

Regulations Implementing
The Developmental Disabilities Act of 1996

Effective: July 1, 2017~~MARCH 2011~~

- Part 1. Definitions
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~~Developmental Disabilities Services Division of Disability and Aging Services~~
Vermont Department of Disabilities, Aging and Independent Living
July 1, 2017

~~March 15, 2011~~

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Department of Disabilities, Aging and Independent Living
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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 ~~eighteen~~ or older. ~~—The term includes people age 18~~eighteen or older who attend school. ~~—~~

1.2 **“Agency”** means the responsible designated agency (DA) ~~or~~ and specialized service agency ~~((DA/SSA)).~~

1.3 **“Appeal”** means a request for an internal review of an action by the Department of Disabilities, Aging and Independent Living (DAAIL) or a DA ~~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 45 of these regulations. ~~—If the applicant is a guardian or family member or a designated agency~~ DA, the term “applicant” also includes the person with a developmental disability.

1.5 ~~—“Autism” means the same as the term “Autistic Disorder” as it is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).~~

1.5 **“Authorized Funding Limit”** means all funding related to an individual’s HCBS budget, including the administration amount, 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 determines whether a provider meets minimum standards for receiving funds administered by the Department to provide services or supports to people with developmental disabilities.

1.7 **“Certified provider”** means ~~an designated agency, specialized service agency, or other corporate organization~~ 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 ~~D~~ department 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.

1.98 **“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.

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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 HCBS Rules.

1.111 **“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.

1.129 **“Day”** means calendar day, not ~~businessworking~~ day, unless otherwise specified.

1.130 **“Department”** means the Department of Disabilities, Aging and Independent Living (DAIL).

1.144 **“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~~ designated agency are ~~explained~~ described in the Department’s *Administrative Rules on Agency Designation*.

1.152 **“Designated Representative”** means an individual, either appointed by a 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 internal managed care entity (MCE) appeal, fair hearing or grievance process.—Unless otherwise stated in this ~~regulation~~ rule, the designated representative has all of the rights and responsibilities of a recipient in obtaining a determination or in dealing with any of the levels of the appeals process.

1.163 **“Developmental Disability”** (DD) means an intellectual disability or an ~~Pervasive Developmental Disorder~~ Autism Spectrum Disorder which occurred before age 18 and which ~~results in~~ has significant deficits in adaptive behavior that ~~were~~ 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.

1.174 **“Division”** means the Developmental Disabilities ~~Division of Disability and Aging 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.

1.1945 **“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.

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1.2016 **“Fiscal Employer/Agent Support Organization” (FE/A)** (Fiscal ISO) 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
- (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 **“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.

1.221 **“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 for an individual with a physical disability. Home support options include supported living, staffed living, shared living, group living, and Intermediate Care Facility (ICF) for people with DD.

1.234 **“Individual Person with a developmental disability”** means a young child, with a developmental disability or a school-age child or an adult with a developmental disability.

1.24 **“Individual Support Agreement” (ISA)** means the agreement between an individual and an agency or Supportive ISO that describes the plan of services and supports.

1.2517 **“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.

1.18 **“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. 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 that were manifest before age 18. “Intellectual disability” was previously known as “mental retardation” as the term is defined and referred to in the Developmental Disabilities Act.

1.2619 **“Network”** means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner of the Department of Disabilities, Aging and Independent Living to provide developmental disabilities services and who provide services on an ongoing basis to recipients.

1.20 **“Pervasive Developmental Disorder” (PDD)** means the same as it is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnostic category of pervasive and developmental disorders includes the five diagnoses currently listed in DSM: Autistic Disorder (Autism), Asperger’s

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~~Disorder, Pervasive Developmental Disorder, Not Otherwise Specified, Rett's Disorder and Childhood Disintegrative Disorder.~~

1.274 **“Pre-service training”** means training that occurs before workers are alone with a person with developmental disabilities. ~~—.~~

1.282 **“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 he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiaryrecipient. —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 this regulation.~~rule.

1.293 **“Psychologist”** means a person licensed to practice psychology in the state where the evaluation occurred.

1.3024 **“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. ~~—.~~

1.3125 **“Recipient”** means a person who meets the criteria contained in ~~Part 2 of these regulations~~, and who has been authorized to receive funding or services, or a family that has been approved to receive ~~services or funding or services under criteria specified in these regulations.~~ system of care plan. ~~A recipient is a person who has been approved to receive services, supports, or cash benefits funded by the Department under criteria specified in the System of Care Plan.~~

1.3226 ~~—.~~ **“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 ~~developmental disabilities services agency; or~~
- (c) A person who meets criteria listed in Section 3.2.

1.33 **“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 cannot be left unsupervised.

1.27 ~~“School age child” means a person who is old enough to enter first grade and younger than age eighteen.~~

1.28 ~~“Self-directed” services means the recipient provides direction to the agency about his or her services but does not manage the services.~~

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1.3429_ —“**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.

1.3530 “**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.

1.364 “**Service**” means a benefit:

- (a) 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);~~
- (b) Included in the State Medicaid Plan if required by CMS;
- (c) Authorized by state regulation~~rule~~ or law; or
- (d) Identified in the Intergovernmental Agreement between the Department~~Office~~ of Vermont Health Access (DVHA) and the Agency of Human Services (AHS) ~~Departments or DVHA and the Department-Agency~~ of Education for the administration and operation of the Global Commitment to Health waiver.—

1.37 “**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 Individual Support Agreement; 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.

1.32 “**Significant deficits in adaptive behavior**” means ~~deficits in adaptive functioning which result in:~~

— (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 also~~

— (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.~~

1.383_ —“**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 rest.

1.394_ —“**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.

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1.4035 **“Specialized service agency”** (SSA) means an agency designated by the Department and 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.

1.4136 **“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.

1.420 **“Supportive Services”** means therapeutic services that cannot be accessed through State Plan Medicaid. These are medically appropriate services that include behavior support and consultation; assessment, consultation and training for communication supports; skills-based training such as DBT skills group or sexuality groups; and other services provided by licensed or certified individuals (such as therapeutic horseback riding).

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

1.442 **“Transportation Services”** means accessible transportation for an individual living with a home provider or family member and mileage for transportation to access Community Supports.

1.38 ~~“Was manifest before age 18” or “were manifest before age 18”~~ means that the impairment and resulting significant deficits in adaptive behavior were observed before age eighteen. 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.

1.4539 **“Worker”** means any employee or contractoree 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 ~~directed~~ respite workers paid by Flexible Family Funding are not included within this definition.

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

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Part 2. ~~Definition of developmental disability and e~~Criteria for determining developmental disability

2.1 Definitions:

~~— (a) “Adult” means a person age eighteen or older. The term includes people age eighteen or older who attend school.~~

~~— (b) “Autism” means the same as the term “Autistic Disorder” as it is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).~~

~~— (c) “Person with a developmental disability” means a young child with a developmental disability or a school age child or adult with a developmental disability.~~

~~— (d) “Psychologist” means a person licensed to practice psychology in the state where the evaluation occurred.~~

~~— (e) “School age child” means a person who is old enough to enter first grade and younger than age eighteen.~~

~~— (f) “Young child” means a person who is not yet old enough to enter first grade.~~

2.2 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:

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Communication
 Social/emotional development
 Motor development
 Daily living skills

(c) ~~An Autism Spectrum Disorder pervasive developmental disorder~~ (Section 2.8-2.10) resulting in 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.

2.23 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 2.12(a)) shall be made by a physician or psychologist.

(b) The documentation of significant delays in cognitive and adaptive behavior (Section 2.12(b)) or significant delays in adaptive behavior for a young child with ~~pervasive developmental disorder~~ Autism Spectrum Disorder (Section 2.12(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 a ~~pervasive developmental disorder~~ Autism Spectrum Disorder shall be made according to Section 2.8-2.10.

2.34 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 person who:

- (1) Has intellectual disability (Section 2.45) or ~~pervasive developmental disorder~~ 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

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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.

2.45 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 2.56. “Intellectual disability” means the same as the term “mental retardation” in the Developmental Disabilities Act of 1996.

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

(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 (be) – (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.

~~(b)~~(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.

~~(be)~~ 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

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account a standard error of measurement for the test used.

(~~cd~~) 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.

(~~de~~) 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.

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

(~~fg~~) 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.

(~~gh~~) 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 ~~an pervasive developmental disorder~~ Autism Spectrum Disorder and is a person with a developmental disability.**

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

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(a4) Diagnosis of ~~an pervasive developmental disorder~~ Autism Spectrum Disorder made according to process outlined in section 2.8-2.10-~~2~~

(b2) Resulting in significant deficits in adaptive behavior; and (Section 2.11~~2~~)

(c3) Manifested before age 18 (Section 2.13).

2.8 ~~_____~~ **Pervasive developmental disorder** **Autism Spectrum Disorder** defined.

~~“Pervasive developmental disorder”~~ **“Autism Spectrum Disorder”** means the same as it is defined in the current Diagnostic and Statistical Manual of Mental Disorders (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 pervasive developmental disorder** **Autism Spectrum Disorder**.

(a) The diagnostic category of ~~pervasive developmental disorders~~ **Autism Spectrum Disorder** includes considerable variability in the presence and intensity of symptoms ~~across and within the five diagnoses currently listed in DSM: Autistic Disorder (Autism), Asperger's Disorder, Pervasive Developmental Disorder, Not Otherwise Specified, Rett's Disorder and Childhood Disintegrative Disorder.~~ ~~Many of the symptoms of pervasive developmental disorders~~ **Autism Spectrum Disorder** overlap with other childhood diagnoses. ~~Because of the complexity in differentially diagnosing pervasive developmental disorders~~ **Autism Spectrum Disorder**, it is essential that clinicians rendering these diagnoses have specific training and experience in child development, ~~pervasive developmental disorders~~ **Autism Spectrum Disorder**, other developmental disorders, and other childhood psychiatric disorders.

(b) Preferably a comprehensive diagnostic evaluation is conducted by an interdisciplinary team of professionals with specific experience and training in diagnosing ~~pervasive developmental disorders~~ **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

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- (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, ~~pervasive developmental disorder~~ Autism Spectrum Disorder, and other developmental and childhood psychiatric disorders of childhood, and a process for assessment and differential diagnosis of ~~pervasive developmental disorder~~ Autism Spectrum Disorder; or supervised clinical experience in the assessment and differential diagnosis of ~~pervasive developmental disorder~~ Autism Spectrum Disorder; and
 - (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 ~~pervasive developmental disorder~~ 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 ~~will~~ 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 ~~pervasive developmental disorders~~ 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 ~~pervasive developmental disorder~~ Autism Spectrum Disorder shall be consistent with the Department's *Best Practice Guidelines for Diagnosis of Pervasive Developmental Disorder* and shall include all of the following components:

- (a) Review of history from multiple sources, including developmental history, medical issues, psychiatric issues, and family history.

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- (b) Systematic ~~pervasive developmental disorders~~Autism Spectrum Disorder diagnostic interview with primary caregivers.
- (c) A systematic observation of social and communicative behavior and play.
- (d) An assessment of peer interaction.
- (e) For older children and adults who can report symptoms, a systematic clinical interview.
- (f) Referral for multidisciplinary assessment, as indicated.
- (g) Comprehensive clinical diagnostic formulation, in which the clinician weighs all the information, integrates findings and provides a differential diagnosis using the criteria in the current version of the DSM. For adults and children in their late teens who have not been previously diagnosed with an Autism Spectrum Disorder, the clinician must clearly articulate a rationale for the diagnosis, particularly when other previous diagnoses had been rendered to explain symptoms.
- (h) Assessments shall be current and based upon the individual's typical functioning.
- (1) A determination of ~~pervasive developmental disorder~~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, or 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 designated agency (DA) believes the child may not have ~~pervasive developmental disorder~~Autism Spectrum Disorder or when applying for HCBS.
- (2) The initial diagnosis of ~~pervasive developmental disorder~~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.

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2.11 Significant deficits in adaptive behavior defined.

“Significant deficits in adaptive behavior” means deficits in adaptive functioning which result in:

- (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 also
- (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 ~~pervasive developmental disorders~~ 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

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behavior were observed before age ~~18~~^{eighteen}. 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.

(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 an language interpreter or a method of augmentative and alternative communication and or needs a personal assistant for communication (~~such as a person who uses sign language or facilitated 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 person with a developmental disability as defined in Part 14.13 above who meets the criteria for financial eligibility and program access for specific services as described in section 4.7.

(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

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- (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 Sections 3.1, ~~and 3.2~~ 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 ~~matching~~ funds are provided by another state, or by another Vermont state department or agency or department).

3.4 People receiving services on July 1, 1996

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 designated agency~~ DA shall provide a copy of the application to all people who contact the ~~agency~~ DA saying they wish to apply for services.

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

(c) The ~~designated agency~~ 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 ~~designated agency~~ DA for the geographic area where the person with a developmental disability lives.—

(b) An application for a person who is incarcerated or living in a residential school, facility or hospital shall be filed at an office of the ~~designated agency~~ DA for the geographic area where the person was living before going to the school, facility or hospital.—

(c) An application for a person who is ~~The designated agency~~ DA for an individual in the custody of the Department for Children and Families (DCF) shall be filed at an office of ~~the designated agency~~ DA for the region in which the individual was placed in DCF custody.

(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 ~~designated agency~~ DA shall complete the application screening process.—The screening process includes all of these steps:

(1) Explaining the application process to the applicant; ~~with the information required,~~ potential service options, how long the process ~~will take,~~ how and when the applicant ~~is~~ will be 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.

(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 ~~designated agency~~ DA determines that the person or family is facing an immediate crisis, the ~~designated agency~~ DA shall make a temporary or expedited decision on the application.

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

(1) Receive services and supports through any certified ~~organization~~ provider in the region, including the ~~designated agency~~ DA and the specialized services agencies (SSA);

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- (2) Share the management of those services with the ~~designated agency~~ DA or SSA ~~specialized services agency~~; or
- (3) Self/family-manage their services through the Supportive ISO.
- (c) Contact and referral information for options for services outside of the ~~designated agency~~ DA must be provided to each applicant and referral assistance provided to ensure ~~assure~~ that a fully informed choice of service options is made. The DA shall have documentation that the applicant was fully informed of his or her options.
- (d) If the applicant wants more information about options or chooses to pursue services outside the ~~designated agency~~ DA, then the DA shall contact the SSA ~~specialized services agency~~ or Supportive ISO on behalf of the applicant ~~shall be contacted by the designated agency at this time.~~

4.5 Assessment

- (a) The ~~designated agency~~ 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 ~~designated agency~~ 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 12 of these regulations, ~~and a person eligible to be a recipient, as defined in~~ Part 3 ~~4.25~~? If so,
- (2) What does the person or his or ~~her~~ family need? ~~This question is answered through a uniform assessment 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? ~~the System of Care plan?~~ 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 ~~designated agency~~ DA shall seek or authorize funding for services to meet identified needs or else 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. ~~state System of Care Plan. The funding amount~~

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~~authorized shall be equal to the amount needed to pay for any support needs requested by the applicant or family that fit within the System of Care Plan funding priorities. Services authorized shall be based upon the most cost-effective method of meeting an individual's assessed needs, the eligibility criteria and funding limitations listed in the Section 4.7, as well as guidance in the *System of Care Plan* and *Medicaid Manual for Developmental Disabilities Services Division*.~~

4.7 **Available Programs and Funding Sources**

~~This section describes the existing programs or funding sources that are available within the funds appropriated by the Legislature, the types of service provided, the criteria for receiving the service or funding and their limitations. Additional details and requirements for each program are included in the *Medicaid Manual for the Developmental Disabilities Services Division* and, in specific, Division guidelines. The available programs are as follows:~~

(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 determined by DCF/Economic Services Division.~~

(C) Access Criteria:

~~Individual must be under the age of 22.~~

~~The Bridge Program is available to children at agencies that have not established Integrated Family Services (IFS) program (Care Coordination is an available service in IFS regions for children with DD).~~

(2) Limitations

(A) Bridge Program Care Coordination may be billed for an

~~individual residing in a nursing home, ICF/DD, hospital, rehabilitation facility, residential school, psychiatric facility, or crisis facility only for the purposes of discharge planning when the service does not duplicate the facility's services and when provided 90 calendar days or less prior to discharge.~~

~~**(B) Bridge Program Care Coordination may not be billed for children who are receiving care coordination, case management or service coordination from another AHS funded source, including HCBS.**~~

~~**(C) Funds must be used in accordance with the *Bridge Program Guidelines*.**~~

(b) Developmental Disabilities Specialized Services Fund

~~This fund covers 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.~~

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(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*.

(2) **Limitations**

(A) There is a limit of \$500 for any one person within a fiscal year for non-dental expenses.

(B) Dental for adults has a maximum limit of \$1000 per person per fiscal year.

(C) Payments can only be made after the service has been rendered.

(D) The fund shall not be used to contribute to high cost projects, such as extensive home modifications, purchasing of vans, high-end adaptive equipment or orthodontic work.

(E) The fund shall not cover services covered by Medicaid State Plan, HCBS funding, Medicare, private insurance or other funding sources.

(c) **Employment Conversion**

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

(1) **Eligibility**

(A) Clinical:

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

(B) Financial:

Vermont Medicaid eligible determined by DCF/Economic Services Division.

(C) Access Criteria

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

(2) **Limitations**

The maximum amount available to add to work supports from this initiative for each individual is \$5,000, which shall be annualized in their individual budget.

(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:

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

(B) Financial:

Vermont Medicaid eligible determined by DCF/Economic Services Division.

(C) Access Criteria:

FMR is available to children up to, but not including, age 21 living with their biological/adoptive families or legal guardian.

(2) **Limitation**

(A) FMR funds are to be used for paying an employee to provide direct care for a child. Family Managed Respite can only be used for direct care provided by a person hired by the family.

(B) FMR funds cannot be used to purchase goods or items, pay for camp or to pay an organization, agency, or facility.

(C) FMR funds cannot be used for individuals receiving HCBS.

(D) Maximum allocation per year shall be specified in the *System of Care Plan*.

(E) Funds must be used in accordance with the *Family Managed Respite Guidelines*, including which family members can be paid to provide respite.

(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 enhance their ability to live together. These income-based funds, determined by a sliding scale, are used at the discretion of the family. FFF is available at DAs in all counties.

(1) **Eligibility**

(A) Clinical:

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

(B) Financial:

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

(C) Access Criteria:

An individual who lives with their family (i.e., unpaid biological, adoptive and/or step-parents, adult siblings, grandparents, aunts/uncles, nieces/nephews and legal guardians) or an unpaid family member who lives with and supports an individual with a developmental disability.

(2) **Limitations**

(A) Individuals receiving HCBS supports are not eligible.

(B) Applicants whose income exceeds the upper limit of the sliding scale are not eligible.

(C) Individuals living independently, or with their spouse, are not eligible.

(D) Flexible Family Funding is limited to a maximum of \$1,000 per year per person. Increases to this maximum amount can be made through the *System of Care Plan*.

(E) Funds must be used in accordance with the Department's *Flexible Family Funding Guidelines*.

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(f) **Global Campus**

The Global Campus program provides 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 determined by DCF/Economic Services Division.

(C) Access Criteria:

Access to Global Campus is limited to the geographic area where it is provided.

(2) **Limitations**

The Department determines the amount of funding allocated to an agency for this program.

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

Developmental Disabilities HCBS are long term services and supports provided 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 throughout the state. Individual HCBS budgets may include funding for any or all of the services and supports listed below. The budgets are based on an all-inclusive daily rate that combines all applicable services and supports provided to the individual. The daily rate 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 *System of Care Plan* and the *Medicaid Manual for the Developmental Disabilities Services Division*.

(1) **Eligibility**

(A) Clinical:

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

(B) Financial:

Vermont Medicaid-eligible determined by DCF/Economic Services Division.

(C) Access Criteria:

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

(1) Individual would otherwise be eligible for 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 a funding priority for HCBS. An individual may have needs that meet more than one funding priority.

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however, it is only necessary to meet one of the following six funding priorities to access funding.

(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).3, infra). [Priority is for adults age 18 and over.]

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

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

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

(F) Parenting: Ongoing, direct supports and/or supervision needed for a parent with developmental disabilities to provide training in parenting skills to help keep a child under the age of 18 at home. Services may not substitute for regular role and expenses of parenting; maximum amount is \$7,800 per person per year. [Priority is for adults age 18 and over.]

(2) Limitations

(A) Services and supports must be the most cost effective option to meet the individual's assessed needs considering the individual's strengths and personal goals.

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(B) All services that can be funded under Medicare, Medicaid State Plan and/or private insurance must be accessed before using developmental disabilities HCBS funding.

(C) HCBS funding may not duplicate or substitute for services and supports that are the responsibility of other support systems.

(D) Funded services shall not duplicate or substitute for available natural supports or unpaid supports.

(E) Funds must be used in accordance with the *System of Care Plan* and the *Medicaid Manual for the Developmental Disabilities Services* and Federal HCBS Rules, including provisions for conflict-free case-management.

(F) New funding must be used to meet an individual's needs and goals related to the identified funding priority. Changes in a funded area of support must continue to meet the needs related to the identified funding priority. For up to one calendar year after approval of new funding, any reductions to an individual's budget, including both existing and new funding, up to the amount newly-funded, must be returned to the appropriate statewide fund (Equity and Public Safety). After one calendar year, these funds are available to the agency and Supportive ISO to reallocate.

(G) An individual's HCBS funding may be suspended for up to a maximum of six months. –Services, in whole or in part, must be suspended if the individual is incarcerated, in a nursing facility, ICF/DD, psychiatric hospitalization or other hospitalization, if there is a 14-day gap in service provision, visits outside of Vermont, leaves services or other circumstances. (See *System of Care Plan* and *Medicaid Manual for the Developmental Disabilities Services Division* for additional information regarding suspensions).

(H) An individual's HCBS funding must be terminated for stays lasting more than six months for incarceration, nursing facility, ICF/DD, extended visits out of state and also for moving out of state, declining services, prolonged suspensions lasting longer than six months and death.

(I) Developmental disabilities HCBS services funding cannot be used to:

(i) Increase the availability of residential settings that provide supports to more than four adults (age 18 and over). Any exceptions to this limitation must be approved by the Division.

(ii) Fund residential settings that provide supports to three or more children (under the age of 18). Any exceptions to this limitation must be approved by the Division.

(iii) Fund placements in residential schools or treatment centers; or in-state or out-of-state nursing facilities, correctional facilities, psychiatric hospitals or ICF/DDs.

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(iv) Fund out-of-state placements for adults unless they pose a risk to public safety, there are no appropriate treatment options in Vermont, and the cost is less than the cost of community-based supports in Vermont. Involvement and approval by the Division is required.

(v) Pay for room and board, including costs of vacations. HCBS funding may be used, however, to cover costs incurred by a paid caregiver to support an individual on vacation (e.g., hotel and food expenses).

(vi) Incentive payments, subsidies, or unrelated vocational training expenses for Supported Employment such as the following:

(1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(2) Payments that are passed through to users of supported employment programs.

(3) Payments for vocational training that are not directly related to individuals' supported employment program.

(4) Payments for group, enclave or sheltered work models.

(vii) Settings that tend to isolate as described in federal HCBS Rules.

(J) Funding for work supports is to maintain an employer-paid job. -The following limits apply to new funding for community supports and work supports:

(i) Community supports and work supports are limited to individuals who are not enrolled in high school who are age 18 and older.

(ii) Individuals receiving work supports only: work support hours may not exceed 25 hours per week, including transportation hours.

(iii) Individuals receiving community supports only: community support hours may not exceed 25 hours per week (community support hours include transportation time).

(iv) Individuals receiving both work supports and community supports: may not exceed a total of 25 hours per week of community supports and work supports combined (including work support transportation hours). An individual is not eligible for new funding for community supports if they are already receiving 25 hours per week of work supports.

(K) Shared living homes must meet the housing safety and accessibility standards.

(i) The home provider, or applicable landlord, is responsible for all costs incurred to comply or to remain in compliance with the housing safety standards.

(ii) HCBS funding may help pay for home modifications for physical accessibility, not to exceed \$10,000. The costs of ramps, widening doorways and accessibility modifications to bathrooms may be appropriate costs to reimburse.

(1) Physical accessibility modifications that do not add to the value of the home may be paid for, when necessary, using the agency and Supportive ISO base allocation, new funding or one-time funding. Once

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a modification is paid for, the additional allocation must be deducted from the individual's budget.

(2) Modifications that improve the value of the home that are made to meet the physical accessibility needs of an individual may only be funded up to 50% of the cost, not to exceed the \$10,000 cap.

(3) Two or more bids are required when construction work is needed to provide the modification. Funding is allocated based on the most cost effective bid.

(4) Home modifications under \$5,000 may be paid in a lump sum.

(L) Individuals who choose to self/family-manage or share-manage cannot manage 24-hour home supports (i.e., shared living, staffed living, group living). Individuals may only self/family-manage up to eight hours per day of paid home supports.

(M) The maximum HCBS funding per person per year is \$200,000. Under extraordinary circumstances, the Division may grant an exception to the maximum on a time-limited basis. -Under no circumstances shall exceptions exceed \$300,000.

(N) All existing and new budgets over \$200,000 shall be reviewed by the Division in order to verify that the funded level of support is needed. The review process shall include a review of relevant information including, but not limited to, the most recent assessment and ISA and consultation with the individual's support team. When the Division review process does not result in a finding that the level of need is verified, the Division Director shall make a final decision regarding the amount of funding based upon the information gathered during the review process and, if necessary, further consultation with the individual's support team. Agencies must be actively pursuing reductions in costs and be able to demonstrate, with supporting documentation, that they are exploring lower costs on a regular basis. Budgets over \$200,000 may be time limited and renewed based on review. Review time frames shall be established at time of approval.

(O) For requests for new funding for clinical and supportive services the follow limits apply:

(i) The maximum number of visits for psychiatry is four⁴ per year for those individuals who are stable on their medications and up to a maximum of 12 per year for those who are not stable on medications.

(ii) The maximum number of visits for individual, group or family therapy is 48 visits per year or a total of 96 visits per year for those needing a combination of those therapies.

(iii) The maximum number of visits for behavioral support and consultation is 96 visits per year.

(iv) Other supportive services are limited to 48 visits per year.

If a needs assessment justifies additional services, one-time or internal agency or Supportive ISO funds may be utilized to increase visits beyond these limits.

(P) Funding for Facilitated Communication shall only be approved when its use is consistent with the DDS guidelines and criteria for the evaluation, ongoing

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monitoring and support of facilitated communication to ensure consistent application of review standards for authorization decisions, to safeguard against unnecessary utilization of care and services and to assure that payments are consistent with efficiency, economy and quality of care.

(3) **Public Safety Funding Criteria**

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

(A) Criteria for Eligibility for Public Safety Funding:

(i) For new applicants, the public safety risk must be identified at the time of application and applicants must meet the Public Safety Funding priority criteria below.

(ii) For individuals currently receiving services, the public safety risk must be newly identified and recipient must meet the Public Safety Funding priority criteria below.

(iii) The Department's Public Safety Risk Assessment must be completed or updated for each individual who applies for Public Safety Funding in accordance with the *Protocols for Evaluating Less Restrictive Placements and Supports for People with I/DD who Pose a Risk to Public Safety*.

(iv) An individual must have proposed services that reflect offense-related specialized support needs and meet at least one of the following criteria:

(1) Committed to the custody of the Commissioner under Act 248 due to being dangerous to others. Services are legally mandated.

(2) Convicted of a sexual or violent crime, has completed their maximum sentence, and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense. Examples of "evidence" may include; recent clinical evaluations and/or recent treatment progress reports which indicate a continued risk to the public; recent critical incident reports which describe risks to public safety; and/or new criminal charges or DCF substantiations which involve harm to a person. Additional supporting evidence may be taken into account.

(3) Substantiated by the Department or DCF for sexual or violent abuse, neglect, or exploitation of a vulnerable person and there is evidence that the individual still poses a substantial risk of committing a sexual or violent offense.

(4) In the custody of DCF for committing a sexual or violent act that would have been a crime if committed by an adult, now aging out of DCF custody, and there is evidence that the individual still poses a 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

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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) Limitations

(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.

(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

Vermont has one six-person Intermediate Care Facility for individuals with Developmental Disabilities (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 the Centers for Medicare and Medicaid Services.

(B) Financial:

Vermont Medicaid eligible determined by DCF/Economic Services Division.

(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.

(2) Limitations

Services must be provided in accordance with Federal ICF/DD regulations.

(i) One Time Funding

One time funds are funds generated from various sources within the Division during each fiscal year. One time funds are used to address short term needs and cannot be used for long

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term needs. These funds may be distributed to agencies at the discretion of the Department and are not guaranteed. The amount and timing of distribution is at the discretion of the Department.

(1) **Eligibility**

(A) Clinical:

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

(B) Financial:

Vermont Medicaid eligible determined by DCF/Economic Services Division.

(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. 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 consumer 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.

(3) **Limitations**

(A) Maximum amount per person is \$5,000 and only for allowable uses described above.

(B) Cannot be used to pay for room and board.

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(j) Post-Secondary Education Initiative

The Post-Secondary Education Initiative (PSEI) is a program funded through a combination of grants and Medicaid Waivers 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. The PSEI is founded on *A Standards-Based Conceptual Framework for Research and Practice in Inclusive Higher Education* for youth with developmental disabilities. Supports are arranged with the Department's PSEI college support organizations; SUCCEED, Think College, and College Steps 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 determined by DCF/Economic Services Division.

(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 any resources beyond what is provided by the PSE program that are needed to participate.

(2) Limitations

(A) Access to the PSEI is limited to the geographic area of partnering colleges, the capacity of the PSEI program to support additional students and the PSEI funds available at the agency.

(B) The individual's existing service budget should be utilized prior to using funds from the PSEI allocations in the Master Grant Agreements. Upon college graduation, PSEI funding is returned to the agency for re-allocation to new students.

(C) Funds pay for support services only and may not be used to pay college tuition.

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

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

(1) Eligibility

(A) Clinical:

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

(B) Financial:

None

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(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.

(2) Limitations

Specialized Services are limited to a maximum of 25 hours per week.

(l) Project SEARCH

Project SEARCH prepares student-interns who are in their last year of high school with technical skills through internship rotations at a host business location. The cornerstone of this one-year program is immersion in a single business for the entire school year where students learn career development skills through job coaching and direct guidance provided by the business' department managers.

(1) Eligibility

(A) Clinical

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

(B) Financial:

Vermont Medicaid eligible determined by DCF/Economic Services Division.

(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.

(2) Limitations

Access to Project SEARCH is limited to the geographic area where it is provided.

(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) Targeted Case Management

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 determined by DCF/Economic Services Division.

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(C) Access Criteria:

TCM is available for adults age 21 and over, and children under 21 when the agency has exhausted Bridge Program funding.

(2) Limitations

(A) Individuals receiving HCBS or other case management services are not eligible.

(B) TCM may be used for discharge planning from a general hospital or Vermont Psychiatric Care Hospital up to 30 days prior to discharge.

(C) Funds must be used in accordance with the *Medicaid Provider Manual for the Developmental Disabilities Services Division*.

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 increased 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*.

4.9 Approaches to Managing within Funds Available

(a) In the event of fiscal pressures (e.g., an appropriation less than projected need, rescission), the Division may reduce agency and Supportive ISO base allocations. The Division shall issue instructions and provide guidance. Options include, but are not limited to, using one or more of the following approaches.

(1) Agencies and Supportive ISO make reductions in administrative costs.

(2) Agencies and Supportive ISO make an across the board reduction to individuals' budgets. Each individual's budget is reduced by the same percentage. Individuals and guardians must be involved in the process of determining what services are reduced.

(3) Agencies and Supportive ISO are given flexibility to determine how to fund the reduction through efficiencies, administrative and/or non-direct service reductions, and/or reductions in individual's budgets. Individuals and guardians must be involved in the process of determining what services are reduced.

(4) The Division identifies specific services that can and/or cannot be reduced.

(b) If services are reduced, individuals and guardians shall be provided with notice of the decision and the right to appeal the reduction.

4.107 Notification of decision on application

(a) Timing of the notices

(1) Within 45 days of the date of the application, the designated agency DA shall notify the applicant in writing of the results of the assessment and the amount of funding, if any, which the applicant will shall receive.

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- (2) If the assessment and authorization of funding is not going to be completed within 45 days of the date of application, the ~~designated agency~~ 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 appeal the decision, including:
- (A) The policy or citations the action is based on (e.g., System of Care Plan 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, ~~South Roylton Legal Clinic~~).
- (2) If the assessment determines the applicant has a developmental disability and has needs that fit within the System of Care Plan 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 ~~64.7(b)~~).
- (3) If the assessment determines the applicant does not have a developmental disability, the notice shall state that the ~~designated agency~~ (DA) will 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 ~~system of care plan~~ funding priority to receive services or funding, the notice shall state that the ~~designated agency~~ DA shall continue to offer information and referral services and shall place the person's name on a waiting list. (Section 4.196).

4.118 Choice of provider

- (a) The ~~agency (DA)~~ shall help a recipient learn about service options, including the option of self/family-managing services.
- (1) It is the DA's responsibility to ensure the individual receives full information in order to make an informed decision when making the choice of options/providers. The DA shall document options discussed and information shared as part of this process.
- (2) If the recipient is not self/family-managing services, the ~~designated agency~~ DA shall ensure that at least one agency within the geographic area will offers the needed services at or below the authorized funding limit.
- (3) If no other agency is available to provide the needed services and the recipient or family does not wish to self/family-manage services, the ~~designated agency~~ DA shall provide the needed services in accordance with its Master Grant Agreement.
- (b) If the recipient's needs are so specialized that no agency in the geographic area can provide the needed services, the ~~designated agency~~ DA may, with the consent of the recipient, contract with an agency outside the geographic region to provide some or all of the needed services.

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- (c) The recipient may choose to receive services from a provider other than the DA if the agency agrees to provide the needed services at or below the authorized funding limit.
- (1) When requesting new funding, if an individual chooses to receive services from a provider other than the DA, 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 agency is not able to provide the services at the lower approved budget, the DA must do so at that lower rate.
- (2) If at any time a recipient chooses or consents to receive some or all needed 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. This includes all funding related to the individual's services, including the current administration amount, but does not include: funding for local crisis services, the FE/A and statewide communication resources.
- (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 ~~D~~irector of the ~~D~~ivision of Disability and Aging Services.
- (d) The recipient may choose to self/family-manage services. (See Part 5).

4.912 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, begins a process to write an ISA ~~support agreement~~ that defines the services and supports to be provided. ~~The recipient may involve any person in the process.~~
- (b) The agency ~~(or the Supportive ISO; (in the case of self/family-managed services), the Supportive ISO)~~ has ultimate responsibility to ensure that an initial ISA ~~support agreement~~ is developed within 30 calendar days after the written authorization of funding or services, of the first day of billable services/supports. ~~but~~ This timeline may be extended at the request of the recipient as specified in the ISA Guidelines.
- (c) Initial and ongoing ~~support agreement~~ ISAs shall be written and reviewed in accordance with the Department's Guidelines for ISA Guidelines Individual Support Agreements. ~~A written ISA support agreement~~ is required even if the recipient chooses to self/family-manage services.
- (d) The ISA ~~support agreement~~ is a contract between the recipient and provider(s) who will provides the service or support.
- (e) An ISA ~~support agreement~~ may be revised at any time.

4.1310 Periodic review of needs

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(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 and level of care 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.

~~At least annually, the responsible designated agency or specialized service agency or Supportive ISO shall conduct an updated needs assessment and, together with the recipient and his or her team, review each recipient's budget and need for services.~~

(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; ~~and~~ or
- ~~(5)~~ Changes in funds available due to insufficient or reduced appropriation or an administrative arithmetic error.

(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 guardian of a recipient 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 ended, the agency or Supportive ISO shall notify the recipient as provided in Section 4.17 and Part 8.

4.1411 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 ~~Pervasive Developmental Disorder~~ Autism Spectrum Disorder does not need to be reassessed to confirm the diagnosis of ~~ASD PDD~~ 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.

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(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 4.16(b) of these regulations.

4.1512 Full reassessment (transition from high school to adulthood)

(a) The ~~designated or specialized service~~ 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 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 4.16(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 support agreement~~ and budget shall be reviewed in accordance with this Section 5.11.

4.1613 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 4.17 and Part 8.

4.1714 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 ended, 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. —

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- (b) The notice shall include the following:
- (1) A statement of the action the agency or Supportive ISO intends to take;
 - (2) When it intends to take the action;
 - (3) The reasons for the intended action;
 - (4) The policy or citations on which the action is based (e.g., System of Care Plan~~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, ~~South Royalton Legal Clinic~~).

4.1815 Notices

- (a) To the extent possible, notices should 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 ~~will~~shall explain the contents of any written notice to an applicant or recipient who cannot read.

4.1916 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 ~~System of Care Plan~~ funding priorities outlined in section 4.7 shall be added to a waiting list maintained by the ~~designated~~ agency or Supportive ISO, as applicable. ~~The designated agency or Supportive ISO shall notify an applicant that his or her name has been added to the waiting list, and explain the rules for periodic review of the needs of people on the waiting list.~~

- (a) Each 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:

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- (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.
- (a) ~~The State System of Care Plan shall specify the procedures for how the waiting list shall operate.~~

~~(b) The designated agency shall conduct or arrange for reassessment of a person on the waiting list upon being notified of a significant change in the person's life situation.~~

~~(c) In addition, the agency shall review the needs of all people on the waiting list at least annually and when there are changes in the System of Care Plan funding priorities.~~

Part 5. Self/Ffamily-Mmanaged Sservices

Note: In this Part, the words "person" or "people" means an "individual" "recipient" or "family" as defined in Part 1; and the word "services" means people receiving Medicaid funded developmental disabilities HCBSservices; and the word "manage" means "self/family manage."

Many people receiving services, or a family member of a person receiving services, can manage their services instead of having the services managed by an agency do it. People may manage their services either independently or with the help of their families. A person or a family member may manage up to 8 hours a day of paid home supports.

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 person or family member must be capable of fulfilling the responsibilities set forth in Section 5.2. The first step is to determine if the person or family can meet the rules in Section 5.2. A Supportive Intermediary Service Organization (called a Supportive ISO) makes this determination.

A person or a family also has the option of managing some, but not all, of the services and have an agency manage some of them. This arrangement, which is called shared-managing. Section 5.76 explains how shared-managing works.

~~Note: In this Part, the words "person" or "people" means a "recipient" or "family" as defined in Part 1; the word "services" means people receiving Medicaid funded developmental disabilities services; and the word "manage" means "self/family manage."~~

5.1 Self/Family-Management Agreement

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A person who is allowed to manage services must sign an agreement with a ~~Supportive Intermediary Service Organization~~ (Supportive ISO). ~~The Department will~~ shall provide an approvable the form for agreements. ~~The agreement must set out what the responsibilities of the person and has to do and what the responsibilities of the Supportive ISO has to do.~~

5.2 Responsibilities of a person who self/family-manages services

A person who manages services must be capable of and carry out the following functions ~~do each of the things in the list below, from (a) through to (o):~~

- (a) Maintain Medicaid eligibility for the person receiving services. Make sure that the person still gets Medicaid the same way. Immediately notify ~~Tell~~ the Supportive ISO of any circumstances that affect Medicaid eligibility if anything about the person's Medicaid changes.
- (b) Make ~~Develop an plan~~ ISA) ~~that reflects~~ says what services the person needs and how much money the person has been provided in their budget ~~given~~ to spend for those services. ~~The plan is called an individual support agreement. Follow the Department's ISA Guidelines to ensure that all required information is included. The plan must specify~~ exactly what each service is supposed to be and how much each service will ~~shall~~ cost each ~~on a monthly basis. The ISA plan must also identify the service provider(s) say who will~~ shall do the service and explain how the services received shall be documented.
- (c) ~~Make~~ Ensure that services and supports are provided ~~given~~ to the person in accordance with the ISA and the way that the plan and the budget ~~say they will~~ shall be given.
- (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.
- (e) ~~Make sure to~~ Follow the rules regarding ~~for~~ all services and supports. ~~Those rules are called the Department's Quality Standards for Services. They are in Section 10.57 of these regulations.~~
- (f) Understand the person's ISA ~~know what the plan and their budget say. Make necessary and changes based on the person's needs~~ them if the person's needs change. ~~To do that, Follow what these regulations and the Department's Guidelines for Individual Support Agreements ISA Guidelines regarding~~ what ~~say~~ to do when there is a change.
- (g) ~~Read~~ Follow the Department's Health and Wellness Guidelines ~~and make sure to do what the guidelines say to take care of the person's health and safety.~~ (g) — Make a complete case record and keep it up to date by writing in it every time that something happens or is supposed to happen
- (h) Follow the rules about reporting critical incidents to the Supportive ISO. Make the reports on time. The rules are in Make sure the reports are filed in accordance with the specific timeline required by the Department's Critical Incident Reporting Guidelines.
- (i) Make a r ~~Report to the Department for Children and Families (DCF) any time you suspect that~~ think abuse or neglect of a child might have occurred or is occurring ~~happened.~~ Make the report to the Department for Children and Families. Make a r ~~Report to Adult Protective Services (APS) any time you suspect~~ think abuse, neglect, or exploitation of a vulnerable adult might have happened. Report that to Adult Protective Services. If a person tells you about any abuse of a vulnerable person, make sure to report it either to DCF or APS, as appropriate. Make sure the reports are filed in accordance with the specific ~~are made on time~~ frames required by law.
- (j) Provide any behavior supports to that the person might need. Follow the directions in accordance with the Department's Behavior Support Guidelines about how to provide behavior

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supports. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

(k) ~~Prepare written back-up plans for when~~Think ahead about what to do if there is a problem so the plan cannot be followed (e.g., like a worker gets sick and/or does not show up for work).~~Write a plan that says what you will~~shall do if that happens. ~~Put in~~ Include in the plan who ~~will~~shall come and work and what ~~will~~shall happen if there is an emergency.~~It is the person's recipient or their family's responsibility~~job to find workers or back-up if the plan cannot be followed. ~~It is not the responsibility of a Supportive ISO's job or an agency to ensure staffing's job.~~

(l) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews.~~Answer surveys about services from the Department or from other places about services.~~ Make any changes that the Department indicates~~says~~ need to be made after it does a quality review or audit.~~Participate in Department-sponsored surveys regarding services.~~

(m) ~~Get a home safety and accessibility inspection through the agency if the person has managed home supports.~~ Make sure that all the necessary changes in the home are made. Follow the requirements of the Housing Safety and Accessibility Review Process to ensure the person is living in a safe and accessible home, when it is required.

(n) When hiring workers, take the following~~all of these steps, 1 through 6:~~

(1) Write a job description~~down what the worker's job is.~~ Complete~~Do~~ reference checks before allowing~~letting~~ the worker to start work by talking to people where the worker worked before;

(2) Interview,~~select~~ and hire workers that meet the requirements of the Department's Background Check Policy,~~but only if their background check is good,~~ or who receive a variance when there is an issue with the background check;

(3) Sign up with the state contracted FE/A. Choose a Fiscal Intermediary Service Organization. Give the FE/A organization all requested information to complete their needs~~to do~~ 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~~the way these~~ regulations require workers to be trained. The rules are in 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.~~do the work that they are supposed to do and put the right amount on their timesheets.~~ Confirm the accuracy of workers' Check their timesheets to verify they reflect the actual hours worked~~to make sure they are right.~~ Sign and send accurate timesheets to the FE/A; ~~and~~

(6) Suspend or fire workers as necessary; ~~and~~

(7) Follow all Department of Labor rules required of employers, including paying overtime as required;

(o) ~~Do all the other things that a person must do to m~~Manage services in accordance with. ~~Those things are in the Department's Guidelines~~guidelines for for People who are Self- Family-Managing Services~~people who are managing services by themselves or with their families.~~

(p) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the System of Care Plan or Medicaid Manual for the Developmental Disabilities

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Services Division. Seek guidance from the Supportive ISO for assistance in determining what expenses are reimbursable.

5.3 Role of the Designated Agency

For new applicants who choose to self/family-manage their services, the DA shall determine its costs to serve the individual, and the individual, who is self/family-managing, shall work with the Supportive ISO to plan how best to provide the services using the approved budget. For existing recipients who are self/family-managing who need an increase in services and funding, the Supportive ISO shall work with the DA to complete a new needs assessment, develop a funding proposal and review the proposal at the DA's local funding committee prior to requesting funding at the statewide funding committees.

5.34 Role of Qualified Developmental Disability Professional (QDDP)

- (a) A person who manages services must choose someone to be their independent QDDP or they must ask the Supportive ISO to find a QDDP for them.
- (b) If a QDDP works for an agency or a sSupportive ISO, the agency or the sSupportive ISO must make sure that the person has the skills to be a QDDP. ~~Before~~If an individual person uses a QDDP who is not~~does not hire~~employed by an agency or by ~~the~~ a sSupportive ISO, the Department's endorsement is required ~~has to agree first to ensure that they have the knowledge and skills to perform the duties of a QDDP.~~ ~~The Department has to agree before the person can be the QDDP and do what a QDDP does a person managing services.~~
- (c) The QDDP ~~will~~shall:
- (1) Approve the person's ISA plan and ensure that it is signed by the individual and guardian, if there is one;
 - (2) ~~Confirm~~Make sure that the ISA plan is being carried out the way it is supposed to be and that it meets the needs of the person;
 - (3) ~~Confirm~~Make sure that services and supports are delivered the way the Department and Medicaid regulations and guidelines require~~say they have to be~~;
 - (4) Contribute to ~~Do~~ the periodic review of the person's needs- conducted by ~~along with~~ the Supportive ISO;
 - (5) ~~Confirm~~Make sure the ISA plan is updated to show the changes in the person's needs and goals;
 - (6) Approve any changes to the ISA plan; and
 - (7) Inform~~Tell~~ the person about his or her rights as that are outlined in the Developmental Disabilities Act of 1996, in Part 5 of these regulations.

5.54 Responsibilities of a Supportive ISO when a person self/family-manages services

When a person manages services, the Supportive ISO ~~will~~shall:

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- (a) ~~Provide Give help and support and assistance to the person to ensure they learn and understand the responsibilities of managed services including following all policies and guidelines for the Division. That help will include e~~ Explaining managed services and the person's employer role and responsibilities;
- (b) ~~Conduct Do the~~ periodic reviews ~~along with contributions from the QDDP, make adjustments to budgets as needed and notify the person of his or her~~ their rights under these regulations;
- (c) ~~Confirm the person's Medicaid eligibility~~ check ~~on an annual basis~~ each year to make sure the person is still eligible for Medicaid;
- (d) Help the person to develop and ~~directly manage the person's authorized funding limit budget and services, ensuring that it is not managed by a third party as well as providing assistance in determining whether a specific service is reimbursable under department rules.~~ Provide the ~~FE/A Fiscal ISO~~ with the person's budget;
- (e) Bill Medicaid upon ~~receipt of documentation that indicates when it receives the right papers to show what services were given and how much money was spent;~~
- (f) ~~Change a person's budget from time to time and R~~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. ~~under the System of Care Plan;~~
- (g) ~~Confirm Make sure that the person has a current ISA plan (individual support agreement) that Make sure the plan matches reflects the areas of support funded in the budget and identifies and addresses . Make sure the plan talks about any known health and safety concerns;~~
- (h) ~~If a person asks, give Provide QDDP services when requested~~ oversight. QDDP ~~services oversight will be are~~ a separately purchased service;
- (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 person or their family member responsible for managing services understands that the person must have a complete case record; ~~in accordance with the requirements outlined in the Guide for People who are Self- or Family-Managing.~~
- (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 Give information to the person about the Department~~ Division's crisis network; ~~to the person or their family member responsible for managing services;~~
- (l) ~~Make sure that the person is able to follow all the necessary parts of doing managed service~~ Determine that the person who is managing the services is capable of carrying out the duties ~~by conducting an initial assessment and providing ongoing monitoring;~~
- (m) ~~Provide Give~~ required pre-service and in-service training to the person's support workers if the person does not ~~provide give that training--.~~ The training ~~requirements~~ rules are ~~located in Part 940 of these regulations;~~ and
- (n) ~~Form and consult with~~ Have an advisory board.

5.65 Determination that the person is unable to self/family-manage services

- (a) The Supportive ISO can ~~terminate stop~~ the management agreement if it decides that the person is not ~~capable of to managing~~ services. ~~The Supportive ISO has to talk with someone from~~

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~~the Department before stopping the agreement. If the person's management agreement is terminated stopped, then the person's services will~~ shall be provided by either the person's designated agency DA or from a SSA willing to provide services. Unless it is an emergency, the Supportive ISO has to inform ~~the~~ the person at least 30 days before terminating ~~ahead if it plans to end~~ the agreement.

(b) The Supportive ISO ~~may~~ can decide that the person is not capable of ~~to~~ managing e-services ~~only~~ for one or more of these reasons:

- (1) The managed services put the person's health or safety at risk (the agreement can be terminated immediately if the person is in imminent danger);
- (2) The person is not able to consistently arrange or provide the necessary services; ~~or~~
- (3) The person Refuses ~~at~~ to participate in the Division's quality assurance reviews; ~~or~~
- (4) Even after receiving ~~getting~~ training and support, the person is not substantially or consistently performing his or her responsibilities for self/family-management as outlined in 5.2 following the rules for an employer that are in the agreement. Not following the rules also means ~~This includes~~ not following policies, regulations, guidelines, or funding requirements or not maintaining and/or ensuring proper documentation for developmental disabilities ~~y services.~~. The Supportive ISO shall document substantial non-performance as follows:

(A) When the Supportive ISO discovers an issue, they shall notify the person 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 person as needed;

(B) If the person has not corrected the issue according to the required timeframe, the Supportive ISO shall send written notice to the person 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 a person is not able to manage services, the person may appeal. ~~The appeal goes to the Division Director. The Director may set a period of time for the person to correct the mistakes or follow the rules. The decision about what to do is up to the Division Director's discretion. The decision of the Division Director may be appealed to the Human Services Board.~~ The Supportive ISO must provide written notice to the person at least 30 days prior to terminating the self/family-management agreement and include the person's rights to appeal. The appeal process is outlined in Part 8 of these regulations.

5.76 Responsibilities of a person who share-manages services

A person ~~may~~ can manage some services and let an agency manage some services. That is called shared-managing. ~~A person who share-manages with an agency must do~~ all of the following ~~each of these things:~~

- (a) Ensure ~~Give~~ services and supports are provided to the person in accordance with the way the ISA plan (individual support agreement) and their budget say they will ~~be given.~~

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- (b) ~~Give~~ Follow the rules regarding all services and supports. Those rules are called ~~the way~~ the Department's *Quality Standards for Services*. ~~say to give them. Follow the rules~~ They are in Section 10.75.
- (c) Make and keep all ~~required~~ papers and records as required by the agency.
- (d) Report critical incidents to the agency. Make sure the reports are filed on time. ~~Report the incidents in accordance with the way the specific timelines required by the Department's *Critical Incident Reporting Guidelines* say to report them.~~
- (e) Make a reports about to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring to the Department for Children and Families. ~~Make a reports about to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring to Adult Protective Services.~~ Make sure these the reports are filed in accordance with the specific on-timeframes required by law. ~~Report if you think the abuse happened or if someone tells you it did.~~
- (f) ~~Provide Give the person any behavior supports to the person in accordance with needs in the way it says to give them in 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 person's or their family'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. Think ahead about what to do if there something happens and the plan cannot be followed, like a worker gets sick and does not show up. Write a plan that says what you will do if that happens. Put in the plan who will come and work and what will happen if there is an emergency. It is the recipient or family's job to find workers or back up if the plan cannot be followed. It is not the Supportive ISO's job or an agency's job.
- (h) ~~Take part in the Department's quality review process.~~ Answer surveys about services from the Department or other places about services. ~~and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates says need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services. Make any changes that the Department says need to be made after it does a review.~~
- (i) When hiring workers, follow steps 1 through 6 take the following steps:
- (1) ~~Write down what the worker's a job description is.~~ Do Complete reference checks before allowing letting the worker to start work by talking to people where the worker worked before;
 - (2) ~~Interview, select and hire workers, but only if their that meet the requirement of the Department's background check policy is good, or if you receive a variance when there is an issue with the background check;~~
 - (3) ~~Choose a Fiscal Intermediary Service Organization. Sign up with the state contracted FE/A. Give the FE/A organization all requested information it needs to do 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 the way these regulations require workers to be trained.~~ The rules are in the See 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 do the work that they are supposed to do and put the right amount on their timesheets.~~ Confirm the accuracy of workers' timesheets. Check their timesheets to make sure they are right. Sign and send accurate timesheets to the FE/A; and
- (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 *Medicaid Manual for the Developmental Disabilities Services Division*. Seek guidance from the agency for assistance in determining what are reimbursable expenses.

Part 6-- Recipient Financial Requirements

6.1 Income and resources; Medicaid-funded programs

For all supports and services funded by Medicaid, the income and resource rules of the Department for Children and Families governing eligibility for Medicaid programs apply, and are incorporated here by reference.

6.2 Room and board; personal spending money

Medicaid developmental disabilities ~~home and community-based services~~ funding does not cover room and board, clothing, or personal effects.

- (a) ~~At least annually, the Commissioner (a) 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-

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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 works 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.

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 will 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.

(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.

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

7.3 Application and limitations

- (a) These sections (Part 7) apply to designated agencies and specialized service agencies (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 ~~person~~ 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.

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- (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 else by a qualified health professional.
- (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 ~~registered~~ nurse has determined that an individual ~~person~~ needs a special care procedure, the agency is responsible for ensuring that a specialized care plan is attached to the ~~individual's support agreement~~ ISA and that every person who is authorized to perform a special care procedure has a copy of the specialized care plan.
- (b) 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 ~~registered~~ nurse to monitor the performance of specialized care procedures. (Sections 7.8 and 7.9)

7.8 Training

- (a) Qualifications of trainer—_Training shall be provided by a ~~registered~~ nurse—_The ~~registered~~ nurse shall have a current 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 ~~will~~ shall define the procedures to be used with a particular individual.

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(e) Documentation of training.—~~The agency responsible for the health needs of the individual is responsible for ensuring that the registered 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 registered nurse shall be notified of any changes in an individual person'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.

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 registered nurse.—The specialized care plan willshall 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 registered 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 registered 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~~person with a developmental disability~~.

7.10 Monitoring

Ongoing monitoring by a ~~registered~~ 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~~yearly~~.

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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.~~

(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 regulations ~~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.~~

(d) 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.

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 an ISA service plan;
- (3) Denial, in whole or in part, of payment for a covered service;

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- (4) Failure to provide a clinically indicated, covered service, when the provider is a state agency, or a ~~designated agency~~ DA or a ~~specialized service agency~~ SSA. ~~(DA/SSA)~~;
- (5) Failure to act in a timely manner when required by state ~~regulation~~ 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~~ DA or a ~~specialized service agency~~ SSA. ~~—~~. In addition, a Supportive ISO ~~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 or Supportive ISO~~.
- (d) “Decision maker” means the person or people empowered to make a decision under Sections 8.4 and 8.5.
- (e) “Expedited Appeal” means an internal MCE appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the recipient’s life, health or ability to attain, maintain, or regain maximum functioning.
- (f) “Fair Hearing” means an appeal filed with the Human Services Board, whose procedures are specified in rules separate from the MCE grievance and appeal process.
- (g) “Filed” or “notified” means personally delivered, or deposited in the U.S. mail with first class postage affixed.
- (h) “Grievance” means an expression of dissatisfaction about any matter that is not an action. ~~—~~. Possible subjects for a grievance include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the recipient’s rights. ~~—~~. If a grievance is not acted upon within the timeframes specified in rule, the recipient may ask for an appeal under the definition above of an action as being a “failure to act in a timely manner when required by state rule.” If a grievance is composed of a clear report of alleged physical harm or potential harm, the agency or Department ~~will~~ shall 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) ~~An designated agency or a specialized services agency~~; and

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- (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 they are/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 ~~regulation~~ rule or law, or 4) identified in the Intergovernmental Agreement between the Department of Vermont Health Access and Agency of Human Services (AHS) departments or the Department of Education for the administration and operation of the Global Commitment to Health waiver.

8.3 Grievances

- (a) A grievance may be initiated by a recipient or the designated representative of a recipient. A grievance may be expressed orally or in writing.
- (b) Grievances shall be filed within 60 days of the pertinent issue in order for the grievance to be considered. ~~Staff members shall assist a recipient if the recipient or his or her representative requests such assistance.~~
- (c) A written acknowledgement of a grievance shall be mailed within ~~five~~ 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~~ shall be acknowledged by the MCE in writing within ~~five~~ 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~~

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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~~shall 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~~five calendar days of receipt.

(h) The grievance review ~~will~~shall assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination—.

The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented—.

The recipient shall be notified in writing of the finding of the grievance review within 90 days.

(i) Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the recipient may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V. S. A. § 3091 (a).

8.4 Right to an internal MCE appeal

(a) When the agency issues an action subject to appeal, including a decision to deny, ~~reduce~~, or terminate eligibility, or deny, reduce, or terminate services, or when an agency fails to act within 45 days upon an application for services, it shall notify the applicant or recipient of the right to appeal—.

Notice shall be provided as described herein—.

In the event the agency fails to provide notice of appeal rights, the time limit for an applicant or recipient to ~~request~~submit an appeal shall be extended from the time proper notice was provided according to the required timeframes.

(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.

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- (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 five -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.
- (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 five 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 agency 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.

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(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~~shall be held during normal business hours and, if necessary, the meeting ~~will~~shall 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~~shall 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~~shall 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~~shall inform the recipient that the request does not meet the criteria for expedited resolution and that the appeal ~~will~~shall be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited internal MCE appeal shall be promptly communicated (within ~~two~~2 calendar days) to the recipient and followed up within ~~two~~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 ~~three~~3 working days. If an expedited appeal cannot be resolved within ~~three~~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 ~~two~~2 calendar days) to the recipient and followed up within ~~two~~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.

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- (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~~ shall 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 ~~they~~ he or she may request that covered services be continued without change as well as the circumstances under which the recipient may be required to pay the costs of those services pending the outcome of any internal MCE appeal or fair hearing.
- (b) The agency shall provide notice, including reference to the applicable policy or citation the action is based on, as described in Sections 4.7, 4.12, 4.14, 4.15 and throughout Part 8, to an applicant or recipient of the rights provided in the Developmental Disabilities Act, 18 V.S.A. §§ 8727 (a) and 8728, and any other rights under state and federal law, as well as the right of grievance.
- (c) All agencies and the Department shall post notices of the right to appeal and the procedure for appealing or initiating a grievance within the public areas of the agency. ~~The Department shall provide such notices for posting, which shall include telephone numbers for receiving help in initiating a grievance, appeal, or fair hearing request.~~

8.8 Continued services

- (a) If requested by the recipient, services shall be continued during an appeal regarding a Medicaid-covered service termination, suspension or reduction under the following circumstances:
- (1) The appeal was filed in a timely manner, meaning before the effective date of the proposed action;
 - (2) The recipient has paid any required premium(s) in full; and
 - (3) The appeal involves the termination, suspension or reduction of a previously-authorized course of treatment or ISA 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;

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- (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 ~~regulation~~ 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~~ shall occur only if an internal MCE appeal, fair hearing decision, secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCE also determines that the recipient should be held liable for service costs.
- (c) If the provider notifies the recipient that a service may not be covered by Medicaid, the recipient can agree to assume financial responsibility for the service. ~~If the provider fails to inform the recipient that a service may not be covered by Medicaid, the recipient is not liable for payment. Benefits will~~ shall 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 notice of action internal appeal decision, or within 30 days of~~

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the date the MCE internal appeal decision was ~~postmarked~~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~~shall 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~~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~~ System of Care Plan and the rules and policies of the Department, unless the Board finds that the ~~System of Care Plan~~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~~ AHS shall review all decisions and orders of the Human Services Board in accordance with 18 V.S.A. §8727 (b) (2).

Part 9. Training

9.1 Purpose

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

9.2 Standards

(a) The ~~Division~~ Department shall specify 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.

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(b) The standards shall ~~ensure that~~ endeavor to involve individuals ~~people~~ with developmental disabilities and their families are involved in the design, delivery, and evaluation of training.

9.3 Agency 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 ~~will~~ 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, ~~will~~ 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
- 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 ~~person with a developmental disability~~.

(b) The training plan shall be written and based on the agency's assessment of ~~the agency's~~ its ability and capacity to meet the needs of the people it serves, the local System of Care Plan ~~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 ~~designated~~ agency, ~~specialized services~~ agency and Supportive ISO shall:

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- (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~~Department for Children and Families, and abuse, neglect and exploitation of vulnerable adults to ~~APS~~Adult Protective Services.
- (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.
 - (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 person~~ who receives support funded by the Department, each worker shall ~~demonstrate knowledge or be trained~~ demonstrate knowledge in all of the following areas:

- (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 person~~ 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 person~~ or family.) For self/family-managed services and share-managed services the ~~recipient employer of record or family~~ is responsible for providing or arranging for this training for their workers. For share-managed services and respite, the agency is responsible for ensuring that the employer of record has provided this training and the worker demonstrates knowledge in the areas below.

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- (1) Whether the ~~individual person~~ has a guardian, and how to contact the guardian;
 - (2) The individual's behavior, including ~~how to recognize and respond to stressors~~ 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 person~~;
 - (4) How to communicate with the ~~individual person~~; and
 - (5) The ~~individual person's ISA~~ individual support agreement, including the amount of supervision the ~~individual person~~ requires.
- (d) Values:
- (1) Individual rights;
 - (2) Confidentiality;
 - (3) Respectful interactions with ~~individuals~~ people with developmental disabilities 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 or demonstrate the knowledge and skills necessary to support individuals, including:
- (1) The worker's role in developing and implementing the ~~individual support agreement (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 support agreement~~ (including facilitating inclusion, teaching and supporting new skills, supporting communication). For self/family-managed services, the recipient or family 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 96 hours.

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(b) In an emergency, if the unavailability of a trained worker creates a health or safety risk for the ~~individual person with a developmental disability~~, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 96 hours as long as essential information about the ~~individual person~~ is communicated to the worker ~~and he or she in brief form~~ has immediate access to all the documents and information covering all areas of Pre-service training (see Section 9.4).

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/~~duration of certification~~

(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).

(~~ab~~) ~~Current providers.— Any designated agency or specialized service agency receiving Department funds on the effective date of these regulations is presumed to be certified.~~

(~~bc~~) ~~New provider.— A new provider that wishes to be certified by the Department shall first establish either that it meets the standards for designation or meets the requirements in subsection (c) below.— 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).~~

~~this Part~~

~~(c) Certification or recertification of providers that do not meet the standards for designation~~

(~~1d~~) ~~Providers that are not designated but who wish to be shall not be certified must meet all the requirements of Part 10 of these regulations.~~

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

(2) ~~When the Department determines that a provider is willing and able to meet certification criteria and provides services consistent with the local and state system of care plans, a~~

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~~provider may be certified for one year. The period of certification may be extended for up to three years in cases of outstanding performance. The duration of certification is dependent upon the level and degree to which the provider meets the certification criteria and its willingness and ability to correct/improve deficiencies.~~

~~(3) The Department makes the final decision as to whether an organization should be certified. The Department will offer the designated agency for each region in which a provider will operate an opportunity to comment about whether a provider is needed and should be certified. The Department will consider the recommendations of the designated agency for the region or regions, as well as input from people with developmental disabilities, family members, and other interested people, and will investigate or consider any concerns related to whether the organization should be certified.~~

~~(d) The Department will specify the format and procedures for applications for certification.~~

~~(e) The Department shall send the applicant a written determination within 9030 days after receiving an application for certification. An organization shall be certified. In order to receive funds administered by the Department, an organization must be certified and have a Master Grant Agreement with the Agency of Human Services.~~

10.3 Monitoring of certification

~~(a) 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 AHSthe Agency of Human Services.~~

~~(b) A certified provider shall be subject to unannounced monitoring visits by the Department at any time, regardless of certification status.~~

10.4 Principles of service

~~(a) To be certified, a provider shall provide services/supports that foster and adhere to these principles:~~

~~(1) Children's Services. Children, regardless of the severity of their disability, need families and enduring relationships with adults in a nurturing home environment. The quality of life of children with developmental disabilities, their families and communities is enhanced by caring for children within their own homes. Children with disabilities benefit by growing up in their own families; families benefit by staying together; and communities benefit from the diversity that is provided when people with varying abilities are included.~~

~~(2) Adult Services. Adults, regardless of the severity of their disability, can make decisions for themselves, can live in typical homes and can contribute as citizens to the communities where they live.~~

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- ~~(3) Full Information. In order to make good decisions, people with developmental disabilities and their families need complete information about the availability, choices and costs of services, how the decision-making process works, and how to participate in that process.~~
- ~~(4) Individualized Support. People with developmental disabilities have differing abilities, needs and goals. To be effective and efficient, services shall be individualized to the capacities, needs and values of each individual.~~
- ~~(5) Family Support. Effective family support services shall be designed and provided with respect and responsiveness to the unique needs, strengths and cultural values of each family and the family's expertise regarding its own needs.~~
- ~~(6) Meaningful Choices. People with developmental disabilities and their families cannot make good decisions without meaningful choices about how they live and the kinds of services they receive. Effective services shall be flexible so they can be individualized to support and accommodate personalized choices, values and needs and assure that each recipient is directly involved in decisions that affect that person's life.~~
- ~~(7) Community Participation. When people with disabilities are segregated from community life, all Vermonters are diminished. Community participation is increased when people with disabilities meet their everyday needs through resources available to all members of the community.~~
- ~~(8) Employment. The goal of job support is to obtain and maintain paid employment in regular employment settings.~~
- ~~(9) Accessibility. Services shall be geographically available so that people with developmental disabilities and their families are not required to move to gain access to needed services, thereby forfeiting natural community support systems.~~
- ~~(10) Health and Safety. The safety and health of people with developmental disabilities is of paramount concern.~~
- ~~(11) Trained Staff. In order to ensure that the goals of this section are attained, all individuals who provide services to people with developmental disabilities and their families shall receive training as required by 18 V.S.A. § 8731 and Part 10 of these regulations.~~
- ~~(12) Fiscal Integrity. The fiscal stability of the service system is dependent upon skillful and frugal management and sufficient resources to meet the needs of Vermonters with developmental disabilities.~~

10.45 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.

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(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.

10.6 ~~Rights of individuals who receive services/supports~~

~~To be certified, a provider shall have a written policy stating its commitment to assuring the rights of all individuals and families who receive services/supports as stated in the Developmental Disabilities Act of 1996. To be certified, a provider shall provide services/supports that respect the rights of individuals and their families. The provider shall assist individuals and families to understand the rights listed in this section as well as rights provided by state or federal law, and shall provide this information in a format and language that is easy to understand.~~

~~— (a) Every recipient has the right to:~~

~~— (1) Be free from aversive procedures, devices and treatments.—~~

~~— (2) Have privacy, dignity, confidentiality and humane care.~~

~~— (3) Associate with and have relationships with individuals of their choice.~~

~~— (4) Communicate in private by mail and telephone.~~

~~— (5) Communicate in his or her primary language and primary mode of communication.~~

~~— (6) Be free from retaliation for making a complaint, voicing a grievance, recommending changes in policies or exercising a legal right.~~

~~— (7) Maintain contact with family, unless contact has been restricted by court order.~~

~~— (8) Refuse or terminate services, except where services are required by court order.~~

~~— (9) Have access to, read and challenge any information contained in any records about the person that are maintained by the Department or any agency or program funded by the Department and to file a written statement in the record regarding any portion of the record with which the person disagrees.~~

~~— (b) Every family that receives services in the context of supporting a family member with a developmental disability has the right to:~~

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- ~~(1) Receive services without relinquishing custody of a child or children except when custody is terminated in accordance with Vermont law.~~
- ~~(2) Privacy and confidentiality.~~
- ~~(3) Communication.~~
- ~~(4) Be free from retaliation for making a complaint, voicing a grievance, recommending a change in policy or exercising a legal right.~~
- ~~(c) People committed to the care of the Commissioner pursuant to Subchapter 3 of Chapter 206 of Title 18, relating to people who present a danger of harm to others, shall have all the rights provided by this section except when the Commissioner or the court restricts those rights for reasons of safety, security or treatment.~~

10.57 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*. values and goals~~

- (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.
 - (h) Communication: Individuals communicate effectively with others.
 - (i) System Outcomes.
- ~~(a) The civil and human rights of individuals are encouraged and respected.~~
 - ~~(b) Individuals direct their own lives.~~
 - ~~(1) Individuals make the decisions that affect their lives.~~
 - ~~(2) Individuals have the opportunity to manage services and choose how resources are used.~~
 - ~~(c) The needs of individuals are met and their strengths and preferences are honored.~~

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- ~~— (1) Services are developed with the person and family's/guardian's input and reflect the individual's strengths, needs, and goals.~~
- ~~— (2) Services are individualized.~~
- ~~— (d) Individuals live and work as independently and interdependently as they choose.~~
- ~~— (1) Services foster personal growth and encourage the development of practical life skills.~~
- ~~— (2) Individuals are safe in their homes and communities.~~
- ~~— (3) Individuals who choose to work have meaningful jobs that are suited to their interests and have the supports necessary to maintain those jobs.~~
- ~~— (e) Individuals experience positive relationships, including connections with family and their natural supports. Individuals are encouraged and receive guidance to maintain relationships that are meaningful to them.~~
- ~~— (f) Individuals participate in their local communities. Individuals have a sense of belonging, inclusion and membership in their community.~~
- ~~— (g) Individuals experience optimal health and well being.~~
- ~~— (1) Individuals have their medical and health needs met.~~
- ~~— (2) Individuals are encouraged and supported to maintain healthy lifestyles and habits.~~
- ~~— (h) Individuals communicate effectively with others. Individuals are able to communicate effectively in their preferred mode. (Communication Bill of Rights)~~
- ~~— (i) Individuals have timely assessments and service plans.~~
- ~~— (j) Individual critical incidents and other reports are made in a timely manner and are in compliance with Department policy.~~
- ~~— (k) Individuals have trained and responsive workers.~~

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 willshall be responsible for including people served by subcontracted providers to verify that they meet quality review standards.

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(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.

~~10.8 Adherence to federal and state rules, regulations, policies and procedures~~

~~To be certified, an agency shall demonstrate knowledge of and ability to abide by state and federal rules, regulations, licensing requirements, policies, guidelines and procedures.~~

~~10.9 Grievances and appeals~~

~~— (a) To be certified, an agency shall have a written policy and procedures for grievances and appeals and for the dissemination of information to individuals with developmental disabilities, consistent with Part 8 of these regulations.~~

~~— (b) To be certified, an agency shall implement the decision of the Human Services Board, issued as the result of a fair hearing request filed in accordance with Part 8 of these regulations.~~

~~10.10 Local System of Care Plans~~

~~To be certified, an agency shall participate in the development of the local system of care plan, and involve people with developmental disabilities, families, workers and other stakeholders who are associated with the agency in the development of this plan.~~

~~10.11 Training~~

~~To be certified, an agency shall implement training as required in Part 9 of these regulations and in Department training standards.~~

~~10.12 Additional certification requirements for providers that are not designated agencies~~

~~In order to be certified, a provider must meet all of the following requirements.~~

~~— (a) Organizational requirements.~~

~~— (1) Incorporation. An organization must be incorporated to do business in the State of Vermont as a nonprofit organization, and have received or applied for federal recognition~~

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~~as a tax-exempt charitable organization as defined in Section 501(c)(3) of the Internal Revenue Code of the United States.~~

~~(2) Governance. An organization must have by laws and a plan for governance and administration that includes a board of directors that consists of citizens who are representative of the general locale and individuals served. The board of directors shall have the powers ordinarily invested in a board of directors, including hiring, evaluation, and termination of the executive director; oversight of budget, operations and property; and assessment of quality of services.~~

~~(3) Policy input from people with developmental disabilities and their natural or adoptive families. A majority of the members of the board shall be composed of both individuals who are or were eligible to receive services from an agency because of their disability, and family members of an individual who is or was eligible to receive services because of his or her disability. At least 25 per cent of the standing committee shall be people with developmental disabilities, and a majority of the standing committee shall be either people with developmental disabilities or family members. The standing committee (or board of directors, if a majority of its members are people with developmental disabilities or family members) shall do the following:~~

~~(A) Evaluate the performance of the provider.~~

~~(B) Recommend or set policy regarding services.~~

~~(C) Participate in the selection and evaluation of key managerial staff.~~

~~(D) Assess the quality and responsiveness of services, and make recommendations as indicated.~~

~~(E) Review the efficiency and effectiveness of the provider's financial and human resources.~~

~~(F) Participate with the designated agency in the development and design of services and supports and in development of the local and state system of care plans.~~

~~(G) Participate in and evaluate the provider's complaint resolution process in a manner that is respectful of individual confidentiality, and as required by Part 9 of these regulations.~~

~~(H) Report its findings and recommendations to the board of directors and to the Division.~~

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- ~~— (b) Fiscal management. In order to be certified, a provider must:~~
- ~~— (1) have fiscal management practices which demonstrate fiscal solvency as defined by the Division, including the ability to meet payroll and pay bills and taxes due in a timely fashion.~~
- ~~— (2) have the ability to monitor provider revenues and expenditures for each individual with developmental disabilities receiving service/support, by staff, service/support area and in total, in accordance with generally accepted accounting principles (GAAP).~~
- ~~— (3) have proof of professional liability insurance, board/officer insurance, and general tort liability insurance within guidelines set by the Division.~~
- ~~— (4) if it is an organization, engage an independent auditor to evaluate the financial records of the provider according to Division established criteria.~~
- ~~— (c) Personnel Policies. To be certified, a provider must have written personnel policies and procedures that prohibit discrimination in accordance with federal and state law. The provider must have performance expectations and experience and education requirements for all positions, including contracted individuals. These requirements and criteria must reflect Department and Division mandates (such as minimum age, background checks, training) and must be sufficient to assure that workers meet the needs of individuals they are supporting.~~
- ~~— (d) Accessibility. To be certified, a provider's offices, housing, transportation, communication, and other services or supports must meet state and federal requirements for accessibility and comply with the Americans with Disabilities Act as it relates to each individual served.~~
- ~~— (e) Nondiscrimination. To be certified, a provider must comply with state and federal anti-discrimination laws and regulations.~~
- ~~— (f) Regional coordination. To be certified, a provider must have a working agreement with the designated agency for the region or regions where it supports people. The agreement shall detail the roles and responsibilities of the two organizations regarding services and administrative functions, including information sharing and reporting, fiscal monitoring, periodic reviews, and support plan implementation. Designated agencies are required to develop working agreements with certified providers or prospective certified providers, except when the designated agency has recommended to the Department that a provider should not be certified, and the recommendation is under consideration by the Department.~~
- ~~— (g) Outcome performance. To be certified, a provider must assure that individuals receiving services and/or supports receive them consistent with their individual support plan.~~

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~~Certified providers must also achieve provider performance outcomes in areas prioritized by the Division, the Department, and the Agency of Human Services.~~

~~— (h) — Data and information systems. To be certified, a provider must collect necessary and reliable data in a format and according to timelines set by the Division, and submit accurate information to the designated agency and/or the Division on costs, outcomes, consumer demographics, and types and frequencies of services and supports.~~

~~— (i) — Confidentiality. To be certified, a provider must protect the confidentiality of information about individuals with developmental disabilities and their families by:~~

~~— (1) — Conforming to all state and federal laws, regulations, and policies concerning confidentiality; and,~~

~~— (2) — Including in all contracts, language that explicitly states expectations about the confidentiality of information pertaining to applicants and recipients.~~

~~— (3) — Assuring that applicants, recipients, and former applicants and recipients have the opportunity to approve or refuse the release of identifiable personal information, except when such release is authorized or required by law or by state, federal or designated agency funding sources.~~

10.13 — Probation and decertification

~~— (a) — If at any time the Department determines that an agency is in significant noncompliance with the quality standards described in this Part, the Department may place the program on probation, or decertify the program, in whole or in part, as follows:~~

~~— (1) — Probationary certification. Probationary certification is used to bring the performance of an existing certified provider with numerous or serious deficiencies up to minimum certification criteria. An organization with probationary certification receives intense review during the period of probation.~~

~~— (A) — A certified provider with probationary certification may be decertified at any time for failure to meet one or more certification criteria. Probationary certification may be granted with or without specific conditions.~~

~~— (B) — A decision to place a provider on probationary certification is appealable to the Commissioner within 15 days of the date the provider receives written notification of probationary status. The Commissioner's decision regarding a probationary status appeal is final.~~

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~~(2) Decertification. A certified provider may be decertified as follows:~~

~~(A) Immediate decertification. If a certified provider knowingly disregards or neglects policies or practices and the result is endangerment of the health or safety of an individual with developmental disabilities, violation of an individual's human or civil rights, severe or intentional fiscal irresponsibility, or falsification of data/record keeping, a certified provider may be immediately decertified.~~

~~(B) Decertification for failure to improve. If the certified provider exhibits unwillingness or inability to improve performance while on probation, as measured by certification criteria and within time frames established by the Department, a certified provider may be decertified.~~

~~(b) A decision by the Department to decertify may be appealed to the Commissioner within 15 days of receipt of written notice of the decision. The Commissioner's decision regarding the decision to decertify is final. If decertification is due to endangerment of the health or safety of one or more people with developmental disabilities, the decertification will be effective on the date of notice, pending the appeal process.~~

~~(c) If necessary for the orderly transition and protection of individuals served, the Department may provide funding for a transitional period to a certified provider which has lost its certification.~~

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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 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.