

Regulations Implementing
The Developmental Disabilities Act of 1996

Effective: October 1, 2017

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

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Part 1. Definitions

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

1.1 **“Adult”** means a person age 18 or older. The term includes people age 18 or older who attend school.

1.2 **“Agency”** means the responsible designated agency or specialized service agency.

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

1.4 **“Applicant”** means a person who files a written application for services, supports or benefits in accordance with Part 4 of these regulations. If the applicant is a guardian or family member or a designated agency, the term “applicant” also includes the person with a developmental disability. 1.5

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

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

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

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

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

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

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

1.12 **“Day”** means calendar day, not business day, unless otherwise specified.

1.13 **“Department”** means the Department of Disabilities, Aging and Independent Living.

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

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

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

1.17 **“Division”** means the Developmental Disabilities Services Division (DDSD) within the Department.

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

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

1.20 **“Fiscal Employer/Agent”** (FE/A) means an organization that is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) A person placed in an out of state school, facility, correctional center, or hospital by a department of the State of Vermont; or
- (b) A person placed and supported in an unlicensed home in an adjoining state by a Vermont agency; or
- (c) A person who meets criteria listed in Section 3.2.

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

1.35 **“Self/family-managed”** services means the recipient or his or her family plans, establishes, coordinates, maintains, and monitors all developmental disabilities services and manages the recipient’s budget within federal and state guidelines.

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

1.37 **“Service”** means a benefit:

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

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1.38 “**Service Coordination**” means assistance to recipients in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Service Coordination responsibilities include, but are not limited to, developing, implementing and monitoring the ISA; coordinating medical and clinical services; establishing and maintaining a case record; reviewing and signing off on critical incident reports; and providing general oversight of services and supports. The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.

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

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

1.41 “**Specialized service agency**” (SSA) means an agency designated by the Department that meets criteria for contracting with the Department as an SSA, as described in the Department’s *Administrative Rules on Agency Designation*, and that contracts with the Department to provide services to individuals with developmental disabilities.

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

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

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

1.45 “**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.

1.46 “**Worker**” means any employee or contractor compensated with funds paid or administered by the Department to provide services to one or more people with a developmental disability. Professionals, such as nurses or psychologists practicing under a license granted by the State of Vermont are not included within this definition. Family-hired respite workers paid by Flexible Family Funding are not included within this definition.

1.47 “**Young child**” means a person who is not yet old enough to enter first grade.

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Part 2. Criteria for determining developmental disability**2.1 Young child with a developmental disability defined.**

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

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

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

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

- Communication
- Social/emotional development
- Motor development
- Daily living skills

- (c) An Autism Spectrum Disorder (Section 2.8-2.10) resulting in significant, observable and measurable delays in at least two of the following areas of adaptive behavior:

- Communication
- Social/emotional development
- Motor development
- Daily living skills.

2.2 Criteria for assessing developmental disability in a young child.

- (a) The diagnosis of a condition which has a high probability of resulting in intellectual disability (Section 2.1(a)) shall be made by a physician or psychologist.
- (b) The documentation of significant delays in cognitive and adaptive behavior (Section 2.1(b))

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or significant delays in adaptive behavior for a young child with Autism Spectrum Disorder (Section 2.1(c)) shall be made through a family-centered evaluation process which includes the family. The evaluation process shall include:

- (1) Observations and reports by the family and other members of the assessment team, such as a physician, behavior consultant, psychologist, speech therapist, physical therapist, occupational therapist, representative from the Part C Early Intervention Team, representative from Early Essential Education (EEE), representative from Children with Special Health Needs, representative from an agency;
 - (2) A review of pertinent medical/educational records, as needed; and
 - (3) Appropriate screening and assessment instruments.
- (c) The diagnosis of Autism Spectrum Disorder shall be made according to Section 2.8-2.10.

2.3 School-age child or adult with developmental disability defined.

- (a) A school-age child (old enough to enter first grade and younger than age 18) or adult with a developmental disability is an individual who:
- (1) Has intellectual disability (Section 2.4) or Autism Spectrum Disorder (Section 2.8) which manifested before age 18 (section 2.13); and
 - (2) Has significant deficits in adaptive behavior (Section 2.11) which manifested before age 18 (section 2.13).
- (b) Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

2.4 Intellectual disability defined.

- (a) “Intellectual disability” means significantly sub-average cognitive functioning that is at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by a full scale score of 70 or below on an appropriate norm-referenced standardized test of intelligence and resulting in significant deficits in adaptive behavior manifested before age 18.
- (b) “Intellectual disability” includes severe cognitive deficits which result from brain injury or disease if the injury or disease resulted in deficits in adaptive functioning before age 18. A person with a diagnosis of “learning impairment” has intellectual disability if the person meets the criteria for determining “intellectual disability” outlined in Section 2.5.

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

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

- (1) Significantly sub-average cognitive functioning (Section 2.6 (b) – (h));
- (2) Resulting in significant deficits in adaptive behavior; and (Section 2.11)
- (3) Manifested before age 18 (Section 2.13).

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

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

- (1) Personally perform, supervise, or review assessments that document significantly sub-average cognitive functioning and deficits in adaptive behavior manifested before age 18; and
- (2) Integrate these test results with other information about the individual's abilities in arriving at a determination.

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

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

- (1) There is reason to believe the original test was invalid (e.g., the person was sick, was not wearing glasses, was in the midst of a psychiatric crisis, etc.).
- (2) The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).
- (3) The individual had mild intellectual disability on a previous test and has since made gains in adaptive behavior.

(d) If past testing of the person has resulted in some scores above 70 and some scores below 70, it is the responsibility of the psychologist to determine which scores most accurately reflect the person's cognitive ability. A determination that a person has intellectual disability for the purpose of these regulations cannot be made if a person's test scores are consistently greater than 70.

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- (e) The diagnosis in questionable cases should be based upon scores over time and multiple sources of measurement.
- (f) The diagnosis of intellectual disability shall not be based upon assessments conducted when the individual was experiencing a short-term psychiatric, medical or emotional crisis which could affect performance. Cognitive testing should not ordinarily be performed when a person is in the midst of a hospital stay.
- (g) If the psychologist determines that standardized intellectual testing is inappropriate or unreliable for the person, the psychologist can make a clinical judgment based on other information, including an adaptive behavior instrument.
- (h) The criteria for determining whether a school-aged child or adult has an intellectual disability for the purposes of these regulations is as outlined in Sections 2.5 -2.6 and not as described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

2.7 Criteria for determining whether a school-age child or adult has an Autism Spectrum Disorder and is a person with a developmental disability.

The determination of whether a school-age child or adult has an Autism Spectrum Disorder and is a person with a developmental disability for the purpose of these regulations requires documentation of the following components:

- (a) Diagnosis of an Autism Spectrum Disorder made according to process outlined in section 2.8-2.10;
- (b) Resulting in significant deficits in adaptive behavior (Section 2.11); and
- (c) Manifested before age 18 (Section 2.13).

2.8 Autism Spectrum Disorder defined.

“Autism Spectrum Disorder” means the same as it is defined in the current DSM. People receiving services as of the effective date of these regulations who were found eligible with a diagnosis of pervasive developmental disorder under previous versions of the DSM continue to be eligible for services if they continue to present the symptoms that resulted in the diagnosis. Autism Spectrum Disorder means the same as the term “autism” in the Developmental Disabilities Act.

2.9 Criteria for determining whether a person has Autism Spectrum Disorder.

- (a) The diagnostic category of Autism Spectrum Disorder includes considerable variability in the presence and intensity of symptoms. Many of the symptoms of Autism Spectrum Disorder overlap with other childhood diagnoses. Because of the complexity in differentially diagnosing Autism Spectrum Disorder, it is essential that clinicians rendering these diagnoses have specific training and experience in child development, Autism Spectrum Disorder, other developmental disorders, and other childhood psychiatric disorders.

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- (b) Preferably a comprehensive diagnostic evaluation is conducted by an interdisciplinary team of professionals with specific experience and training in diagnosing Autism Spectrum Disorder. In the absence of an interdisciplinary team, a single clinician with the qualifications listed below may conduct a multidisciplinary assessment integrating information from other professionals.
- (c) At a minimum, an evaluation shall be performed by a single clinician who has the following qualifications or an interdisciplinary team that includes:
- (1) A board certified or board eligible psychiatrist; or
 - (2) A psychologist; or
 - (3) A board certified or board eligible neurologist or developmental-behavioral or neurodevelopmental disabilities pediatrician.
- (d) The psychiatrist, psychologist, neurologist or pediatrician shall have the following additional experience and training:
- (1) Graduate or post-graduate training encompassing specific training in child development, Autism Spectrum Disorder, and other developmental and psychiatric disorders of childhood, and a process for assessment and differential diagnosis of Autism Spectrum Disorder; or supervised clinical experience in the assessment and differential diagnosis of Autism Spectrum Disorder;
 - (2) Training and experience in the administration, scoring and interpreting of psychometric tests, or training in understanding and utilizing information from psychometric testing in the diagnosis of Autism Spectrum Disorder; and
 - (3) Experience in the evaluation of individuals with the age range of the person being evaluated.
- (e) Clinicians shall follow the ethical guidelines for their profession regarding practicing within their area of expertise and referring to other professionals when needed. When a single clinician is conducting the assessment, he or she should determine whether other professionals need to evaluate the person to gain additional information before rendering a diagnosis. Additional evaluators may include psychologists, speech language pathologists, medical sub-specialists, developmental-behavioral or neurodevelopmental disabilities pediatricians, occupational therapists, psychiatrists, and neurologists. For evaluations of children from birth to age six, a developmental-behavioral or neurodevelopmental disabilities pediatrician or pediatric neurologist shall perform the assessment or be part of the assessment team.
- (f) In the event a shortage of qualified assessors prevents timely evaluations, the state shall assist agencies to identify available qualified assessors or may, in its discretion, waive the provision of rule 2.9(d).

2.10 Essential components of an assessment to determine Autism Spectrum Disorder.

New applicants must be assessed using the DSM criteria in effect at the time of application. An assessment to determine whether an individual has an Autism Spectrum Disorder shall include all of the following components:

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- (a) Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history;
- (b) Systematic Autism Spectrum Disorder diagnostic interview with primary caregivers;
- (c) A systematic observation with the individual to assess social interaction, social communication, and presence of restricted interests and behaviors;
- (d) For older children and adults who can report symptoms, a systematic clinical interview;
- (e) Referral for multidisciplinary assessment, as indicated;
- (f) 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; and
- (g) Current assessments based upon the individual's typical functioning.

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

(2) The initial diagnosis of Autism Spectrum Disorder shall not be based upon assessments and observations conducted when the individual is experiencing a psychiatric, medical or emotional crisis or when a person is in the midst of a hospital stay. Further assessment should be completed when the person stabilizes and/or returns to the community.

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

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

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

2.11 Significant deficits in adaptive behavior defined.

"Significant deficits in adaptive behavior" means deficits in adaptive functioning which result in:

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

2.12 Criteria for assessing adaptive behavior in a school-age child or adult.

- (a) Adaptive functioning shall be measured by the current version of a standardized norm-referenced assessment instrument. The assessment tool shall be standardized with reference to people of similar age in the general population. Adaptive functioning shall not be measured with an instrument that is norm-referenced only to people in institutions or people with intellectual disability or Autism Spectrum Disorder.
- (b) The assessment instrument shall be completed by a person qualified to administer, score, and interpret the results as specified in the assessment tool's manual.
- (c) The assessment shall be current. A current assessment is one which was completed within the past three years, unless there is reason to think the individual's adaptive functioning has changed.
- (d) Based upon the assessment, the evaluator shall determine whether the person is performing two or more standard deviations below the mean with respect to adaptive functioning, compared to a national sample of similar-aged people.
- (e) Ordinarily, assessments shall be based upon the person's usual level of adaptive functioning. Assessments shall not ordinarily be performed when the individual is in the midst of an emotional, behavioral or health crisis, or should be repeated once the individual stabilizes. An assessment performed while the individual was in a nursing facility or residential facility shall be repeated when the individual is in a community setting.
- (f) It is the responsibility of the psychologist to ensure that the adaptive behavior assessment is based upon information from the most accurate and knowledgeable informant available. It may be necessary to integrate information on adaptive functioning from more than one informant.

2.13 Manifested before age 18

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

2.14 Nondiscrimination in assessment

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

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- (a) People whose background or culture differs from the general population shall be assessed with methods and instruments that take account of the person's background.
- (b) A person shall be assessed in the language with which he or she communicates most comfortably.
- (c) People with language, motor, and hearing disabilities shall be assessed with tests which do not rely upon language, motor ability, or hearing.
- (d) If a person uses hearing aids, glasses, or other adaptive equipment to see, hear, or communicate, the evaluator shall ensure that the individual has access to the aids or adaptive equipment during the evaluation.
- (e) If a person uses a language interpreter or a method of augmentative and alternative communication and or needs a personal assistant for communication, the evaluator (e.g., the psychologist) is responsible for deciding how best to conduct the overall assessment in order to achieve the most authentic and valid results. However, scores for standardized tests are valid only if testing was performed in accordance with the criteria set forth in the test manual.

Part 3. Recipient Criteria**3.1 Who can be a recipient**

- (a) A recipient shall be an individual with a developmental disability as defined in Part 1 who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.
- (b) Services or supports to a family member of a recipient shall be in the context of supporting the recipient and are for the purpose of assisting the family to provide care and support for their family member with a developmental disability.

3.2 Recipients shall be Vermont residents

- (a) A recipient shall be a resident of Vermont. In the case of a minor child, at least one custodial parent of the child shall be a resident of Vermont.
- (b) A person or family who leaves Vermont for a vacation, visit, temporary move, or trial move may continue to be a recipient for a period not to exceed six months.

3.3 Exceptions

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

3.4 People receiving services on July 1, 1996

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

3.5 Eligibility after leave of service

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

Part 4. Application, Assessment, Funding Authorization, Programs and Funding Sources, Notification, Support Planning and Periodic Review**4.1 Who may apply**

- (a) Any person who believes he or she has a developmental disability or is the family member of such a person may apply for services, supports, or benefits. In addition, the guardian of the person may apply.
- (b) Any other person may refer a person who may need services, supports, or benefits.
- (c) An agency or a family member may initiate an application for a person with a developmental disability or a family member but shall obtain the consent of the person or guardian to proceed with the application.

4.2 Application form

- (a) The Department shall adopt an application form to be completed by or on behalf of all applicants. The DA shall provide a copy of the application to all people who contact the DA saying they wish to apply for services.
- (b) Copies of the application form shall be available from the Department, on the Department's website, and from every office of a DA. A person may request an application form in person, by mail, by electronic format, by facsimile (FAX), or by telephone.
- (c) The DA shall provide assistance to an applicant who needs or wants help to complete the application form.

4.3 Where to apply

- (a) An application shall be filed at an office of the DA for the geographic area where the person with a developmental disability lives.
- (b) An application for a person, who is new to services, who is incarcerated or living in a residential school, facility or hospital shall be filed at an office of the DA for the geographic area where the person was living before going to the school, facility or hospital. For individuals who

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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.

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

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

4.4 Screening

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

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

(2) Notifying the applicant of the rights of recipients, including the procedures for filing a grievance or appeal;

(3) Discussing options for information and referral; and

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

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

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

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

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

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

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

4.5 Assessment

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- (a) The DA is responsible for conducting the assessment or assuring that it is conducted. The assessment process shall involve consultation with the applicant, and, with the consent of the applicant, other organizations which support the applicant.
- (b) The DA shall offer information and referral to the applicant at any time that it may be helpful.
- (c) Assessment consists of in-depth information-gathering to answer the four following questions:
 - (1) Is this a person with a developmental disability, as defined in Part 1 of these regulations, and a person eligible to be a recipient, as defined in Part 3? If so,
 - (2) What does the person or his or her family need? This question is answered through a uniform needs assessment and process approved by the Department, which determines with each person or family their service or support needs, including identification of existing supports and family and community resources.
 - (3) Does the situation of the person or family meet the criteria for receiving any services or funding defined as a funding priority in Section 4.7 of these regulations? If so,
 - (4) What are the financial resources of the person with a developmental disability and his or her family to pay for some or all of the services?

4.6 Authorization of funding for services

Based on the answers to the questions in Section 4.5(c), the DA shall seek or authorize funding for services to meet identified needs or shall determine that the individual is not eligible for the requested funding for services. The procedures for authorizing funding or services are described in the *System of Care Plan*. Services and the funding amount authorized 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 less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful.

4.7 Available Programs and Funding Sources

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

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

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

(1) Eligibility**(A) Clinical:**

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

(B) Financial:

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

(C) Access Criteria:

Individual must be under the age of 22.

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

(b) Developmental Disabilities Specialized Services Fund

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

(1) Eligibility**(A) Clinical:**

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

(B) Financial:

None

(C) Access Criteria:

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

(c) Employment Conversion

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

(1) Eligibility**(A) Clinical:**

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

(B) Financial:

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

(C) Access Criteria:

Individuals with HCBS funding who must have transferred at least 50% of their existing community supports funding to work supports.

(d) Family Managed Respite

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

(1) Eligibility**(A) Clinical:**

Individual with a developmental disability or eligible to receive services from Children's Mental Health Services.

(B) Financial:

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

(C) Access Criteria:

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

(e) Flexible Family Funding

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

(1) Eligibility**(A) Clinical:**

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

(B) **Financial:**

Income-based on sliding fee scale outlined in *Flexible Family Funding Guidelines*.

(C) **Access Criteria:**

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

(f) **Growth and Lifelong Learning**

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

(1) **Eligibility**

(A) **Clinical:**

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

(B) **Financial:**

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

(C) **Access Criteria:**

Access is limited to the geographic area where the approved program is provided.

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

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

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

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(1) Eligibility**(A) Clinical:**

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

(B) Financial:

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

(C) Access Criteria:**(i) Must meet all 3 of the following criteria:**

- (1) Individual would otherwise be eligible for Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD) level of care;
- (2) The individual has an unmet need related to their developmental disability; and
- (3) The individual's unmet need meets one of the following six funding priorities for HCBS.

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

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

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

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

(C) Preventing Institutionalization – Nursing Facilities: Ongoing, direct supports and/or supervision needed to prevent or

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end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. [Priority is for children and adults.]

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

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

(F) Parenting: Ongoing, direct supports and/or supervision needed for a parent with developmental disabilities to provide training in parenting skills to help keep a child under the age of 18 at home. Services may not substitute for regular role and expenses of parenting. [Priority is for adults age 18 and over.]

(2) Public Safety Funding Criteria

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

(A) Criteria for Eligibility for Public Safety Funding:

- (i) For new applicants, the public safety risk must be identified at the time of application and applicants must meet the Public Safety Funding priority criteria below.
- (ii) For individuals currently receiving services, the public safety risk must be newly identified and recipient must meet the Public Safety Funding priority criteria below.
- (iii) The Department's Public Safety Risk Assessment must be completed or updated for each individual who applies for Public Safety Funding in accordance with the *Protocols for Evaluating Less Restrictive Placements and Supports for People with I/DD who Pose a Risk to Public Safety*.
- (iv) An individual must have proposed services that reflect offense-related specialized support needs and meet at least one of the following criteria:

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- (1) Committed to the custody of the Commissioner under Act 248 due to being dangerous to others. Services are legally mandated.
 - (2) Convicted of a sexual or violent crime, has completed their maximum sentence, and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense. Examples of “evidence” may include; recent clinical evaluations and/or recent treatment progress reports which indicate a continued risk to the public; recent critical incident reports which describe risks to public safety; and/or new criminal charges or DCF substantiations which involve harm to a person. Additional supporting evidence may be taken into account.
 - (3) Substantiated by the Department or DCF for sexual or violent abuse, neglect, or exploitation of a vulnerable person and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense.
 - (4) In the custody of DCF for committing a sexual or violent act that would have been a crime if committed by an adult, now aging out of DCF custody, and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense.
 - (5) Not charged with or convicted of a crime, but the individual’s risk assessment contains evidence that the individual has committed an illegal act and still poses a substantial risk of committing a sexual or violent offense.
 - (6) Convicted of a crime and under supervision of the Department of Corrections (DOC) (e.g., probation, parole, pre-approved furlough, conditional re-entry) and DOC is actively taking responsibility for supervision of the individual for public safety. Public Safety Funding only pays for supports needed because of the individual’s developmental disability. Offense-related specialized support needs, such as sex offender therapy, cannot be funded by the Department for an individual who is under the supervision of DOC.
- (B) Access Restrictions:
- (i) It is not a priority to use Division funding to prevent an individual who has been charged with or convicted of a crime from going to or staying in jail or to prevent charges from being filed.
 - (ii) Public Safety Funding shall not be used to fund services for individuals believed to be dangerous to others but for whom there is no clear evidence they pose a risk to public safety, and who have not committed an act that is a crime in Vermont. These individuals may be funded if the individual meets another funding priority.

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(iii) Public Safety Funding shall not be used to fund services for individuals who have committed an offense in the past, and:

(1) Whose proposed services do not reflect any offense-related specialized support needs, or

(2) Who do not still pose a risk to commit a sexual or violent offense.

(h) **Intermediate Care Facility for Individuals with Developmental Disabilities**

Vermont has one six-person ICF/DD. This residence enables Vermont to provide comprehensive and individualized health care and rehabilitation services to individuals, as an alternative to HCBS, to promote their functional status and independence at an ICF/DD level of care.

(1) **Eligibility**

(A) Clinical:

(i) Individuals who meet the criteria for developmental disability as defined in these regulations.

(ii) Individual must have significant medical needs.

(iii) Individuals must meet nursing home level of care, as well as ICF/DD level of care as defined by CMS.

(B) Financial:

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

(C) Access Criteria:

Access to the ICF/DD is based upon availability of a bed and prioritization of referrals by the operating DA and the Division.

(i) **One Time Funding**

One time funds are generated from the new and returned caseload dollars for the Equity and Public Safety funding pools. One time funds are used to address short term needs and cannot be used for long term needs. When there are one-time funds available, those funds shall be distributed to agencies. The amount and timing of distribution is at the discretion of the Department.

(1) **Eligibility**

(A) Clinical:

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

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

(C) **Access Criteria:**
Recipients and individuals who meet clinical and financial eligibility who are not current recipients of funding to meet one of the needs listed below:

(2) Allowable Uses for One-Time Funding by Agencies and Supportive ISO:

(A) One-time funding must be prioritized for use as Flexible Family Funding (FFF).
One-time allocations used as FFF for individuals with developmental disabilities and families waiting for FFF are not to exceed the FFF maximum allocation per person per year, regardless of source.

(B) One-time allocations to address personal health or safety or public safety issues for individuals with developmental disabilities.

(C) Short-term increases in supports to individuals already receiving services to resolve or prevent a crisis.

(D) Assistive technology, adaptive equipment, home modifications to make the individual's home physically accessible, and other special supports and services not covered under the Medicaid State Plan.

(E) Supports that may not meet funding priorities but are proactive and short-term in nature.

(F) Transitional support to assist an adult to become more independent in order to reduce or eliminate the need for services.

(G) Small grants to self-advocates, families and others that promote the Principles of Developmental Disabilities Services; for innovative programs that increase a consumer's ability to make informed choices, promote independent living, and offer mentorship or career building opportunities.

(H) Funding for people receiving developmental disabilities services to attend a training or conference that increases consumer ability to make informed choices, promote independent living, offer mentorship or career building opportunities. One time funds can only be used to cover the costs of training/conference registration fee and/or transportation costs for the individual, if needed, to attend a training or conference.

(j) Post-Secondary Education Initiative

The Post-Secondary Education Initiative (PSEI) is a program funded through a combination of grants and HCBS funding that assists transition age youth 18 to 28 with developmental disabilities to engage in typical college experiences through self-designed education plans that lead to marketable careers in competitive employment and independent living. Supports are arranged with

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the Department's approved PSEI college support organizations to provide academic, career and independent living skill development through a peer mentoring model.

(1) Eligibility**(A) Clinical:**

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

(B) Financial:

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

(C) Access criteria:

Adults who have graduated from high school or have a GED who have been accepted for enrollment in post-secondary programs facilitated by the PSEI support programs. The individual must also have access to resources that are needed to participate beyond what is provided by the PSEI program.

(k) Pre-Admission Screening and Resident Review (PASRR) Specialized Services

PASRR Specialized Services are available to individuals living in a nursing facility and who need additional services related to their developmental disability (e.g., social, behavior, communication) that are beyond the scope of the nursing facility.

(1) Eligibility**(A) Clinical:**

Individual with a developmental disability or related condition as defined by Federal PASRR regulations.

(B) Financial:

None

(C) Access Criteria:

Individual over 18 years of age living in a nursing facility and having been determined to be in need of Specialized Services through PASRR evaluation.

(l) Projects for Transition Support

These Department approved projects prepare student-interns who are in their last year of high school

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with technical skills through internship rotations at a host business location. The cornerstone of these projects is immersion in a single business for the entire school year where students learn career development skills through job coaching and direct guidance provided by the business' department managers.

(1) Eligibility**(A) Clinical:**

Individuals who meet the criteria for developmental disability as defined in these regulations (see exceptions in Access Criteria Section (1)(1)(C)).

(B) Financial:

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

(C) Access Criteria:

This program serves students in their last year of high school who have been determined to have developmental disabilities. If space allows, adults between the ages of 21 and 28 may apply to the program on a case-by-case basis. In addition, if space allows, students who receive special education and do not have developmental disabilities, but do have other challenges that are supported by an Individual Education Plan (IEP), may apply on a case-by-case basis.

(m) Public Guardianship Fund

This fund pays for unanticipated services and for small expenses directly related to the well-being of individuals receiving public guardianship services. Access to funds is at the discretion of the Division's Office of Public Guardian.

(n) Special Populations Clinic and Rehabilitation Services

Clinic and Rehabilitation services are mental health services provided within a community mental health or developmental disability service setting for individuals who are not receiving HCBS funding. Services include:

- diagnosis and evaluation (D & E)
- individual psychotherapy
- group therapy
- emergency care
- Medication Evaluation, Management and Consulting Services (Chemotherapy, med-Check)

(1) Eligibility

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(A) Clinical:

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

(B) Financial:

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

(C) Access Criteria:

Access to these services is determined by the agency based upon need and available resources. An agency may not bill for these services and HCBS on the same day.

(o) Targeted Case Management for Persons with Developmental Disabilities

Targeted Case Management (TCM) is a Medicaid State Plan service that provides assessment, care planning, referral and monitoring. Services are provided by the agency and designed to assist adults and children to gain access to needed services.

(1) Eligibility**(A) Clinical:**

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

(B) Financial:

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

(C) Access Criteria:

TCM is available for adults age 21 and over, and children under 21 when the agency has exhausted Bridge Program funding. An agency may not bill for TCM and HCBS or other Medicaid funded case management services on the same day.

4.8 Special initiatives

The Division may invest in initiatives that enhance the overall system of support for people with developmental disabilities and their families. The Division may use funding to support initiatives that shall enhance choice and control, and increase opportunities for individuals receiving developmental disabilities services and their families. The timing and amount of funding for any initiative shall be identified in the *System of Care Plan*. For all special initiatives, specific outcome measures will be required and results will be reported by DDS.

4.9 Notification of decision on application**(a) Timing of the notices**

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- (1) Within 45 days of the date of the application, the DA shall notify the applicant in writing of the results of the assessment and the amount of funding, if any, which the applicant shall receive.
 - (2) If the assessment and authorization of funding is not going to be completed within 45 days of the date of application, the DA shall notify the applicant in writing of the estimated date of completion of the assessment and authorization of services or funding. A pattern of failure to complete the process within 45 days shall be taken into account in determining whether to continue the designation of an agency.
- (b) Content of notices
- (1) If some or all of the services requested by the applicant are denied, or the applicant is found not eligible the written notice shall include information about the basis for the decision, and how to the appeal the decision, including:
 - (A) The policy or citations the action is based on (e.g., funding priorities, regulations);
 - (B) The right to appeal the decision and the procedures for doing so (see Part 8);
 - (C) Resources for legal representation (such as Disability Law Project).
 - (2) If the assessment determines the applicant has a developmental disability and has needs that fit within the funding priorities outlined in section 4.7, the notice shall state the amount of funding and services the applicant shall receive. The notice shall also state what costs, if any, the recipient is responsible to pay (Section 6).
 - (3) If the assessment determines the applicant does not have a developmental disability, the notice shall state that the DA shall continue to offer information and referral services to the applicant.
 - (4) If the assessment determines the person has a developmental disability but does not meet a funding priority to receive services or funding, the notice shall state that the DA shall continue to offer information and referral services and shall place the person's name on a waiting list (Section 4.18).

4.10 Choice of provider

- (a) The DA shall help a recipient learn about service options, including the option of self/family-managed services.
 - (1) 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

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- and information shared as part of this process. The DA shall provide the choices in an unbiased manner to reduce the potential for conflict of interest.
- (2) If the recipient is not self/family-managing services, the DA shall ensure that at least one provider within the geographic area offers the authorized services at or below the amount of funding authorized at the DA.
- (3) 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) The recipient or family may receive services from any willing agency in the state.
- (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.
- (b) If the recipient's needs are so specialized that no provider in the geographic area can provide the authorized services, the DA may, with the consent of the recipient, contract with a provider outside the geographic region to provide some or all of the authorized services.
- (c) The recipient may choose to receive services from an agency other than the DA if the agency agrees to provide the authorized services at or below the amount of funding authorized for the DA to provide services.
- (1) When requesting new funding, if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider shall submit a budget to the DA and the DA shall determine its costs to serve the individual and shall submit the lower of the two budgets to the funding committee. If an alternative provider is not able to provide the services at the lower approved budget, the DA must do so at the amount of funding authorized for the DA to provide services.
- (2) 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.
- (3) When an individual chooses to transfer to another agency or to self/family-manage, the receiving agency or Supportive ISO must fully inform the recipient and the individual's designated representative, if applicable, prior to the transfer, of the impact on the amount of services that can be provided within the approved budget based upon the agency or Supportive ISO's costs for services.
- (4) Any disputes about the amount of funding to be transferred shall be resolved by the director of the Division.
- (d) The recipient may choose to self/family-manage services (See Part 5).

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4.11 Individual support agreement (ISA)

- (a) Once a recipient has received written authorization of services or funding (Section 4.7), the recipient, together with the agency or Supportive ISO, writes an ISA that defines the services and supports to be provided. The recipient may ask any person to support him or her in establishing a person-centered process, making decisions, and choosing services, supports and/or providers.
- (b) The agency or the Supportive ISO (in the case of self/family-managed services), has ultimate responsibility to ensure that an initial ISA is developed within 30 calendar days of the first day of billable services/supports. This timeline may be extended at the request of the recipient as specified in the *ISA Guidelines*.
- (c) Initial and ongoing ISAs shall be written and reviewed in accordance with the Department's *ISA Guidelines*. A written ISA is required even if the recipient chooses to self/family-manage services.
- (d) The ISA is a contract between the recipient and provider(s) who provides the service or support.
- (e) An ISA may be revised at any time.

4.12 Periodic review of needs

- (a) The needs of each individual currently receiving services shall be re-assessed annually by the agency or Supportive ISO, together with the individual and his or her team, using the needs assessment to assure the individual's budget reflects current needs, strengths and progress toward personal goals. An Annual Periodic Review shall take place as part of the planning for the individual's next ISA or ISA review. This shall include an examination of the utilization of services in the past year as compared to the authorized funding limit. The individual's budget shall be adjusted to reflect current needs.
- (b) The agency or Supportive ISO shall make adjustments in a recipient's budget and/or services, if indicated, based upon the following:
 - (1) Changes in the recipient's needs;
 - (2) Changes in use of funded services;
 - (3) Changes in the cost of services to meet the needs;
 - (4) Changes in the *System of Care Plan* or these regulations; or
 - (5) Changes in funds available due to insufficient or reduced appropriation or an administrative arithmetic error.

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- (c) As part of the periodic review, the agency or Supportive ISO shall ask each recipient about his or her satisfaction with services, and provide each recipient and individual's designated representative with an explanation of the rights of recipients and how to initiate a grievance or appeal (See Part 8).
- (d) If a periodic review results in a determination that services or funding should be reduced, changed, suspended or terminated, the agency or Supportive ISO shall notify the recipient as provided in Section 4.16 and Part 8.

4.13 Full reassessment of a young child

- (a) The agency or Supportive ISO shall conduct or arrange for a full clinical reassessment of a child at the time he or she enters first grade to determine whether the child is a person with a developmental disability. Assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.
- (b) *Exception:* A child receiving limited services as the result of a diagnosis of Autism Spectrum Disorder does not need to be reassessed to confirm the diagnosis of ASD at the time he or she enters first grade. An adaptive behavior assessment is required at this time to confirm the child continues to have significant deficits in adaptive behavior as defined in Part 2.
- (c) If the reassessment determines that the child is no longer a person with a developmental disability, benefits for the child and family shall be phased out as provided in section 4.15(b) of these regulations.

4.14 Full reassessment (transition from high school to adulthood)

- (a) The agency or Supportive ISO shall conduct or arrange for a full clinical reassessment and a reassessment of needs of a recipient one year prior to his or her last month of high school. If the agency or Supportive ISO has less than one year's prior notice of the person's leaving high school, it shall conduct the reassessment as soon as it learns that the person is going to leave high school or has left high school. The reassessment shall consider (1) whether the young adult is a person with a developmental disability and (2) the future service and support needs of the person and his or her family. The needs assessment should be reviewed and updated prior to requesting funding if there have been significant changes in circumstances that impact services and supports needed. Any assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.
- (b) If the reassessment determines that the young adult is no longer a person with a developmental disability, services to the young adult and his or her family shall be phased out as provided in Section 4.15(b) of these regulations.
- (c) If the reassessment determines that the support needs of the person or family will change or increase when the young adult is no longer in school, the ISA and budget shall be reviewed in accordance with this section.

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4.15 Full reassessment

- (a) The agency or Supportive ISO shall conduct or arrange for full clinical reassessment of an adult or child if there is reason to believe the person may no longer have substantial deficits in adaptive behavior, or may no longer have a developmental disability.
- (b) If the reassessment determines that the individual is no longer a person with a developmental disability, services to the person shall be phased out within twelve months or less, unless the individual is eligible to continue to receive services based on Section 3.4. Upon the determination of ineligibility, the agency or Supportive ISO shall provide timely notice of the decision to the recipient and the individual's designated representative, if applicable, and as provided for in Section 4.16 and Part 8.

4.16 Notification of results of reassessment or periodic review

- (a) If a reassessment or review results in a determination that the recipient is no longer eligible, or services should be reduced, suspended, or terminated, the agency or Supportive ISO shall notify the recipient and individual's designated representative, if applicable, in writing of the results of the review or reassessment, and of the right to appeal the decision. The notification shall be mailed at least 11 days prior to the planned change unless an exception in Medicaid Rule 4150(B) is met.
- (b) The notice shall include the following:
 - (1) A statement of the adverse benefit determination the agency or Supportive ISO intends to take;
 - (2) When it intends to take the adverse benefit determination;
 - (3) The reasons for the intended adverse benefit determination;
 - (4) The policy or citations on which the adverse benefit determination is based (e.g., *System of Care Plan*, these regulations);
 - (5) The right to appeal the decision and the procedures for doing so (See Part 8);
 - (6) A statement that services may continue at the current level if the appeal is filed in accordance with the timelines contained in Part 8; and
 - (7) Resources for legal representation (such as the Disability Law Project).

4.17 Notices

- (a) Notices shall be written in language and in a form that the applicant or recipient can understand.
- (b) The agency or Supportive ISO shall ensure that someone shall explain the contents of any written notice to an applicant or recipient who cannot read.

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4.18 Waiting list

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

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

- (1) Individuals eligible for HCBS based on their developmental disability, including those already receiving services, but whose request for services is denied, in whole or in part, because the individual's needs do not meet a funding priority.
- (2) Individuals eligible for, but denied, FFF because of insufficient funds (including people who receive partial funding and/or one-time funding).
- (3) Individuals eligible for, but denied, TCM because of insufficient funds.
- (4) Individuals eligible for, but denied, FMR funds because of insufficient funds.
- (5) Individuals eligible for, but denied, PSEI funds because of insufficient funds or lack of capacity of the PSEI program to support additional students.

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

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

Part 5. Self/Family-Managed Services

Many individuals receiving services, or a family member of an individual receiving services, can manage the services instead of having the services managed by an agency. Individuals may manage their services either independently or with the help of their families. An individual or a family member may manage up to 8 hours a day of paid home supports.

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Self/family-management is a service option that is designed to provide choice and control to an individual or family. Self/family-management requires individuals or their family members to hire and oversee their own employees and function as the employer of record. Except for supportive services, clinical services provided by licensed professionals, or camps that provide respite, individuals and families may not purchase services from a non-certified entity or organization.

In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in Section 5.2. A Supportive ISO makes this determination.

An individual or a family member also has the option of managing *some, but not all*, of the services and have an agency manage some of them. This arrangement is called shared-managing. Section 5.7 explains how shared-managing works.

5.1 Self/Family-Management Agreement

An individual or family member who is allowed to manage services must sign an agreement with a Supportive ISO. The Department shall provide an approval form for agreements. The agreement must set out the responsibilities of the individual or family member and the responsibilities of the Supportive ISO.

5.2 Responsibilities of an individual or family member who manages services

An individual or family member who manages services must be capable of and carry out the following functions:

- (a) Maintain Medicaid eligibility for the individual receiving services. Immediately notify the Supportive ISO of any circumstances that affect Medicaid eligibility.
- (b) Develop an ISA that reflects what services the individual needs and how much money the individual has been provided in their budget to spend for those services. Follow the Department's *ISA Guidelines* to ensure that all required information is included. The plan must specify what each service is supposed to be and how much each service shall cost on an annual basis. The ISA must also identify the individual's service provider(s) and explain how the services received shall be documented.
- (c) Ensure that services and supports are provided to the individual in accordance with the ISA and the budget .
- (d) Maintain a complete and up-to-date case record that reflects details regarding the delivery of services. Follow the *Guide for People who are Self- Family-Managing* regarding what needs to be included in the case record. Retain case records in accordance with the record retention schedule adopted by the Department.
- (e) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are in Section 10.5 of these regulations.
- (f) Understand the individual's ISA and their budget. Make necessary changes based on the individual's needs. Follow these regulations and the Department's *ISA Guidelines* regarding what to do when there is a change.

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- (g) Follow the Department's *Health and Wellness Guidelines* to take care of the individual's health and safety.
- (h) Follow the rules about reporting critical incidents to the Supportive ISO. Make sure the reports are filed in accordance with the specific timeline required by the Department's *Critical Incident Reporting Guidelines*.
- (i) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.
- (j) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.
- (k) Prepare written back-up plans for when the plan cannot be followed (e.g., a worker gets sick and/or does not show up for work). Include in the plan who shall come and work and what shall happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.
- (l) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.
- (m) Follow the requirements of the Housing Safety and Accessibility Review Process to ensure the individual is living in a safe and accessible home.
- (n) Take the following steps when hiring workers:
- (1) Write a job description. Complete reference checks before allowing the worker to start work;
 - (2) Interview and hire workers that meet the requirements of the Department's Background Check Policy, or who receive a variance when there is an issue with the background check;
 - (3) Sign up with the state contracted FE/A. Give the FE/A all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;
 - (4) Train or have someone else train all workers in accordance with these regulations. The rules are in the Department's pre-service and in-service standards in Part 9;

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- (5) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets to verify they reflect the actual hours worked. Sign and send accurate timesheets to the FE/A;
- (6) Suspend or fire workers as necessary; and
- (7) Follow all Department of Labor rules required of employers, including paying overtime as required.
- (o) Manage services in accordance with the Department's *Guidelines for People who are Self-Family-Managing Services*.
- (p) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the Supportive ISO for assistance in determining what expenses are reimbursable.

5.3 Role of the Designated Agency

For existing recipients who are self/family managing who have a new need as determined by a new needs assessment and need an increase in services and funding, the Supportive ISO develops and submits proposals to the Supportive ISO funding committee and then to the appropriate statewide funding committee. For complex situations, the Supportive ISO may consult with an independent evaluator, the Division or the local DA to determine strategies regarding how an individual's needs may best be met. This may include a collaborative effort between the Supportive ISO and DA regarding assessments and funding proposals as needed.

5.4 Role of Qualified Developmental Disability Professional (QDDP)

- (a) An individual or family member who manages services must choose someone to be his or her independent QDDP or must ask the Supportive ISO to find a QDDP for him or her.
- (b) All QDDP's must meet the criteria specified in the Division's *Qualified Developmental Disabilities: Definitions, Qualifications and Roles*. For QDDPs employed by an agency, the agency is responsible for ensuring that the QDDP meets that criteria. QDDPs not employed by an agency, including those working for the Supportive ISO, must be endorsed by the Department as an independent QDDP, before being paid as a QDDP.
- (c) The QDDP shall:
 - (1) Approve the individual's ISA and ensure that it is signed by the individual and guardian, if there is one;
 - (2) Confirm that the ISA is being carried out the way it is supposed to be and that it meets the needs of the individual;

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- (3) Confirm that services and supports are delivered the way the Department and Medicaid regulations and guidelines require;
- (4) Contribute to the periodic review of the individual's needs conducted by the Supportive ISO;
- (5) Confirm the ISA is updated to show the changes in the individual's needs and goals;
- (6) Approve any changes to the ISA; and
- (7) Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996.

5.5 Responsibilities of a Supportive ISO when an individual or family member manages services

When an individual or family member manages services, the Supportive ISO shall:

- (a) Provide support and assistance to the individual or family member to ensure he or she understands the responsibilities of managed services including following all policies and guidelines for the Division. Explain managed services and the individual's or family member's employer role and responsibilities;
- (b) Conduct periodic reviews with contributions from the QDDP, make adjustments to budgets as needed and notify the individual of his or her rights under these regulations;
- (c) Confirm the individual's Medicaid eligibility on an annual basis;
- (d) Help the individual or family member to develop an authorized funding limit (AFL), provide guidance in self-managing the AFL, ensure the AFL is not managed by a third party, as well as, provide assistance in determining whether a service is reimbursable under Department rules. Provide the FE/A with the individual's AFL;
- (e) Bill Medicaid according to the procedures outlined in the provider agreement between the Supportive ISO and the Department;
- (f) Review requests for more money and seek funding according to the process outlined in Section 4 of these regulations and the *System of Care Plan*. Requests for short term increases in funding shall be addressed internally by the Supportive ISO. Requests for long term increases shall be sent to the appropriate statewide funding committee;
- (g) Confirm that the individual has a current ISA that reflects the areas of support funded in the budget and identifies and addresses any known health and safety concerns;
- (h) Provide QDDP services when requested. QDDP services are a separately purchased service;

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- (i) Maintain a minimum case record in accordance with the requirements outlined in the *Guide for People who are Self- or Family-Managing*. Make sure that the individual or family member responsible for managing services understands that the individual must have a complete case record in accordance with the requirements outlined in the *Guide for People who are Self- or Family-Managing*. Retain case records in accordance with the record retention schedule adopted by the Department;
- (j) Review and appropriately manage all reported critical incidents. If applicable, report the critical incidents to the Department in accordance with requirements in the *Critical Incident Reporting Guidelines*;
- (k) Provide information about the Division's crisis network to the individual or family member responsible for managing services;
- (l) Determine that the individual or family member who is managing the services is capable of carrying out the duties by conducting an initial assessment and providing ongoing monitoring;
- (m) Provide required pre-service and in-service training to the individual's support workers if the individual or family member does not provide that training. The training requirements are located in Part 9 of these regulations; and
- (n) Form and consult with an advisory committee.

5.6 Determination that the individual or family member is unable to manage services

- (a) The Supportive ISO can terminate the management agreement if it decides that the individual or family member is not capable of managing services. If the individual's or family member's management agreement is terminated, then the individual's services shall be provided by the individual's DA or from a SSA willing to provide services. Unless it is an emergency, the Supportive ISO has to inform the individual or family member at least 30 days before terminating the agreement.
- (b) The Supportive ISO may decide that the individual or family member is not capable of managing services for one or more of these reasons:
 - (1) The managed services put the individual's health or safety at risk (the agreement can be terminated immediately if the individual is in imminent danger);
 - (2) The individual or family member is not able to consistently arrange or provide the necessary services;
 - (3) The individual or family member refuses to participate in the Division's quality assurance reviews; or
 - (4) Even after receiving training and support, the individual or family member is not substantially or consistently performing his or her responsibilities for self/family-

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management as outlined in Section 5.2. This includes not following policies, regulations, guidelines, or funding requirements or not maintaining and/or ensuring proper documentation for developmental disabilities services. The Supportive ISO shall document substantial non-performance as follows:

- (A) When the Supportive ISO discovers an issue, they shall notify the individual or family member in writing of the issue and what is needed to correct the issue along with a timeline to do so; and offer support and training to the individual or family member as needed;
- (B) If the individual or family member has not corrected the issue according to the required timeframe, the Supportive ISO shall send written notice to the individual or family member indicating that if the issues are not corrected in 30 days, the agreement for self/family-management may be terminated.
- (C) Repeated documented failures to follow requirements shall be evidence to justify termination of the self/family-management agreement.

(c) If the Supportive ISO decides an individual or family member is not able to manage services, the individual or family member may appeal. The Supportive ISO must provide written notice to the individual or family member at least 30 days prior to terminating the self/family-management agreement and include the individual's or family member's rights to appeal. The appeal process is outlined in Part 8 of these regulations.

5.7 Responsibilities of an individual or family member who share-manages services

An individual or family member may manage some services and let an agency manage some services. That is called shared-managing. The agency is responsible for providing information and guidance to the individual or family member regarding his or her responsibilities for share-management. An individual or family member who share-manages with an agency must do all of the following:

- (a) Ensure services and supports are provided to the individual in accordance with the ISA and his or her budget.
- (b) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are in Section 10.5.
- (c) Make and keep all papers and records as required by the agency.
- (d) Report critical incidents to the agency. Make sure the reports are filed in accordance with the specific timelines required by the Department's *Critical Incident Reporting Guidelines*.
- (e) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

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- (f) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.
- (g) Prepare written back-up plans for when the plan cannot be followed (e.g., the worker gets sick and/or does not show up for work). Include in the plan who shall come and work and what shall happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.
- (h) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.
- (i) Take the following steps when hiring workers:
- (1) Write a job description. Complete reference checks before allowing the worker to start work;
 - (2) Interview and hire workers that meet the requirement of the Department's background check policy, or upon receipt of a variance when there is an issue with the background check;
 - (3) Sign up with the state contracted FE/A. Give the FE/A all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;
 - (4) Train or have someone else train all workers in accordance with these regulations. See the Department's pre-service and in-service standards in Part 9;
 - (5) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets. Sign and send accurate timesheets to the FE/A;
 - (6) Suspend or fire workers as necessary; and
 - (7) Follow all Department of Labor rules required of employers, including paying overtime as required.
- (j) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the agency for assistance in determining what are reimbursable expenses.

Part 6. Recipient Financial Requirements

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6.1 Income and resources; Medicaid-funded programs

For all supports and services funded by Medicaid, the income and resource rules of Department of Vermont Health Access (DVHA) governing eligibility for Medicaid programs apply, and are incorporated here by reference.

6.2 Room and board; personal spending money

Medicaid developmental disabilities funding does not cover room and board, clothing, or personal effects.

- (a) At least annually, the Commissioner or the Commissioner's designee shall publish a schedule of rates for room and board and rates for personal spending allowances for recipients. The personal spending allowance shall not be less, and may be more, than the personal spending allowance for nursing home residents. The sum of the room and board rates and the personal spending allowance shall be equal to the current Supplemental Security Income (SSI) rates, including state supplement.
- (b) Payment of the rate set by the Commissioner's schedule shall be considered payment in full for the recipient's room and board if the recipient receives residential services funded by the Department. Recipients who receive income from a source other than SSI shall be charged the same rate for room and board as SSI recipients.
- (c) In unusual circumstances the Division Director may permit non-Medicaid funds of the Department to be used to subsidize the excess costs of a recipient's room and board.
- (d) Recipients who rent or own their own home or apartment, and have room and board costs in excess of the Commissioner's schedule shall receive assistance in accessing rent subsidy, low interest loans, fuel assistance, and other sources of housing assistance for low income Vermonters. To the extent authorized by the *System of Care Plan*, the Commissioner may provide non-Medicaid funds to subsidize the excess costs of a recipient's rent or house payment, if the recipient is unable to afford the cost.
- (e) Recipients who rent or own their own home or apartment and who work may elect to use their earnings to pay rent or mortgage or room and board costs in excess of the Commissioner's schedule.
- (f) The recipient, in consultation with his or her representative payee, if any, shall determine how to spend the personal spending allowance.

6.3 Financial responsibility of parents

The parents of a child under age 18 with a developmental disability are financially responsible for costs not covered by any Medicaid program or funded by the Department, specifically: housing; food; clothing; non-medical transportation; personal items; and child care necessary for a parent to work.

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Part 7. Special Care Procedures**7.1 Purpose**

The purpose of these regulations is to ensure that people with developmental disabilities who have specialized health care needs receive safe and competent care while living in home and community settings funded by the Department.

7.2 Special Care Procedure

- (a) The purpose of classifying a procedure as a "special care procedure" is to provide a system for ensuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for. These regulations follow the Vermont State Board of Nursing Position Statement – The role of the nurse in delegating nursing interventions.
- (b) Examples of special care procedures are as follows:
- (1) Enteral care procedures. Procedures that involve giving medications, hydration, and/or nutrition through a gastrostomy or jejunostomy tube. Special care procedures include replacement of G and J tubes, trouble-shooting a blocked tube, care of site, checking for placement, checking for residuals, use, care and maintenance of equipment; follow up regarding dietitians' recommendations, obtaining and following up lab work, mouth care, and care of formula.
 - (2) Procedures to administer oxygen therapy. Use of O2 tanks, regulators, humidification, concentrators, and compressed gas. This may include need for O2 assistance through use of SaO2 monitor, use of cannulas, tubing, and masks.
 - (3) Procedures that require suctioning techniques. Oropharyngeal (using Yankeur), nasopharyngeal (soft flexi tube) and tracheal components, which may include suctioning; clean versus sterile suctioning, care and maintenance of equipment, including stationary and portable systems.
 - (4) Administration of respiratory treatments. Using nebulizer set-up, care and maintenance of equipment.
 - (5) Tracheotomy care. Including cleaning of site and replacement of trach.
 - (6) Procedures that include placement of suprapubic and urethral catheters, intermittent catheterization, use and care of leg bags, drainage bags, when and how to flush, clean versus sterile catheterization.
 - (7) Procedures that include care of colostomy or ileostomy. Care of the stoma and maintenance of equipment.

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- (8) Diabetes care, including medications, use of insulin, monitoring.

7.3 Application and limitations

- (a) These sections (Part 7) apply to DAs and SSAs (including their staff and contractors).
- (b) These sections (Part 7) apply to managed services, but they do not apply to care provided by natural or adoptive family members unless the family member is compensated for providing the care with funds administered or paid by the Department.
- (c) These regulations do not apply to care provided in hospitals or nursing homes.

7.4 Determining that a procedure is a special care procedure

The determination that a care procedure is a "special care procedure" has three components:

- (a) The procedure requires specialized nursing skill or training not typically possessed by a lay individual;
- (b) The procedure can be performed safely by a lay individual with appropriate training and supervision; and
- (c) The individual needing the procedure is stable in the sense that outcomes are predictable.

7.5 Who determines special care procedures

- (a) The initial identification of the possible need for a special care procedure may be made by the agency that serves the individual, by nursing staff of the Department, or by any other health providers.
- (b) A registered nurse shall determine whether a procedure is a special care procedure.

7.6 Who may perform a special care procedure

- (a) A special care procedure may be performed only by a person over the age of 18 who receives training, demonstrates competence, and receives monitoring in accordance with these regulations.
- (b) Competence in performing a special care procedure is individualized to the particular needs, risks, and characteristics of an individual. The fact that an employee or contractor may have been approved to perform a special care procedure for one individual does not create or imply approval for that person to perform a similar procedure for another individual.
- (c) The agency responsible for the health needs of the individual shall ensure that special care procedures are performed by lay people trained in accordance with the regulations, or by a qualified health professional.

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(d) The agency is responsible for having a back-up plan for situations where the person or people trained to perform a special care procedure for an individual are unavailable. If a trained lay person is not available, the procedures shall be performed by a qualified health professional. In the case of managed services, the services coordinator bears responsibility for having a back-up plan.

7.7 Specialized care plan

(a) If a nurse has determined that an individual needs a special care procedure, the agency is responsible for ensuring that a specialized care plan is attached to the ISA and that every person who is authorized to perform a special care procedure has a copy of the specialized care plan.

(b) A registered nurse shall complete an assessment of the person prior to developing the specialized care plan. The specialized care plan shall be developed by the registered nurse and shall identify the specialized care procedures and the nurse responsible for providing training, determining competence, and reviewing competence. The specialized care plan shall also include a schedule for the nurse to monitor the performance of specialized care procedures. (Section 7.10)

7.8 Training

(a) Qualifications of trainer. Training shall be provided by a nurse. The nurse shall have a valid State of Vermont nursing license.

(b) Timeliness. Training shall be provided before any caregiver who is not a health professional provides a special care procedure without supervision. Training shall be provided in a timely manner so as not to impede services for an individual.

(c) Best practice. Training in special care procedures shall conform to established best practice for performance of the procedure.

(d) Individual accommodations. Individuals with developmental disabilities have had unique experiences that may enhance or obstruct the ability to provide care. Within the framework of special care procedures, a combination of best practice and accommodation of individual characteristics shall define the procedures to be used with a particular individual.

(e) Documentation of training. The agency responsible for the health needs of the individual is responsible for ensuring that the nurse provides a record of training for any person who is carrying out a special care procedure. The records shall include information about who provided the training, when the training was provided, who received training, what information was provided during the training, and the conditions under which reassessment and retraining need to occur.

(f) Emergencies. The nurse shall be notified of any changes in an individual's condition or care providers. The agency responsible for the health needs of the individual shall ensure that special care procedures are performed by lay people trained in accordance with the regulations, or else by nursing personnel. If the nurse determines that, as a result of the emergency, a trained lay person cannot safely perform the procedure, the procedure shall be performed by a qualified health professional.

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7.9 Competence

The determination of competence is a determination that a person demonstrates adequate knowledge to perform a task, including use of equipment and basic problem solving skills. Competence includes capability, and adequate understanding.

- (a) Determination of competence. Determination of competence shall be made by a nurse. The specialized care plan shall identify the nurse responsible for making this determination.
- (b) Supervised practice. An individual who is working toward but has not yet achieved status of a competent special care provider shall provide specialized care under the supervision of a nurse.
- (c) Competence defined. Competence involves demonstrating safe performance of each step of the special care procedure and proper use and maintenance of equipment, basic problem solving skills, consistency of performance, and sufficient theoretical understanding.
- (d) Documentation of competence. The record shall document which people are determined competent to perform a special care procedure.
- (e) Review of competence. A specialized care provider's competence shall be reviewed by a nurse at least annually, and also when that worker's competence is in question, or at any time when there is change in the condition of the individual.

7.10 Monitoring

Ongoing monitoring by a nurse ensures that a special care provider's skills and knowledge continue to be current. The individual's specialized care plan shall include monitoring requirements, including expectations for monitoring the performance of special care procedures and patient outcomes at least annually.

Part 8. Grievance, Internal Appeal and Fair Hearing 8.1 Global Commitment and Grievances

- (a) Medicaid-funded services for eligible individuals with developmental disabilities are part of the Global Commitment to Health 1115(a) Medicaid Waiver, which is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Department of Vermont Health Access (DVHA), as a Managed Care Entity (MCE) under the Global Commitment 1115(a) waiver, is required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between recipients and MCE employees, representatives of the MCE, and state-designated agencies, including Designated Agencies and Specialized Service Agencies.

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- (b) The MCE and any part of the MCE receiving funds for the provision of services under the Global Commitment to Health shall be responsible for resolving all grievances and all appeals initiated under these rules.
- (c) Recipients and providers shall not be subject to retribution or retaliation for filing a grievance or an appeal with the MCE.
- (d) Services funded with investments dollars are not included, as they are separate from the Global Commitment to Health waiver.

NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

Note: Collaborative decisions of any type made by multi-disciplinary groups that include MCE and non-MCE members such as local interagency teams (LIT), the State Interagency Team (SIT), the State or Local Team for Functionally Impaired, and the Case Review Committee (CRC) are not actions of the MCE and therefore are not governed by these regulations.

8.2 Definitions

- (a) “Action” means an occurrence of one or more of the following by the agency for which an internal agency appeal may be requested:
 - (1) Denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
 - (2) Reduction, suspension or termination of a previously authorized covered service or a service plan;
 - (3) Denial, in whole or in part, of payment for a covered service;
 - (4) Failure to provide a clinically indicated, covered service, when the provider is a state agency, or a designated agency or a specialized service agency (DA/SSA);
 - (5) Failure to act in a timely manner when required by state rule;
 - (6) Denial of a recipient's request to obtain covered services outside the network.
- (b) “Agency” for purposes of this section means a designated agency or a specialized service agency. In addition, a Supportive Intermediary Service Organization is considered an “agency” for the purposes of this section when making decisions about reductions or denials of services or funding.
- (c) “Appeal” means a request for an internal review of an action by the Department or agency.
- (d) “Decision maker” means the person or people empowered to make a decision under Sections 8.4 and 8.5.
- (e) “Expedited Appeal” means an internal MCE appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the recipient’s life, health or ability to attain, maintain, or regain maximum functioning.

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- (f) “Fair Hearing” means an appeal filed with the Human Services Board, whose procedures are specified in rules separate from the MCE grievance and appeal process.
- (g) “Filed” or “notified” means personally delivered, or deposited in the U.S. mail with first class postage affixed.
- (h) “Grievance” means an expression of dissatisfaction about any matter that is not an action. Possible subjects for a grievance include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the recipient’s rights. If a grievance is not acted upon within the timeframes specified in rule, the recipient may ask for an appeal under the definition above of an action as being a “failure to act in a timely manner when required by state rule.” If a grievance is composed of a clear report of alleged physical harm or potential harm, the agency or Department will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulations board, Adult Protective Services).
- (i) “Managed Care Entity” (MCE) means:
- (1) The Department of Vermont Health Access (DVHA);
 - (2) Any state department with which DVHA has an Intergovernmental Agreement under the Global Commitment to Health 1115(a) waiver, excluding the Department of Education, that results in that department administering or providing services under the Global Commitment waiver (i.e. Department for Children and Families; Department of Disabilities, Aging and Independent Living; Department of Health; Department of Mental Health);
 - (3) A designated agency or a specialized services agency; and
 - (4) Any contractor authorizing service authorizations or performing prior authorizations on behalf of the MCE.
- (j) “Network” means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner of the Department of Disabilities, Aging and Independent Living and who provide services on an ongoing basis to recipients. It does not include a provider who enrolls on a one-time basis for the purpose of serving a specific recipient.
- (k) “Provider” means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual’s medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that manages services is not a provider for purposes of this rule.
- (l) “Service” means a benefit 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Department of Vermont Health Access and Agency of Human Services departments or the Department of Education for the administration and operation of the Global Commitment to Health waiver.

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8.3 Grievances

- (a) A grievance may be initiated by a recipient or the designated representative of a recipient. A grievance may be expressed orally or in writing.
- (b) Grievances shall be filed within 60 days of the pertinent issue in order for the grievance to be considered. Staff members shall assist a recipient if the recipient or his or her representative requests such assistance.
- (c) A written acknowledgement of a grievance shall be mailed within 5 calendar days of receipt by the MCE. The acknowledgement shall be made by the part of the MCE responsible for the service area that is the subject of the grievance. If the MCE decides the issue within the five-day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.
- (d) Recipients or their designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within 5 calendar days.
- (e) All grievances shall be addressed within 90 calendar days of receipt. The person making the decision shall provide the recipient with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the recipient, the notice shall also inform the recipient of his or her right to initiate a grievance review with the MCE as well as information on how to initiate such review.
- (f) If a grievance is decided in a manner adverse to the recipient, the recipient may request a review by the MCE within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.
- (g) The MCO shall acknowledge grievance review requests within 5 calendar days of receipt.
- (h) The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The recipient shall be notified in writing of the finding of the grievance review within 90 days.
- (i) Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the recipient may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V. S. A. § 3091 (a).

8.4 Right to an internal MCE appeal

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- (a) When the agency issues an action subject to appeal, including a decision to deny, reduce, or terminate eligibility, or deny, reduce, or terminate services, or when an agency fails to act within 45 days upon an application for services, it shall notify the applicant or recipient of the right to appeal. Notice shall be provided as described herein. In the event the agency fails to provide notice of appeal rights, the time limit for an applicant or recipient to submit an appeal shall be extended.
- (b) An applicant or recipient may request an internal MCE appeal of an MCE action, and a fair hearing before the Human Services Board. An applicant or recipient may use the internal MCE appeal process while a fair hearing is pending or before a fair hearing is requested (8.11), except when a benefit or service is denied, reduced or eliminated as mandated by federal or state law or rule, in which case the recipient cannot use the MCE appeal process and shall challenge the decision only by requesting a fair hearing.
- (1) The agency shall notify the Department within one working day of receipt of the request for appeal. The agency and the Department shall render a final MCE decision.
 - (2) The applicant or recipient shall have 30 calendar days from the date of the final MCE decision to request a fair hearing.
- (c) An internal MCE appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid.
- (d) If an applicant or recipient requests an internal MCE appeal regarding only a Medicaid eligibility or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (DCF), Economic Services Department. They will then notify the applicant or recipient in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the internal MCE appeal process and will be considered a request for fair hearing as of the date the MCE received it.
- (e) Applicants or recipients may file requests for internal MCE appeals orally or in writing for any MCE action. Representatives of the applicant or recipient may initiate internal appeals only after a determination that the third party involvement is being initiated at the applicant's or recipient's request. Internal MCE appeals of actions shall be filed with the MCE within 90 calendar days of the date of the MCE notice of action. The date of the appeal, if mailed, is the postmark date. The internal MCE appeal process will include assistance by staff members of the MCE, as needed, for the applicant or recipient to initiate and participate in the appeal. Recipients shall not be subject to retribution or retaliation for appealing an MCE action.
- (f) An initial applicant who files an appeal shall not receive benefits pending the appeal.
- (g) Written acknowledgement of the internal MCE appeal shall be mailed within 5 calendar days of receipt by the part of the MCE that receives the appeal request. If a recipient files an appeal with the wrong entity, that entity will notify the recipient in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the MCE, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part of the MCE. This does not extend the deadline by which an internal MCE appeal shall be determined.

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- (h) Recipients or their designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within 5 calendar days.
- (i) The recipient or his or her designated representative has the right to participate in person, by telephone or in writing in the meeting in which the MCE is considering the final decision regarding the internal MCE appeal. If the appeal involves an agency decision, a representative of the DA/SSA may also participate in the meeting. Recipients or their designated representative may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting. Upon request, the MCE shall provide the recipient or his or her designated representative with all the information in its possession or control relevant to the internal appeal process and the subject of the internal appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The MCE will not charge the recipient for copies of any records or other documents necessary to resolve the internal appeal.
- (j) The individual who hears the internal MCE appeal shall not have made the decision that is subject to appeal and shall not be a subordinate of the individual who made the original decision.
- (k) Internal MCE appeals shall be decided and written notice sent to the applicant or recipient within 45 calendar days of receipt of the appeal. The applicant or recipient shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 45-day time limit, the time frame may be extended up to an additional 14 days, by request of the applicant or recipient or by the MCE if the extension is in the best interest of the applicant or recipient. If the extension is at the request of the MCE, it shall give the applicant or recipient written notice of the reason for the delay. The maximum total time period for the resolution of an internal MCE appeal, including any extension requested either by the applicant/recipient or the MCE, is 59 days. If a meeting cannot be scheduled within these timeframes, a decision will be rendered by the MCE without a meeting with the applicant or recipient, or the designated representative.

8.5 Expedited internal MCE appeal requests

- (a) Expedited internal MCE appeals may be requested in emergent situations in which the recipient or designated representative indicates that taking the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the MCE for any MCE actions subject to appeal. The MCE will not take any punitive action against a provider who requests an expedited resolution or supports a recipient's appeal.
- (b) If the request for an expedited internal MCE appeal is denied because it does not meet the criteria, the MCE will inform the recipient that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited internal MCE appeal shall be promptly

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communicated (within 2 calendar days) to the recipient and followed up within 2 calendar days of the oral notification with a written notice.

(c) If the expedited internal MCE appeal request meets the criteria for such appeals, it shall be resolved within 3 working days. If an expedited appeal cannot be resolved within 3 working days, the time frame may be extended up to an additional 14 calendar days by request of the recipient, or by the MCE if the extension is in the best interest of the recipient. If the extension is at the request of the MCE, it shall give the recipient written notice of the reason for the delay. An oral notice of the expedited appeal decision shall be promptly communicated (within 2 calendar days) to the recipient and followed up within 2 calendar days of the oral notification with a written notice. The written notice for any expedited internal MCE appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the recipient's right to request a fair hearing if not already requested.

8.6 Participating provider decisions

(a) Provider decisions shall not be considered MCE actions and are not subject to appeal using this process.

(b) A state agency shall be considered a provider if it provides a service that is:

- (1) Claimed at the Medicaid service matching rate;
- (2) Based on medical or clinical necessity; and
- (3) Not prior-authorized.

(c) Designated agencies/specialized service agencies (DA/SSA) are providers when their decisions do not affect recipient eligibility or services.

8.7 Notices

(a) The part of the MCE issuing a services decision that meets the definition of an action shall provide the recipient with written notice of its decision. In cases involving a termination or reduction of services, such notice of decision shall be mailed at least 11 days before the change will take effect. Where the decision is adverse to the recipient, the notice shall inform the recipient when and how to file an internal MCE appeal or fair hearing. In addition, the notice shall inform the recipient that he or she may request that covered services be continued without change as well as the circumstances under which the recipient may be required to pay the costs of those services pending the outcome of any internal MCE appeal or fair hearing.

(b) The agency shall provide notice, including reference to the applicable policy or citation the action is based on, as described in Sections 4.7, 4.12, 4.14, 4.15 and throughout Part 8, to an applicant or recipient of the rights provided in the Developmental Disabilities Act, 18 V.S.A. §§ 8727 (a) and 8728, and any other rights under state and federal law, as well as the right of grievance.

(c) All agencies and the Department shall post notices of the right to appeal and the procedure for appealing or initiating a grievance within the public areas of the agency. The Department shall provide

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such notices for posting, which shall include telephone numbers for receiving help in initiating a grievance, appeal, or fair hearing request.

8.8 Continued services

(a) If requested by the recipient, services shall be continued during an appeal regarding a Medicaid-covered service termination, suspension or reduction under the following circumstances:

- (1) The appeal was filed in a timely manner, meaning before the effective date of the proposed action;
- (2) The recipient has paid any required premium(s) in full; and
- (3) The appeal involves the termination, suspension or reduction of a previously-authorized course of treatment or services plan.

(b) Where properly requested, a service shall be continued until any one of the following occurs:

- (1) The recipient withdraws the appeal;
- (2) Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
- (3) The MCE issues an appeal decision adverse to the recipient, and the recipient does not request a fair hearing within the applicable time frame;
- (4) A fair hearing is conducted and the Human Services Board issues a decision adverse to the recipient; or
- (5) The time period or service limits of a previously authorized service has been met.

(c) Continuation of benefits without change does not apply when the appeal is based solely on a reduction, suspension or elimination of a benefit or service required by federal or state law or rule affecting some or all recipients, or when the decision does not require the minimum advance notice as specified in Medicaid Rule 4150.

(d) Recipients may waive their right to receive continued benefits pending appeal.

8.9 Recipient liability

(a) A recipient may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

(b) The MCE may recover from the recipient the value of any continued benefits paid during the appeal period when the recipient withdraws the appeal before the relevant internal MCE appeal or fair hearing decision is made, or following a final disposition of the matter in favor of the MCE. Recipient liability will occur only if an internal MCE appeal, fair hearing decision, secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCE also determines that the recipient should be held liable for service costs.

(c) If the provider notifies the recipient that a service may not be covered by Medicaid, the recipient can agree to assume financial responsibility for the service. If the provider fails to inform the recipient

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that a service may not be covered by Medicaid, the recipient is not liable for payment. Benefits will be paid retroactively for recipients who assume financial responsibility for a service and who are successful on such service coverage appeal.

8.10 Appeals regarding proposed services

- (a) If an appeal is filed regarding a denial of service eligibility, the MCE is not required to initiate service delivery.
- (b) The MCE is not required to provide a new service or any service that is not a Medicaid-covered service while a fair hearing determination is pending.

8.11 Fair hearing

- (a) A recipient may use the MCE internal appeal process and be entitled to a fair hearing before the Human Services Board. Fair hearings or internal MCE appeals shall be filed within 90 days of the date the notice of action was mailed by the MCE, or if not mailed, within 90 days after the action occurred. A request for a fair hearing challenging an MCE internal appeal decision shall be made within 90 days of the date of the original notice of the MCE internal appeal decision, or within 30 days of the date the MCE internal appeal decision was mailed. If the recipient's original request for an MCE internal appeal was filed before the effective date of the adverse action, the recipient has requested continuing benefits before the effective date of the adverse action, and the recipient has paid in full any required premium(s), the recipient's services will continue consistent with Section 8.8.
- (b) The Department shall have standing to be a party to any request for fair hearing filed with the Human Services Board.
 - (1) Appeals to the Human Services Board shall be conducted in accordance with the rules governing the conduct of fair hearings by the Human Services Board, 3 V.S.A. Section 3091.
 - (2) The fair hearing officer shall assure that the person with a developmental disability has access to legal representation, if desired.
 - (3) The fair hearing officer may order an independent evaluation at no cost to the person with a developmental disability if he or she finds that it would aid in resolution of the issue on appeal.
- (c) The Human Services Board may reverse or modify a decision of the Department or an agency only if the decision is inconsistent with the System of Care Plan and the rules and policies of the Department. The Human Services Board shall not reverse a decision of the MCE if the decision is consistent with the System of Care Plan and the rules and policies of the Department, unless the Board finds that the System of Care Plan rules, or policies of the Department conflict with state or federal law.
- (d) The Secretary of the Agency of Human Services shall review all decisions and orders of the Human Services Board in accordance with 18 V.S.A. §8727 (b) (2).

Part 9. Training

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9.1 Purpose

Training is an ongoing process that helps ensure safety and quality services and reflects the principles of services of the Developmental Disabilities Act of 1996, generally accepted best practices, and promising practices and the priorities of the *System of Care Plan* and these regulations.

9.2 Standards

(a) The Division shall develop training standards and periodically update them to ensure that workers:

- (1) Understand the values and philosophy underlying services and supports;
- (2) Acquire skills necessary to address the individual needs of the recipient for whom they provide services and support;
- (3) Acquire skills to implement the principles and purposes of the Developmental Disabilities Act of 1996; and
- (4) Are exposed to best and promising practices in supporting individuals with developmental disabilities.

(b) In developing the standards the Division shall endeavor to involve individuals with developmental disabilities and their families in the design, delivery, and evaluation of training.

9.3 Agency and Supportive Intermediary Support Organization responsibilities

(a) Each agency shall adopt and implement a training plan which ensures adherence to the following minimum standards:

- (1) Workers compensated with funds paid or administered by the agency shall receive pre-service and in-service training or have knowledge and skills in the areas addressed by pre-service and in-service training consistent with Department and Division standards and these regulations.
- (2) Workers, on an ongoing basis, shall have opportunities to broaden and develop their skills and knowledge in the following areas:
 - (A) Best and promising practices;
 - (B) Values including:

The principles of supporting people to have valued roles in their community including:

- The dignity of valued roles
- Sharing ordinary places
- Making choices and the dignity of risk

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- Relationships in living a full life
 - Making contributions to others
- The principles of person-centered thinking including:
- How to respectfully address significant issues of health or safety while supporting choice
 - How to sort what is important for people from what is important to the people we support
 - How rituals and routines play a role in what is important to the people we support
 - The importance of having power with rather than power over the people we support;
- (C) Current and emerging worker responsibilities; and
- (D) Current and emerging needs of the individual.
- (b) The training plan shall be written and based on the agency's assessment of its ability and capacity to meet the needs of the people it serves, the local *System of Care Plan*, and the training needs of its staff and board members.
- (c) The training plan shall be updated as needed but at least every three years.
- (d) Each agency, and Supportive ISO shall:
- (1) Have a system to verify that all workers compensated with funds administered or paid by the organization have received pre-service and in-service training in accordance with these regulations, or have knowledge and skills in the areas addressed by pre-service and in-service training.
 - (2) Make pre-service and in-service training available to all workers at no cost to the family or recipient.
 - (3) Involve people with disabilities and their families in the design, delivery, and evaluation of training and invite them to participate in training.
 - (4) Have a system to verify that all workers have been told about and understand the requirement to report abuse and neglect of children to the DCF, and abuse, neglect and exploitation of vulnerable adults to APS.
- (e) Each agency and Supportive ISO shall:
- (1) Inform each person that self/family-manages services or share-manages services about the recipients or family's responsibility for ensuring that all workers receive pre-service and in-service training in accordance with these regulations.

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- (2) Inform each person that self/family-manages or share-manages services about the availability of pre-service and in-service training at no cost to the family.

9.4 Pre-service training

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

- (a) Abuse reporting requirements:
- (1) The requirements of Vermont law to report suspected abuse or neglect of children; and
 - (2) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.
- (b) Health and Safety:
- (1) Emergency procedures, including where to locate the emergency fact sheet;
 - (2) What to do if the individual is ill or injured;
 - (3) Critical incident reporting procedures; and
 - (4) How to contact a supervisor or emergency on-call staff.
- (c) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)
- (1) Whether the individual has a guardian, and how to contact the guardian;
 - (2) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;
 - (3) Health and safety needs of the individual;
 - (4) How to communicate with the individual; and
 - (5) The individual's ISA, including the amount of supervision the individual requires.
- (d) Values:
- (1) Individual rights;

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- (2) Confidentiality;
 - (3) Respectful interactions with individuals and their families; and
 - (4) Principles of service contained in the Developmental Disabilities Act of 1996.
- (e) How to access additional support, training, or information.

9.5 In-service training

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

- (1) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;
 - (2) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, supporting communication). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;
 - (3) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and
 - (4) Basic first aid.
- (b) Workers shall be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

9.6 Exception for emergencies

- (a) For the purposes of this section, "emergency" means an extraordinary and unanticipated situation of fewer than 72 consecutive hours.
- (b) 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

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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).

(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.

Part 10. Certification of Providers**10.1 Purpose of certification**

In order to receive funds administered by the Department to provide services or supports to people with developmental disabilities, providers shall be certified to enable the Department to ensure that an agency can meet certain standards of quality and practice.

10.2 Certification status

(a) To meet certification standards, an agency must:

(1) Meet the standards for designation as a DA or SSA (see *Administrative Rules on Agency Designation*);

(2) Meet the Department's *Quality Standards for Services* (section 10.5); and

(3) Provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728).

(b) Current providers. Any agency receiving Department funds on the effective date of these regulations is presumed to be certified.

(c) New provider. A new provider that wishes to be certified by the Department shall first establish that it meets the standards for designation. Upon being designated, an organization shall apply in writing to the Department for certification. The application shall include policies, procedures, and other documentation demonstrating that the organization is able to meet the quality standards for certification contained in section 10.5 and provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728).

(d) Providers that are not designated shall not be certified.

(e) If a certified provider loses its designation status, the provider is automatically de-certified.

(f) The Department shall send the applicant a written determination within 30 days after receiving an application for certification. In order to receive funds administered by the Department, an organization must be certified and have a Master Grant Agreement with the AHS.

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10.3 Monitoring of certification

The Department shall monitor certified providers through a variety of methods including, but not limited to, quality reviews, other on-site visits, review of critical incident reports and mortality reviews, investigation of complaints from recipients and the public, input from Department staff and staff or employees of other departments of AHS.

10.4 Services available regardless of funding source

- (a) Any services or supports which are provided to people who are eligible for Medicaid shall be made available on the same basis to people who are able to pay for the services or who have other sources of payment.
- (b) The rate charged to recipients who are able to pay for services or who have payment sources other than Medicaid shall be the same as the rate charged to Medicaid-eligible recipients, *except that* the rate may be discounted to reflect lower administrative or implementation costs, if any, for non-Medicaid recipients. If a provider establishes a sliding fee scale for such services, the provider shall have a source of funding (such as United Way, state funds, donated services) for the difference between the cost of providing the service and the fee charged.
- (c) Any services not funded by Medicaid may be made available in accordance with a sliding fee schedule.

10.5 Quality standards for services

To be certified, an agency shall provide or arrange for services that achieve the following outcomes as specified in *Guidelines for the Quality Review Process of Developmental Disabilities Services*.

- (a) Respect: Individuals feel that they are treated with dignity and respect.
- (b) Self Determination: Individuals direct their own lives.
- (c) Person Centered: Individuals' needs are met, and their strengths and preferences are honored.
- (d) Independent Living: Individuals live and work as independently and interdependently as they choose.
- (e) Relationships: Individuals experience positive relationships, including connections with family and their natural supports.
- (f) Participation: Individuals participate in their local communities.
- (g) Well-being: Individuals experience optimal health and well-being.

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- (h) Communication: Individuals communicate effectively with others.
- (i) System Outcomes.

10.6 Status of non-designated providers

- (a) Any non-designated entity or organization that provides services or supports to individuals with funds administered by the Department must be a subcontractor of an agency. This requirement does not apply to persons employed as independent direct support providers. The decision to subcontract with an entity or organization is at the discretion of the agency.
- (b) The Department quality service reviews shall be responsible for including people served by subcontracted providers to verify that they meet quality review standards.
- (c) Any subcontract shall contain provision for operations in accordance with all applicable state and federal policies, rules, guidelines and regulations that are required of agencies.
- (d) Agencies shall require the following through all of its subcontracts: reserve the right to conduct inquiries or investigations without prior notification in response to incidents, events or conditions that come to its attention that raise concerns as to person-specific allegations regarding safety, quality of supports, the well-being of people who receive services or any criminal action. Further, the Department may conduct audits without advanced notice.
- (e) Having a subcontract does not terminate an agency receiving funds under Vermont's Medicaid program from its responsibility to ensure that all activities and standards under their Master Grant Agreement with AHS are carried out by their subcontractors.

Part 11. Evaluation and Assessment of the Success of Programs

The Department shall evaluate and assess the success of programs using the following processes:

- (a) The review of services provision as outlined in the *Guidelines for Quality Review of Developmental Disabilities Services* as well as those processes outlined in Appendix B of the quality review guidelines *Sources of Quality Assurance and Protection for Citizens with Developmental Disabilities*;
- (b) The designation process for DA and SSAs as outlined in the *Administrative Rules on Agency Designation*;
- (c) Review of the data reported by agencies on required performance measures and monitoring of

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programs as described in the agencies' Master Grant Agreements with the AHS; and

- (d) Review of performance measures submitted to AHS as required by Act 186.

The information gathered shall be used for informing the continuation of programs, quality improvement, innovations in service delivery and policy development.