriately and fully described in the proposed Rule for each priority program under the Eligibility section (Clinical, Financial and Access Criteria). The Department has re-inserted into the Rule any and all limitations related to eligibility. The remaining limitations will be included in the SOCP. The Department does not agree that "criteria

	Certain "categories" of the Department's plan for the nature, extent, allocation and timing of services must be adopted by rule. Those categories include "criteria for receiving services or funding," 18 V.S.A. §1825(a)(2). The "**criteria for receiving services or funding**" includes **funding limitations**. These must be adopted by rule, and amended by rule, rather than addressed in the SOCP or other department guidelines. The criteria for receiving funding and services, including their limitations, must be restored to the rule. Other stakeholders disagree with the above interpretation and believe that details funding limitations belong in the SOCP. They prefer the flexibility of allowing for the Commissioner to make decisions related to allocation of resources, with the advice of the State Program Standing Committee. Another stakeholder indicated that there are pros and cons to setting out funding limits in the Regulations. One obvious benefit of including limits in the Regulations is that it establishes minimum thresholds for services that could only be reduced or eliminated through a rule change. The downside of this approach is that services could only be increased by a rule change, as well. To ensure that significant reductions in funding limits receive sufficient scrutiny one commenter suggested adding a provision to the Regulations requiring legislative review of funding limit reductions of a certain magnitude. It was suggested prohibiting reductions in funding limits of 25% or greater from being made by the Commissioner in the State System of Care Plan. There is concern that in the current climate, if significant cuts are made to Medicaid, that HCBS services, which are not an entitlement, would be cut before other Medicaid entitlement services. The stakeholders agreed that they could accept the limitations remaining in the SOCP and not in the rules if the rules included language to the effect that any proposed reductions to the services or funding would go back to the legislature for approval. Specifically, it was suggested that committees of jurisdiction or joint fiscal approve any proposed reduction.	for receiving services or funding" includes limitations. The recommendation that the Department return to the Legislature for approval when there are proposed reductions to services or funding was reviewed. The statute requires the Department to utilize the rulemaking process whenever changes are proposed to any of the following 4 categories: 1) Priorities for continuation of existing programs or development of new programs; 2) Criteria for receiving services or funding; 3) Type of services provided and 4) A process for evaluating and assessing the success of programs. As such, if the Department were proposing to eliminate programs, or change the eligibility criteria or types of services offered, the Department would be required to adopt changes through the rulemaking process. It is worth noting that current law sets forth a process for legislative input and action whenever major reductions or adjustments are required by reduced State revenues or other reasons. See 32 V.S.A. §704, Interim budget and appropriations adjustments.

		This statute provides that during the Legislative session, major budget reductions or adjustments should be made, whenever possible, by an act of the Legislature. When the Legislature is not in session, this statute provides for the Secretary of Administration to prepare and implement a plan for reductions when revenue projections are below a certain threshold. Above a certain threshold, the plan must be approved by the Joint Fiscal Committee. The Department is required to follow the requirements of this statute in the event of reductions in the appropriation for Developmental Services.
124	**4.7(a)(1)(C)** It was noted that any language related to eligibility for services should be in regulation.	The Department agrees with this and adds the following to this section: "Children who are receiving care coordination, case management or service coordination from another AHS-funded source listed in the Bridge Program Guidelines are not eligible to receive Bridge Program Care Coordination."
125	**4.7(d)(1)(C)** It was noted that any language related to eligibility for services should be in regulation.	The Department agrees with this and revises this section to read as follows: "FMR is available to children up to, but not Including, age 21 living with their biological/adoptive families

		or legal guardian and who are not receiving HCBS funding."
126	**4.7(e)(1)(C)** It was noted that any language related to eligibility for services should be in regulation.	The Department agrees with this and amends this section as follows: "An individual who lives with their family (i.e., unpaid biological, adoptive and/or step-parents, adult siblings, grandparents, aunts/uncles, nieces/nephews and legal guardians) or an unpaid family member who lives with and supports an individual with a developmental disability is eligible. Individuals living independently, or with their spouse, and those receiving HCBS are not eligible."
127	**4.7(i)** The language in 4.7(i) that indicates One-Time Funding *may* be distributed to agencies and is not guaranteed. Stakeholders argue that One-Time Funding is one of the prioritized programs listed in 4.7 and as such must be funded. It is an essential funding source for goods and services that cannot be funded through other sources. They also noted that the majority of the one-time funding is retained by the department. They recommend that the regulations include guidance related to how the department uses those funds and reports on their use. Another stakeholder suggested additional language to be included, "Priority for new and returned caseload dollars from the Equity and Public Safety Funding pools shall be given to Flexible Family Funding and One Time Funds allocated to consumers to address short term needs." Another stakeholder echoed that the funds should be prioritized for the individual needs over programmatic or system investments. There is concern that flexibility in the system is being eroded.	The Department agrees to strike, "These funds may be distributed to agencies at the discretion of the Department and are not guaranteed" and replace that sentence with, "When there are one-time funds available, a portion of those funds shall be distributed to agencies." The final sentence in the section remains the same. The language contained in this section fully complies with the requirements of 18 V.S.A. § 8725, and no additional language is added.

	While we support the many initiatives supported by DAIL out of new and Returned caseload funds, we believe that the priority should go to direct funding for consumers. This is what the Legislature allocated these funds for. It was also noted that these funds that accrue annually in the One-Time Funds Program were appropriated by the legislature for the purpose of supporting client needs within the Developmental Services System. They do not believe that the legislature intended to give the Commissioner the authority to divert these funds to other programs within the Agency of Human Services, or even those under the umbrella of DAIL. Vesting the Commissioner discretion with respect to the One-Time Funds Program is contrary to the plain-meaning and intent of 18 V.S.A. §1825(a)(3). Vermont law requires that types of services be adopted by rule, and amended by rule, rather than addressed in the System of Care Plan or other department guidelines. Recommendation was to replace "These funds may be distributed to agencies at the discretion of the Department and are not guaranteed" with "The funds shall be distributed to agencies" and retain the sentence "The amount and timing of the distribution is at the discretion of the Department." The Department had suggested "Subject to availability, these funds shall be distributed to agencies." The use of "subject to availability" seems to retain the ability of the Commissioner to decide if funds will be distributed. Therefore, this change did not alleviate the concern that funds might not be distributed.	
128	**4.7(n)(1)(C)** It was noted that any language related to eligibility for services should be in regulation.	The Department agrees with this and adds the following to the end of this section: "An agency may not bill for these services and HCBS on the same day."
129	**4.7(o)(1)(C)** It was noted that any language related to eligibility for services should be in regulation.	The Department agrees with this and adds the following to the end of this section:

		"An agency may not bill for TCM and HCBS or other Medicaid funded case management services on the same day."
130	**4.9 of the initially filed rule.** Based upon the comments received after the initial filing, the Department removed section 4.9 and indicated that ways of managing insufficient funding would be addressed in the SOCP. The stakeholders agreed with the removal of the language in 4.9, but believe that the Department should return to the legislature when need for services was higher than anticipated and funding is inadequate. Rather than assume that agencies will make cuts to services for people already receiving services, the regulations should state what happens in such situations. (see comment #123)	See response to #123, and, more specifically, 32 V.S.A. §704, Interim budget and appropriations adjustments.
131	**4.10(c) and 4.10(c)(1)** It was recommended that for clarity the "amount of funding authorized at the DA" be changed to the "amount of funding authorized by DAIL."	The Department agrees to change the language from "at the DA" to "for the DA to provide services."
132	**5.3** There was an objection to the DA having a role in assisting the Supportive ISO in complex situations in 5.3. The DAs do not feel that it is appropriate for them to have a role in assisting the Supportive ISO in developing funding requests for people in complex situations needing increased funding. People who receive support from the Supportive ISO have left the DA's services and they are no longer involved. They also believe that families may not want them to involve the DA. The recommendation was to remove the DA's involvement and have the consultation come from the Department. After further discussion, there was agreement that we would include DAIL in the list of those with whom the ISO could consult. It is not a requirement to go back to the DA, the language says "may".	The Department agrees to change the second sentence as follows: "For complex situations, the Supportive ISO may consult with an independent evaluator, the Division or the local DA to determine strategies regarding how an individual's needs may best be met."
133	**8.** Removal of Grievance and Appeals language in Section 8 of the regulations and citing the Federal regulations by reference is not user friendly or adequate. The paragraph replacing the language in Part	DAIL agrees to strike the current language in its entirety and restore Sections 8.1 through 8.11, as set forth

	8 of the regulations is not in plain language that is understandable.	in the existing *Regulations.* In addition, definitions related to grievance and appeals in Section 1 that were added or amended will be deleted or changed back to the definition in the current rule. The Agency of Human Services will be developing new regulations for grievance and appeals related to Medicaid-funded services to comply with the new Federal requirements. Concurrently, DAIL will amend through rulemaking the grievance and appeal language currently in the *Regulations Implementing the DD Act.*
134	**9.5(a)** It was recommended to change the word "and" to "or" in first sentence of this section. DAIL decided to replace the word "*or"* in the first sentence with "*and,"* such that someone who might have been recently trained while working with another individual must go through all the in-service training again. This is not a cost-effective approach, so the word "*and"* should be changed back to "*or*."	The Department agrees to the following change: "(a) Within three months of being hired or entering into a contract, workers shall be trained in and demonstrate the knowledge and skills necessary to support individuals, in (a)(1) and (2) of this section. Workers shall be trained in or demonstrate knowledge and skills necessary to support individuals, in (a)(3) and (4) of this section. The employer of record, whether recipient, family, shared living provider or agency, is responsible for providing or arranging for this training for their workers." (a)(1) and (2) are related to information specific to an individual's services. (a)(3) and (4) are knowledge and

		skills needed for working with many people.
135	**9.6(a) & (b)**. Stakeholders were concerned that 96 hours (4 days) is too long to allow for untrained staff to work with people. The group recommended it be changed to 72 hours. Also, there was a suggestion to make it explicit that the exception does not apply to people with special care procedures.	The Department agrees to change section **9.6(a)** to read as follows: "For the purposes of this section "emergency" means an extraordinary and unanticipated situation of fewer than 72 consecutive hours." **9.6(b)** is amended as follows: "In an emergency, if the unavailability of a trained worker creates a health or safety risk for the individual, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 72 hours after the worker first begins to work with the individual in response to the emergency, as long as essential information about the individual is communicated to the worker and he or she has immediate access to all the documents and information covering all areas of Pre-service training (see Section 9.4)." The Department agrees to add the following to section **9.6**: (c) This exception does not apply to workers performing special care procedures. All requirements in Section 7 of these regulations must be met prior to staff performing special care procedures.