

TABLE OF CONTENTS

7.100.1 Developmental Disabilities Services Purpose and Scope (04/15/2020, GCR 19-059)	4
7.100.2 Definitions	4
7.100.3 Criteria for determining developmental disability	9
(a) Young child with a developmental disability defined.	9
(b) Criteria for assessing developmental disability in a young child.	9
(c) School-age child or adult with developmental disability defined.	10
(d) Intellectual disability defined.	10
(e) Criteria for determining whether a school-age child or adult has intellectual disability.	11
(f) Process for determining whether a school-aged child or adult has an intellectual disability.	11
(g) Criteria for determining whether a school-age child or adult has an autism spectrum disorder and is a person with a developmental disability.	12
(h) Autism spectrum disorder defined.	12
(i) Criteria for determining whether a person has autism spectrum disorder.	12
(j) Essential components of an assessment to determine autism spectrum disorder.	14
(k) Significant deficits in adaptive behavior defined.	15
(l) Criteria for assessing adaptive behavior in a school-age child or adult.	15
(m) Manifested before age 18	15
(n) Nondiscrimination in assessment	15
(o) Missing information to document developmental disability.....	20
7.100.4 Recipient Criteria	16
(a) Who can be a recipient	16
(b) Recipients must be Vermont residents	16
(c) Exceptions	16
(d) People receiving services on July 1, 1996.....	17
(e) Eligibility after leave of service	17
7.100.5 Application, Assessment, Funding Authorization, Programs and Funding Sources, Notification, Support Planning and Periodic Review	17
(a) Who may apply.....	17
(b) Application form	17
(c) Where to apply	17
(d) Screening.....	18
(e) Assessment	18
(f) Authorization of funding for services	19
(g) Available Programs and Funding Sources	19
(h) Special Initiatives	19
(i) Notification of decision on application	20
(j) Choice of provider.....	20
(k) Individual support agreement (ISA).....	21
(l) Periodic review of needs	22
(m) Full reassessment of a young child	22
(n) Full reassessment (transition from high school to adulthood).....	23
(o) Full reassessment.....	23
(p) Notification of results of reassessment or periodic review.....	23
(q) Waiting list	24
7.100.6 Self/Family-Managed Services	24

Disability Services – Developmental Disabilities

(a) Self/Family-Management Agreement	24
(b) Responsibilities of an individual or family member who manages services	25
(c) Role of the Designated Agency	26
(d) Role of Qualified Developmental Disability Professional (QDDP).....	26
(e) Responsibilities of a Supportive ISO when an individual or family member manages services	27
(f) Determination that the individual or family member is unable to manage services	28
(g) Responsibilities of an individual or family member who share-manages services	29
7.100.7 Recipient Financial Requirements	30
(a) Income and resources; Medicaid-funded programs.....	30
(b) Room and board; personal spending money	31
(c) Financial responsibility of parents.....	31
7.100.8 Special Care Procedures.....	31
(a) Purpose	31
(b) Special Care Procedure	31
(c) Application and limitations	32
(d) Determining that a procedure is a special care procedure	32
(e) Who determines special care procedures.....	33
(f) Who may perform a special care procedure.....	33
(g) Specialized care plan	33
(h) Training	33
(i) Competence.....	34
(j) Monitoring	34
7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings	35
7.100.10 Training	35
(a) Purpose	35
(b) Standards	35
(c) Agency and Supportive Intermediary Support Organization responsibilities	36
(d) Pre-service training	37
(e) In-service training.....	38
(f) Exception for emergencies.....	39
7.100.11 Certification of Providers	39
(a) Purpose of certification.....	39
(b) Certification status.....	39
(c) Monitoring of certification	40
(d) Services available regardless of funding source.....	40
(e) Quality standards for services.....	40
(f) Status of non-designated providers	41
7.100.12 Evaluation and Assessment of the Success of Programs	41

7.100.1 Developmental Disabilities Services Purpose and Scope (04/15/2020, GCR 19-059)

- (a) The purpose of these regulations is to fulfill the requirements of the Developmental Disabilities Act of 1996 (DD Act) (18 V.S.A Chapter 204A) to include specific details for implementation of the Act. These rules are adopted pursuant to 18 V.S.A. § 8726.
- (b) The Developmental Disabilities Services program operates within the State’s Global Commitment to Health 1115 Waiver, providing long-term services and supports to individuals with developmental disabilities.
- (c) The Program is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

7.100.2 Definitions

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

- (a) **“Adult”** means a person age 18 or older. The term includes people age 18 or older who attend school.
- (b) **“Agency”** means the responsible designated agency or specialized service agency.
- (c) **“Applicant”** means a person who files a written application for services, supports or benefits in accordance with 7.100.5 of these regulations. If the applicant is a guardian or family member or a designated agency, the term “applicant” also includes the person with a developmental disability.
- (d) **“Authorized Funding Limit”** (AFL) means all funding related to an individual’s home and community-based services budget, including the administration amount available to transfer (as specified in division policy), but does not include: funding for state and local crisis services, the employment program base and statewide communication resources.
- (e) **“Authorized Representative”** means an individual or organization, either appointed, by an applicant or beneficiary, or authorized under State or other applicable law, to act on behalf of the applicant or beneficiary in assisting with the application and renewal of eligibility, the internal appeal, grievance, or State fair hearing processes, and in all other matters with the Department, as permitted under 42 CFR § 435.923. Unless otherwise stated in law, the authorized representative has the same rights and responsibilities as the applicant or beneficiary in obtaining a benefit determination and in dealing with the internal appeal, grievance, and State fair hearing processes.
- (f) **“Certification”** means the process by which the Department of Disabilities, Aging, and Independent Living determines whether a provider meets minimum standards for receiving funds it administers to provide services or supports to people with developmental disabilities.
- (g) **“Certified provider”** means an agency that has as one of its primary purposes to deliver services and supports for people who have developmental disabilities and that currently is certified by the Department of Disabilities, Aging and Independent Living in accordance with 7.100.11 of these regulations.
- (h) **“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.

Disability Services – Developmental Disabilities

- (i) **“Commissioner”** means the Commissioner of the Department of Disabilities, Aging, and Independent Living.
- (j) **“Community Supports”** means support provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (two or more people). Community supports includes transportation to access the community. Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal home and community-based services rules.
- (k) **“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.
- (l) **“Day”** means calendar day, not business day, unless otherwise specified.
- (m) **“Department”** means the Department of Disabilities, Aging, and Independent Living.
- (n) **“Designated Agency”** (DA) means an agency designated by the Department, pursuant to 18 V.S.A. § 8907, and the regulations implementing that law, to oversee, provide and ensure the delivery of services and/or service authorizations for eligible individuals with developmental disabilities in an identified geographic area of the state. The requirements for being a DA are explained in the Department’s *Administrative Rules on Agency Designation*.
- (o) **“Developmental Disability”** (DD) means an intellectual disability or an autism spectrum disorder which occurred before age 18 and which results in significant deficits in adaptive behavior that manifested before age 18 (See 7.100.3). 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.
- (p) **“Division”** means the Developmental Disabilities Services Division (DDSD) within the Department.
- (q) **“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.
- (r) **“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.
- (s) **“Fiscal/Employer Agent”** (F/EA) means an organization that is:
- (1) Qualified under Internal Revenue Service rules to pay taxes and provide payroll services for employers as a fiscal agent; and
 - (2) Under contract with the Department to handle payroll duties for shared living providers who

Disability Services – Developmental Disabilities

hire workers and recipients or families who choose to self/family-manage or share-manage services.

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

(u) **“Home and Community-Based Services” (HCBS)** means an array of long term services developed to support individuals to live and participate in their home and community rather than in an institutional setting, consistent with Centers for Medicare and Medicaid Services (CMS) federal HCBS Rules.

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

(w) **“Individual”** means a young child, a school-age child or an adult with a developmental disability.

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

(y) **“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.

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

(aa) **“Pre-service training”** means training that occurs before workers are alone with a person with developmental disabilities.

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

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

(dd) **“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.

(ee) **“Recipient”** means a person who meets the criteria contained in these regulations, and who has been

Disability Services – Developmental Disabilities

authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

(ff) **“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:

- (1) A person placed in an out of state institution, as defined by Health Benefits Eligibility and Enrollment (HBEE) Rule 3.00, by a department of the State of Vermont, or
- (2) A person placed and supported in an unlicensed home in an adjoining state by a Vermont agency, or
- (3) A person who meets criteria listed in 7.100.4 (b).

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

(hh) **“School-age child”** means a child age 6 and younger than age 18.

(ii) **“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.

(jj) **“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.

(kk) **“Service”** means a benefit:

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

(ll) **“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:

- (1) Developing, implementing and monitoring the ISA
- (2) Coordinating medical and clinical services
- (3) Establishing and maintaining a case record
- (4) Reviewing and signing off on critical incident reports
- (5) Providing general oversight of services and supports

The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.

Disability Services – Developmental Disabilities

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

(nn) “**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.

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

(pp) “**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.

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

(rr) “**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 be provided to people with developmental disabilities and their families.

(ss) “**Transportation Services**” means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member or reimbursement for mileage for transportation to access Community or Employment Supports.

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

(uu) “**Young child**” means a person who is under age 6.

7.100.3 Criteria for determining developmental disability

(a) 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:

(1) A diagnosed physical or mental condition so severe that it has a high probability of resulting in intellectual disability. This includes conditions such as:

- Anoxia
- Congenital or 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
- Shaken baby syndrome
- Trisomy 21, 18, and 13
- Tuberous sclerosis

(2) A condition of clearly observable and measurable delays in cognitive development and significant, observable and measurable delays in at least two of the following developmental domains:

- Communication
- Social/emotional Motor (physical)
- Self-help skills

(3) An autism spectrum disorder (7.100.3(h)-(j)) resulting in significant, observable and measurable delays in at least two of the following developmental domains:

- Communication
- Social/emotional Motor (physical)
- Self-help skills.

(b) Criteria for assessing developmental disability in a young child.

(1) The diagnosis of a condition which has a high probability of resulting in intellectual disability (7.100.3(a)(1)) must be made by a physician.

(2) The documentation of delays in cognitive and other developmental domains (7.100.3(a) (2)-(3)) must be made through a family-centered evaluation process which includes the family. The evaluation process must include:

(A) Observations and reports by the family and other members of the assessment team, such as a physician, behavior consultant, psychologist, speech therapist, audiologist, physical therapist, occupational therapist, childcare provider, representative from the Children's Integrated Services - Early Intervention (CIS-EI) Team, representative from Early Childhood

Disability Services – Developmental Disabilities

Special Education (ECSE), representative from Children with Special Health Needs, representative from an agency;

(B) A review of pertinent medical/educational records, such as assessments used to determine eligibility for CIS-EI and ECSE, as needed; and

(C) Appropriate screening and assessment instruments.

(3) The diagnosis of autism spectrum disorder must be made according to 7.100.3(h)-(j).

(c) School-age child or adult with developmental disability defined.

(1) A school-age child (age 6 and younger than age 18) or adult with a developmental disability is an individual who:

(A) Has intellectual disability (7.100.3(d)-(f)) or autism spectrum disorder (7.100.3(h)-(j)) which manifested before age 18 (7.100.3(m)); and

(B) Has significant deficits in adaptive behavior (7.100.3(k)-(l)) which manifested before age 18 (7.100.3(m)).

(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.

(d) Intellectual disability defined.

(1) **“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, or up to 75 or below when taking into account the standard error of measurement, on an appropriate norm-referenced standardized test of intelligence and resulting in significant deficits in adaptive behavior manifested before age 18.

(2) **“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 7.100.3(e).

Disability Services – Developmental Disabilities

(e) Criteria for determining whether a school-age child or adult has intellectual disability.

(1) 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:

- (A) Significantly sub-average cognitive functioning (7.100.3(d) and (f));
- (B) Resulting in significant deficits in adaptive behavior; and (7.100.3(k)-(l))
- (C) Manifested before age 18 (7.100.3(m)).

(2) The criteria for determining whether a school-aged child or adult has an intellectual disability is as defined in these regulations as outlined in 7.100.3(e-f) and not as described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

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

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

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

(2) 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 must be used, and the psychologist must use clinical judgment to determine the best tests to use for the individual. Diagnosis based on interpretation of test results takes into account a standard error of measurement for the test used.

(3) A determination that a person has intellectual disability for the purpose of these regulations must 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:

- (A) 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.).
- (B) The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).
- (C) The individual had mild intellectual disability on a previous test and has since made gains in adaptive behavior.

Disability Services – Developmental Disabilities

(4) If IQ testing of the person has resulted in some Full-Scale IQ (FSIQ) scores above 70 and some FSIQ scores below 70, taking into account the standard error of measurement, it is the responsibility of the psychologist to determine which FSIQ scores are the best estimate of the person's cognitive ability. When there is a wide variation between test scores, the psychologist should render his/her clinical opinion, including the rationale, regarding which FSIQ scores are the best estimate of the person's cognitive ability. A determination that a person has intellectual disability for the purpose of these regulations cannot be made if all of the person's FSIQ test scores are greater than 75.

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

(6) The diagnosis of intellectual disability must 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.

(7) 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.

(g) Criteria for determining whether a school-age child or adult has an autism spectrum disorder and is a person with a developmental disability.

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

(1) Diagnosis of an autism spectrum disorder made according to process outlined in 7.100.3(h)-(j)

(2) Resulting in significant deficits in adaptive behavior (7.100.3(k)-(l)); and

(3) Manifested before age 18 (7.100.3(m)).

(h) Autism spectrum disorder defined.

Autism spectrum disorder means the same as it is defined in the current DSM. People receiving services as of October 1, 2017, 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.

(i) Criteria for determining whether a person has autism spectrum disorder.

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

Disability Services – Developmental Disabilities

(2) Preferably a comprehensive diagnostic evaluation is conducted by an interdisciplinary team of professionals with specific experience and training in diagnosing autism spectrum disorder. In the absence of an interdisciplinary team, a single clinician with the qualifications listed below may conduct a multidisciplinary assessment integrating information from other professionals.

(3) At a minimum, an evaluation must be performed by a single clinician who has the following qualifications or an interdisciplinary team that includes:

(A) A board certified or board eligible psychiatrist; or

(B) A psychologist; or

(C) A board certified or board eligible neurologist or developmental-behavioral or neurodevelopmental disabilities pediatrician.

(4) The psychiatrist, psychologist, neurologist, or pediatrician must have the following additional experience and training:

(A) Graduate or post-graduate training encompassing specific training in child development, autism spectrum disorder, and other developmental and psychiatric disorders of childhood, and a process for assessment and differential diagnosis of autism spectrum disorder; or supervised clinical experience in the assessment and differential diagnosis of autism spectrum disorder;

(B) Training and experience in the administration, scoring and interpreting of psychometric tests, or training in understanding and utilizing information from psychometric testing in the diagnosis of autism spectrum disorder; and

(C) Experience in the evaluation of individuals with the age range of the person being evaluated.

(5) Clinicians must 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.

Disability Services – Developmental Disabilities

(6) In the event a shortage of qualified assessors prevents timely evaluations, the state will assist agencies to identify available qualified assessors or may, in its discretion, waive the provision of rule(i)(4).

(j) Essential components of an assessment to determine autism spectrum disorder.

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

(1) Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history;

(2) Systematic autism spectrum disorder diagnostic interview with primary caregivers;

(3) A systematic observation with the individual to assess social interaction, social communication, and presence of restricted interests and behaviors;

(4) For older children and adults who can report symptoms, a systematic clinical interview;

(5) Referral for multidisciplinary assessment, as indicated;

(6) Comprehensive clinical diagnostic formulation, in which the clinician weighs all the information from (7.100.3(j)(1) through (5), integrates findings and provides a well-formulated differential diagnosis using the criteria in the current version of the DSM; and

(7) Current assessments based upon the individual's typical functioning.

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

(B) The initial diagnosis of autism spectrum disorder must 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.

(C) 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:

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

Disability Services – Developmental Disabilities

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

(k) Significant deficits in adaptive behavior defined.

Significant deficits in adaptive behavior means deficits in adaptive functioning which result in an overall composite score on a standardized adaptive behavior scale at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by an overall composite score of 70 or below, taking into account the standard error of measurement for the assessment tool used.

(l) Criteria for assessing adaptive behavior in a school-age child or adult.

(1) Adaptive functioning must be measured by the current version of a standardized norm-referenced assessment instrument. The assessment tool must be standardized with reference to people of similar age in the general population. Adaptive functioning must not be measured with an instrument that is norm-referenced only to people in institutions or people with intellectual disability or autism spectrum disorder.

(2) The assessment instrument must be completed by a person qualified to administer, score, and interpret the results as specified in the assessment tool's manual. The administration of the tool must follow the protocol for administration specified in the assessment tool's manual.

(3) The assessment must 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.

(4) Based upon the assessment, the evaluator must 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.

(5) Ordinarily, assessments must be based upon the person's usual level of adaptive functioning. Assessments should not ordinarily be performed when the individual is in the midst of an emotional, behavioral or health crisis, or must be repeated once the individual stabilizes. An assessment performed while the individual was in a nursing facility or residential facility must be repeated when the individual is in a community setting.

(6) 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.

(m) Manifested before age 18

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

(n) Nondiscrimination in assessment

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

Disability Services – Developmental Disabilities

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

(o) Missing information to document developmental disability

There may be circumstances in which considerable effort is made to obtain all the required history and documentation to determine whether a person has a developmental disability, but the required information cannot be obtained. This may include situations in which there are no available informants to document a person's functioning prior to age 18, previous records cannot be obtained, or do not exist. In these circumstances, the determination of whether the person meets the criteria for having a developmental disability should be based upon the current assessment and all available information, including other life factors that occurred after age 18 that could potentially impact cognitive, adaptive, or other functioning.

7.100.4 Recipient Criteria

(a) Who can be a recipient

- (1) A recipient is an individual with a developmental disability, as defined in 7.100.2 (o) and (ee), who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.
- (2) Services or supports to a family member of a recipient must 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.

(b) Recipients must be Vermont residents

- (1) A recipient must be a resident of Vermont as defined in 7.100.2(ff). In the case of a minor child, at least one custodial parent of the child must be a resident of Vermont.
- (2) 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.

(c) Exceptions

Disability Services – Developmental Disabilities

The Commissioner may make exceptions to the requirements of the program access criteria in 7.100.4(a), in order to promote the purposes of the Developmental Disabilities Act, if the exception will not deprive other people who meet the criteria for being recipients of needed services or benefits (e.g., when funds are provided by another state, or by another Vermont state agency or department).

(d) People receiving services on July 1, 1996

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

(e) Eligibility after leave of service

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

7.100.5 Application, Assessment, Funding Authorization, Programs and Funding Sources, Notification, Support Planning and Periodic Review

(a) Who may apply

(1) Any person who believes he or she has a developmental disability or is the family member or authorized representative of such a person may apply for services, supports, or benefits. In addition, the guardian of the person may apply.

(2) Any other person may refer a person who may need services, supports, or benefits.

(3) An agency or a family member may initiate an application for a person with a developmental disability or a family member but must obtain the consent of the person or guardian to proceed with the application.

(b) Application form

(1) Department will adopt an application form to be completed by or on behalf of all applicants. The DA must provide a copy of the application to all people who contact the DA saying they wish to apply for services.

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

(3) The DA must provide assistance to an applicant who needs or wants help to complete the application form.

(c) Where to apply

(1) An application must be filed at an office of the DA for the geographic area where the person with a developmental disability lives.

(2) An application for a person, who is new to services, who is incarcerated or living in a residential school, facility or hospital must be filed at an office of the DA for the geographic area where the person was living before going to the school, facility or hospital. For individuals who were receiving services just prior to being in one of these facilities, an application must be filed at the DA which

Disability Services – Developmental Disabilities

was last responsible prior to the individual entering the facility.

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

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

(d) Screening

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

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

(B) Notifying the applicant of the rights of recipients in plain language, including the procedures for filing a grievance or appeal and their rights as outlined in the federal CMS HCBS rules;

(C) Discussing options for information and referral; and

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

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

(A) Receive services and supports through any certified provider in the region,

(B) Share the management of those services with the DA or SSA, or

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

(3) Contact and referral information for options for services outside of the DA must be provided to each applicant and referral assistance provided to ensure the applicant is informed of his or her choice of all the service options listed in 7.100.5(d)(2). The DA must have documentation that the applicant was informed of all of these options.

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

(e) Assessment

(1) The DA is responsible for conducting the assessment or assuring that it is conducted. The

Disability Services – Developmental Disabilities

assessment process must involve consultation with the applicant, and, with the consent of the applicant, other organizations which support the applicant.

(2) The DA must offer information and referral to the applicant at any time that it may be helpful.

(3) Assessment consists of in-depth information-gathering to answer the four following questions:

(A) Is this a person with a developmental disability, as defined in 7.100.2(o) of these regulations, and a person eligible to be a recipient, as defined in 7.100.4? If so,

(B) What does the person or his or her family need? This question is answered through a uniform needs assessment and process approved by the Department, which determines with each person or family their service or support needs, including identification of existing supports and family and community resources.

(C) Does the situation of the person or family meet the criteria for receiving any services or funding defined as a funding priority in the *System of Care Plan*? If so,

(D) 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?

(f) Authorization of funding for services

Based on the answers to the questions in 7.100.5 (e), the DA will seek or authorize funding for services to meet identified needs or will determine that the individual is not eligible for the requested funding for services. The procedures for authorizing funding or services are described in the *System of Care Plan*. Services and the funding amount authorized must be based upon the most cost-effective method of meeting an individual's assessed needs, the eligibility criteria listed in the *System of Care Plan*, as well as guidance in the *System of Care Plan* and current *Medicaid Manual for Developmental Disabilities Services*. When determining cost effectiveness, consideration will be given to circumstances in which less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful.

(g) Available Programs and Funding Sources

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

(h) 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 will

Disability Services – Developmental Disabilities

enhance choice and control and increase opportunities for individuals receiving developmental disabilities services and their families. The timing and amount of funding for any initiative will be identified in the *System of Care Plan*. For all special initiatives, specific outcome measures will be required, and results will be reported by DDS.

(i) Notification of decision on application

(1) Timing of the notices

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

(B) If the assessment and authorization of funding is not going to be completed within 45 days of the date of application, the DA must 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 will be considered in determining whether to continue the designation of an agency.

(2) Content of notices

(A) If some or all of the services requested by the applicant are denied, or the applicant is found not eligible, the written notice must include the right to appeal the decision, the procedures for doing so, and the content of notices as specified in 7.100.9 and 8.100). Denials of eligibility must follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 must be followed regarding the timing and content of those notices.

(B) If the assessment determines the applicant has a developmental disability and has needs that fit within the funding priorities outlined in the *System of Care Plan*, the notice must state the amount of funding and services the applicant will receive. The notice must also state what costs, if any, the recipient is responsible to pay (7.100.7).

(C) If the assessment determines the applicant does not have a developmental disability, the notice must state that the DA will continue to offer information and referral services to the applicant.

(D) If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based Services funding, the notice must state that the DA will continue to offer information and referral services and will place the person's name on a waiting list (7.100.5 (q)).

(j) Choice of provider

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

(A) It is the DA's responsibility to ensure the individual is informed of his or her choice of all services options listed in 7.100.5(d)(2), so that the individual can make an informed decision when choosing between and among management options/service providers. The DA must

Disability Services – Developmental Disabilities

document options discussed and information shared as part of this process. The DA must provide the choices in an unbiased manner to reduce the potential for conflict of interest.

(B) If the recipient is not self/family-managing services, the DA will ensure that at least one provider within the geographic area offers the authorized services at or below the amount of funding authorized at the DA.

(C) If no other provider is available to provide the authorized services and the recipient or family does not wish to self/family-manage services, the DA must provide the authorized services in accordance with its Provider Agreement.

(D) The recipient or family may receive services from any willing agency in the state.

(E) A recipient or family may request that an agency sub-contract with a non-agency provider to provide some or all of the authorized services; however, the decision to do so is at the discretion of the agency.

(2) If the recipient's needs are so specialized that no provider in the geographic area can provide the authorized services, the DA may, with the consent of the recipient, contract with a provider outside the geographic region to provide some or all of the authorized services.

(3) The recipient may choose to receive services from an agency other than the DA if the agency agrees to provide the authorized services at or below the amount of funding authorized for the DA to provide services.

(A) When requesting new funding, if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider will submit a budget to the DA and the DA will determine its costs to serve the individual and must submit the lower of the two budgets to the funding committee. If an alternative provider is not able to provide the services at the lower approved budget, the DA must do so at the amount of funding authorized for the DA to provide services.

(B) If at any time a recipient chooses or consents to receive some or all authorized services or supports from a different agency, the agency currently serving the recipient must promptly transfer the individual's authorized funding limit to the agency selected according to the procedures outlined in Division guidelines.

(C) 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 authorized 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.

(D) Any disputes about the amount of funding to be transferred will be resolved by the director of the Division.

(4) The recipient may choose to self/family-manage services (See 7.100.6).

(k) Individual support agreement (ISA)

(1) Once a recipient has received written authorization of services or funding (7.100.5 (f)), the recipient, together with the agency or Supportive ISO, writes an ISA that defines the services and

Disability Services – Developmental Disabilities

supports to be provided. The recipient may ask any person to support him or her in establishing a person-centered process, making decisions, and choosing services, supports and/or providers.

(2) The agency or, in the case of self/family-managed services, the Supportive ISO, has ultimate responsibility to ensure that an initial ISA is developed within thirty (30) days of the first day of billable services/supports or authorized start date for HCBS. This timeline may be extended at the request of the recipient, as specified in the *ISA Guidelines*.

(3) Initial and ongoing ISAs must be written and reviewed in accordance with the Department's *ISA Guidelines*. A written ISA is required even if the recipient chooses to self/family-manage services.

(4) The ISA is a contract between the recipient and provider(s) who provides the service or support.

(5) An ISA may be revised at any time.

(l) Periodic review of needs

(1) The needs of each individual currently receiving services must be re-assessed annually by the agency or Supportive ISO, together with the individual and his or her team, using the needs assessment to assure the individual's budget reflects current needs, strengths and progress toward personal goals. An Annual Periodic Review will take place as part of the planning for the individual's next ISA or ISA review. This will include an examination of the utilization of services in the past year as compared to the authorized funding limit. The individual's budget must be adjusted to reflect current needs.

(2) The agency or Supportive ISO must make adjustments in a recipient's budget and/or services, if indicated, based upon the following:

(A) Changes in the recipient's needs;

(B) Changes in use of funded services;

(C) Changes in the cost of services to meet the needs;

(D) Changes in the *System of Care Plan* or these regulations; or

(E) Changes in funds available due to insufficient or reduced appropriation or an administrative arithmetic error.

(3) As part of the periodic review, the agency or Supportive ISO must ask each recipient about his or her satisfaction with services and provide each recipient and individual's authorized representative with an explanation of the rights of recipients, including those outlined in the federal CMS HCBS rules, and how to initiate a grievance or appeal (See 7.100.9 and 8.100).

(4) If a periodic review results in a determination that services or funding should be reduced, changed, suspended or terminated, the agency or Supportive ISO must notify the recipient as provided in Section 7.100.5 (p) and Part 7.100.9 and 8.100.

(m) Full reassessment of a young child

(1) The agency or Supportive ISO must conduct or arrange for a full clinical reassessment of a child at the time he or she turns six to determine whether the child is a person with a developmental disability. Assessments conducted by schools or other organizations should be used whenever

Disability Services – Developmental Disabilities

possible to avoid duplication.

(2) *Exception:* A child receiving limited services as the result of a diagnosis of autism spectrum disorder does not need to be reassessed to confirm the diagnosis of ASD at the time he or she turns six. An adaptive behavior assessment is required at this time to confirm the child continues to have significant deficits in adaptive behavior as defined in 7.100.3.

(3) If the reassessment determines that the child is no longer a person with a developmental disability, benefits for the child and family must be phased out as provided in 7.100.5 (o)(2) of these regulations.

(n) Full reassessment (transition from high school to adulthood)

(1) The agency or Supportive ISO must 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 must conduct the reassessment as soon as it learns that the person is going to leave high school or has left high school. The reassessment must consider: (A) whether the young adult is a person with a developmental disability; and (B) the future service and support needs of the person and his or her family. The needs assessment should be reviewed and updated prior to requesting funding if there have been significant changes in circumstances that impact services and supports needed. Any assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

(2) 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 must be phased out as provided in 7.100.5(o)(2) of these regulations.

(3) If the reassessment determines that the support needs of the person or family will change or increase when the young adult is no longer in school, the ISA and budget must be reviewed in accordance with this section.

(o) Full reassessment

(1) The agency or Supportive ISO must 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.

(2) If the reassessment determines that the individual is no longer a person with a developmental disability, services to the person must be phased out within twelve months or less, unless the individual is eligible to continue to receive services based on 7.100.4 (d). Upon the determination of ineligibility, the agency or Supportive ISO must provide timely notice of the decision to the recipient and the individual's authorized representative, if applicable, and as provided for in 7.100.5 (p), 7.100.9, and 8.100.

(p) Notification of results of reassessment or periodic review

If a reassessment or review results in a determination that the recipient is no longer eligible, or services should be reduced, suspended, or terminated, the agency or Supportive ISO must notify the recipient and individual's authorized representative, if applicable, in writing of the results of the review or reassessment, and of the right to appeal the decision and the procedures for doing so. The notice will include the content as specified in 7.100.9 and 8.100. Denials of eligibility should follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 would be followed regarding the timing and content of those notices.

Disability Services – Developmental Disabilities

(q) Waiting list

A person with a developmental disability whose application for Home and Community-Based Services, Flexible Family Funding or Family Managed Respite is denied must be added to a waiting list maintained by the Designated Agency. The Designated Agency must 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.

(1) The Division will provide instructions to the Designated Agency for reporting waiting list information to the Division.

(2) Each Designated Agency must 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 must occur:

(A) When there are changes in the funding priorities or funds available; or

(B) When notified of significant changes in the individual's life situation.

(3) Waiting list information will be included the DDS Annual Report and will be reviewed annually by the DDS State Program Standing Committee.

7.100.6 Self/Family-Managed Services

Many individuals receiving services, or a family member of an individual receiving services, may be eligible to manage the services instead of having the services managed by an agency. Individuals may manage their services either independently or with the help of their families. An individual or a family member may manage up to 12 hours a day of In-home Family Supports or Supervised Living, but may not self/family manage Staffed Living, Group Living or Shared Living.

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

In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in 7.100.6(b). A Supportive ISO, in making this determination, must consider the reasons set forth in 7.100.6(f)(2), as well as any and all criteria established by the Department. An individual or a family member also has the option of managing *some, but not all*, of the services and have an agency manage some of them. This arrangement is called shared-managing. 7.100.6(g) explains how shared-managing works.

(a) Self/Family-Management Agreement

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

Disability Services – Developmental Disabilities

(b) Responsibilities of an individual or family member who manages services

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

- (1) Maintain Medicaid eligibility for the individual receiving services. Immediately notify the Supportive ISO of any circumstances that affect Medicaid eligibility.
- (2) Develop an ISA that reflects what services the individual needs and how much money the individual has been provided in their budget to spend for those services. Follow the Department's *ISA Guidelines* to ensure that all required information is included and completed according to specified timelines. The plan must specify what each service is supposed to be and how much each service will cost on an annual basis. The ISA must also identify the individual's service provider(s) and explain how the services received must be documented.
- (3) Ensure that services and supports are provided to the individual in accordance with the ISA and the budget.
- (4) Maintain a complete and up-to-date case record that reflects details regarding the delivery of services. Follow the *Guide to Self/Family Management* regarding what needs to be included in the case record. Retain case records in accordance with the record retention schedule adopted by the Department.
- (5) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are set forth in 7.100.11(e).
- (6) Understand the individual's ISA and their budget. Make necessary changes based on the individual's needs. Follow these regulations and the Department's *ISA Guidelines* regarding what to do when there is a change.
- (7) Follow the Department's *Health and Wellness Guidelines* to take care of the individual's health and safety.
- (8) Follow the rules about reporting critical incidents to the Supportive ISO. Make sure the reports are filed in accordance with the specific timeline required by the Department's *Critical Incident Reporting Guidelines*.
- (9) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.
- (10) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.
- (11) Prepare written back-up plans for when the plan cannot be followed (e.g., a worker gets sick and/or does not show up for work). Include in the plan who will come and work and what will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

Disability Services – Developmental Disabilities

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

(13) Take the following steps when hiring workers:

(A) Write a job description. Complete reference checks before allowing the worker to start work;

(B) Interview and hire workers that meet the requirements of the Department's Background Check Policy, or who receive a variance when there is an issue with the background check;

(C) Sign up with the state contracted F/EA. Give the F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

(D) Train or have someone else train all workers in accordance with these regulations. The rules are in the Department's pre-service and in-service standards in 7.100.10;

(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets to verify they reflect the actual hours worked. Sign and send accurate timesheets to the F/EA;

(F) Suspend or fire workers as necessary; and

(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

(14) Manage services in accordance with the Department's *Guide to Self/Family Management*.

(15) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the Supportive ISO for assistance in determining what expenses are reimbursable. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

(c) Role of the Designated Agency

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

(d) Role of Qualified Developmental Disability Professional (QDDP)

(1) An individual or family member who manages services must choose someone to be his or her independent QDDP or must ask the Supportive ISO to find a QDDP for him or her.

Disability Services – Developmental Disabilities

(2) All QDDP's must meet the criteria specified in the Division's *Vermont Qualified Developmental Disabilities Professional Protocol*. For QDDPs employed by an agency, the agency is responsible for ensuring that the QDDP meets those criteria. QDDPs not employed by an agency, including those working for the Supportive ISO, must be endorsed by the Department as an independent QDDP, before being paid as a QDDP.

(3) The QDDP must:

(A) Approve the individual's ISA and ensure that it is signed by the individual and guardian, if there is one;

(B) Confirm that the ISA is being carried out the way it is supposed to be and that it meets the needs of the individual;

(C) Confirm that services and supports are delivered the way the Department and Medicaid regulations and guidelines require;

(D) Contribute to the periodic review of the individual's needs conducted by the Supportive ISO;

(E) Confirm the ISA is updated to show the changes in the individual's needs and goals;

(F) Approve any changes to the ISA;

(G) Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996 and the rights outlined in the federal CMS HCBS rules; and

(H) Review and sign off on all critical incident reports according to the *Critical Incident Reporting Guidelines*.

(e) Responsibilities of a Supportive ISO when an individual or family member manages services

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

(1) Provide support and assistance to the individual or family member to ensure he or she understands the responsibilities of managed services including following all policies and guidelines for the Division. Explain managed services and the individual's or family member's employer role and responsibilities;

(2) Conduct periodic reviews with contributions from the QDDP, make adjustments to budgets as needed and notify the individual of his or her rights under these regulations;

(3) Confirm the individual's Medicaid eligibility on an annual basis;

(4) Help the individual or family member to develop an authorized funding limit (AFL), provide guidance in self-managing the AFL, ensure the AFL is not managed by a third party, as well as provide assistance in determining whether a service is reimbursable under Department rules. Provide the F/EA with the individual's AFL;

(5) Bill Medicaid according to the procedures outlined in the provider agreement between the Supportive ISO and the Department;

Disability Services – Developmental Disabilities

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- (6) Review requests for more money and seek funding according to the process outlined in 7.100.5 of these regulations and the *System of Care Plan*. Requests for short term increases in funding will be addressed internally by the Supportive ISO. Requests for long term increases will be sent to the appropriate statewide funding committee;
 - (7) Confirm that the individual has a current ISA that reflects the areas of support funded in the budget and identifies and addresses any known health and safety concerns; Notify the individual/family that funding may need to be suspended if there is not a current signed ISA, according to the timelines outlined in the ISA guidelines;
 - (8) Provide QDDP services when requested. QDDP services are a separately purchased service;
 - (9) Maintain a minimum case record in accordance with the requirements outlined in the *Guide to Self/Family Management*. Make sure that the individual or family member responsible for managing services understands that the individual must have a complete case record in accordance with the requirements outlined in the *Guide to Self/Family Management*. Retain case records in accordance with the record retention schedule adopted by the Department;
 - (10) 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*;
 - (11) Provide information about the Division's crisis network to the individual or family member responsible for managing services;
 - (12) Determine that the individual or family member who is managing the services is capable of carrying out the duties by conducting an initial assessment and providing ongoing monitoring;
 - (13) Provide required pre-service and in-service training to the individual's support workers if the individual or family member does not provide that training. The training requirements are located in Part 7.100.10 of these regulations; and
 - (14) Form and consult with an advisory committee.
- (f) Determination that the individual or family member is unable to manage services
- (1) The Supportive ISO may deny a request to self- or family-manage, or may terminate the management agreement, if it decides that the individual or family member is not capable of carrying out the functions listed in 7.100.6(b). If the individual's or family member's request is denied, or a management agreement is terminated, then the individual's services must be provided by the individual's DA or from a SSA willing to provide services. Unless it is an emergency, the Supportive ISO has to inform the individual or family member at least thirty (30) days before terminating the agreement.
 - (2) The Supportive ISO may decide that the individual or family member is not capable of carrying out the functions listed in 7.100.6(b) for reasons which include the following:
 - (A) The managed services put the individual's health or safety at risk (the agreement can be terminated immediately if the individual is in imminent danger);
 - (B) The individual or family member is not able to consistently arrange or provide the necessary services;

Disability Services – Developmental Disabilities

- (C) The individual or family member refuses to participate in the Division's quality assurance reviews; or
- (D) Even after receiving training and support, the individual or family member is not substantially or consistently performing his or her responsibilities for self/family-management as outlined in Section 7.100.6 (b). This includes not following policies, regulations, guidelines, or funding requirements or not maintaining and/or ensuring proper documentation for developmental disabilities services. The Supportive ISO must document substantial non-performance as follows:
- (i) When the Supportive ISO discovers an issue, they must notify the individual or family member in writing of the issue and what is needed to correct the issue along with a timeline to do so; and offer support and training to the individual or family member as needed;
 - (ii) If the individual or family member has not corrected the issue according to the required timeframe, the Supportive ISO must send written notice to the individual or family member indicating that if the issues are not corrected in 30 days, the agreement for self/family-management may be terminated.
 - (iii) Repeated documented failures to follow requirements will be evidence to justify termination of the self/family-management agreement.
- (3) If the Supportive ISO decides an individual or family member is not able to manage services, the individual or family member may file a request for a fair hearing with the Human Services Board, as provided in 3 V.S.A. § 3091. The Supportive ISO must provide written notice to the individual or family member at least 30 days prior to terminating a self/family-management agreement and the Supportive ISO's notice must include the individual or family member's right to request a fair hearing within 30 days of the date of the notice.
- (g) Responsibilities of an individual or family member who share-manages services
- An individual or family member may manage some services and let an agency manage some services. That is called shared-managing. The agency is responsible for providing information and guidance to the individual or family member regarding his or her responsibilities for share-management. An individual or family member who share-manages with an agency must do all of the following:
- (1) Ensure services and supports are provided to the individual in accordance with the ISA and his or her budget.
 - (2) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are in 7.100.11(e).
 - (3) Make and keep all papers and records as required by the agency.
 - (4) Report critical incidents to the agency. Make sure the reports are filed in accordance with the specific timelines required by the Department's *Critical Incident Reporting Guidelines*.
 - (5) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is

Disability Services – Developmental Disabilities

suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

(6) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

(7) 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 will come and work and what will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

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

(9) Take the following steps when hiring workers:

(A) Write a job description. Complete reference checks before allowing the worker to start work;

(B) Interview and hire workers that meet the requirement of the Department's Background Check Policy, or upon receipt of a variance when there is an issue with the background check;

(C) Sign up with the state contracted F/EA. Give the F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

(D) Train or have someone else train all workers in accordance with these regulations. See the Department's pre-service and in-service standards in 7.100.10;

(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets. Sign and send accurate timesheets to the F/EA;

(F) Suspend or fire workers as necessary; and

(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

(10) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the agency for assistance in determining what are reimbursable expenses. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

7.100.7 Recipient Financial Requirements

(a) Income and resources; Medicaid-funded programs

Disability Services – Developmental Disabilities

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

(b) Room and board; personal spending money

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

(1) At least annually, the Commissioner or the Commissioner's designee will publish a schedule of rates for room and board and rates for personal spending allowances for recipients. The personal spending allowance will 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 will be equal to the current Supplemental Security Income (SSI) rates, including state supplement.

(2) Payment of the rate set by the Commissioner's schedule will 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 will be charged the same rate for room and board as SSI recipients.

(3) 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.

(4) Recipients who rent or own their own home or apartment and have room and board costs in excess of the Commissioner's schedule will receive assistance in accessing rent subsidy, low interest loans, fuel assistance, and other sources of housing assistance for low-income Vermonters. To the extent authorized by the *System of Care Plan*, the Commissioner may provide non-Medicaid funds to subsidize the excess costs of a recipient's rent or house payment, if the recipient is unable to afford the cost.

(5) Recipients who rent or own their own home or apartment and who work may elect to use their earnings to pay rent or mortgage or room and board costs in excess of the Commissioner's schedule.

(6) The recipient, in consultation with his or her representative payee, if any, will determine how to spend the personal spending allowance.

(c) 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 childcare necessary for a parent to work.

7.100.8 Special Care Procedures

(a) Purpose

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

(b) Special Care Procedure

Disability Services – Developmental Disabilities

(1) The purpose of classifying a procedure as a "special care procedure" is to provide a system for ensuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for. These regulations follow the Vermont State Board of Nursing Position Statement – The role of the nurse in delegating nursing interventions.

(2) Examples of special care procedures are as follows:

(A) 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.

(B) 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.

(C) 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.

(D) Administration of respiratory treatments. Using nebulizer set-up, care and maintenance of equipment.

(E) Tracheotomy care. Including cleaning of site and replacement of trach.

(F) 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.

(G) Procedures that include care of colostomy or ileostomy. Care of the stoma and maintenance of equipment.

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

(c) Application and limitations

(1) These sections (7.100.8) apply to DAs and SSAs (including their staff and contractors).

(2) These sections (7.100.8) 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.

(3) These regulations do not apply to care provided by hospital or nursing home staff.

(d) Determining that a procedure is a special care procedure

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

Disability Services – Developmental Disabilities

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

(e) Who determines special care procedures

- (1) 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.
- (2) A registered nurse must determine whether a procedure is a special care procedure.

(f) Who may perform a special care procedure

- (1) 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.
- (2) 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.
- (3) The agency responsible for the health needs of the individual must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or by a qualified health professional.
- (4) 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 must be performed by a qualified health professional. In the case of managed services, the services coordinator bears responsibility for having a back-up plan.

(g) Specialized care plan

- (1) If a nurse has determined that an individual needs a special care procedure, the agency is responsible for ensuring that a specialized care plan is attached to the ISA and that every person who is authorized to perform a special care procedure has a copy of the specialized care plan.
- (2) A registered nurse must complete an assessment of the person prior to developing the specialized care plan. The specialized care plan must be developed by the registered nurse and must identify the specialized care procedures and the nurse responsible for providing training, determining competence, and reviewing competence. The specialized care plan must also include a schedule for the nurse to monitor the performance of specialized care procedures. (7.100.8(j)).

(h) Training

- (1) Qualifications of trainer. Training must be provided by a nurse. The nurse must have a valid

Disability Services – Developmental Disabilities

State of Vermont nursing license.

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

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

(4) 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 define the procedures to be used with a particular individual.

(5) Documentation of training. The agency responsible for the health needs of the individual is responsible for ensuring that the nurse provides a record of training for any person who is carrying out a special care procedure. The records must 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.

(6) Emergencies. The nurse must be notified of any changes in an individual's condition or care providers. The agency responsible for the health needs of the individual must 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 must be performed by a qualified health professional.

(i) 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.

(1) Determination of competence. Determination of competence must be made by a nurse. The specialized care plan must identify the nurse responsible for making this determination.

(2) Supervised practice. An individual who is working toward but has not yet achieved status of a competent special care provider must provide specialized care under the supervision of a nurse.

(3) 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.

(4) Documentation of competence. The record must document which people are determined competent to perform a special care procedure.

(5) Review of competence. A specialized care provider's competence must be reviewed by a nurse at least annually and also when that worker's competence is in question, or at any time when there is change in the condition of the individual.

(j) Monitoring

Disability Services – Developmental Disabilities

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

7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings

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. As set forth in the Demonstration, the Agency of Human Services (AHS), as the state, and the Department of Vermont Health Access (DVHA), as if it were a non-risk prepaid in-patient health plan (PIHP), must comply with all aspects of 42 C.F.R. Part 438, Subpart F, regarding a grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Medicaid services, including developmental disabilities services.

AHS has adopted Health Care Administrative Rule (HCAR) 8.100, which fully sets forth the responsibilities of the Vermont Medicaid Program, as required by 42 CFR Part 438, Subpart F. This rule details, among other things, the content and timing of notices of an Adverse Benefit Determination, the circumstances relating to continuing services pending appeal and potential beneficiary liability, and the State fair hearing and grievance processes.

For provisions that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical, and clinical eligibility for developmental disabilities services, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

The Division will develop a plain language guide to the Internal Appeals, Grievances, Notices, and State Fair Hearings, in collaboration with stakeholders. The guide will be made available to all applicants and authorized representatives during the initial screening and all recipients during the annual periodic review, as well as whenever an applicant or recipient is notified of a decision regarding eligibility or service authorization. The plain language guide will include specifics related to how to file a grievance or appeal, to whom it should be directed, timelines and where to get assistance in filing.

7.100.10 Training**(a) Purpose**

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

(b) Standards

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

(A) Understand the values and philosophy underlying services and supports;

(B) Acquire skills necessary to address the individual needs of the recipient for whom they provide services and support;

Disability Services – Developmental Disabilities

(C) Acquire skills to implement the principles and purposes of the Developmental Disabilities Act of 1996; and

(D) Are exposed to best and promising practices in supporting individuals with developmental disabilities.

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

(3) The minimum standards for training are outlined in (c) – (f).

(c) Agency and Supportive Intermediary Support Organization responsibilities

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

(A) Workers compensated with funds paid or administered by the agency must 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.

(B) Workers, on an ongoing basis, must have opportunities to broaden and develop their skills and knowledge in the following areas:

(i) Best and promising practices;

(ii) Values including:

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

- (1) The dignity of valued roles
- (2) Sharing ordinary places
- (3) Making choices and the dignity of risk
- (4) Relationships in living a full life
- (5) Making contributions to others

The principles of person-centered thinking including:

- (1) How to respectfully address significant issues of health or safety while supporting choice
- (2) How to sort what is important for people from what is important to the people we support
- (3) How rituals and routines play a role in what is important to the people we support
- (4) The importance of having power with rather than power over the people we support;

(iii) Current and emerging worker responsibilities; and

Disability Services – Developmental Disabilities

(iv) Current and emerging needs of the individual.

(2) The training plan must be written and based on the agency's assessment of its ability and capacity to meet the needs of the people it serves, the local *System of Care Plan*, and the training needs of its staff and board members.

(3) The training plan must be updated as needed but at least every three years.

(4) Each agency, and Supportive ISO must:

(A) 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.

(B) Make pre-service and in-service training available to all workers at no cost to the family or recipient.

(C) Involve people with disabilities and their families in the design, delivery, and evaluation of training and invite them to participate in training.

(D) Have a system to verify that all workers have been told about and understand the requirement to report abuse and neglect of children to the DCF, and abuse, neglect and exploitation of vulnerable adults to APS.

(5) Each agency and Supportive ISO must:

(A) 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.

(B) 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.

(d) Pre-service training

Before working alone with an individual who receives support funded by the Department, each worker must be trained and demonstrate knowledge in (1) through (5) of this section. The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(1) Abuse reporting requirements:

(A) The requirements of Vermont law to report suspected abuse or neglect of children; and

(B) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

(2) Health and Safety:

Disability Services – Developmental Disabilities

- (A) Emergency procedures, including where to locate the emergency fact sheet;
 - (B) What to do if the individual is ill or injured;
 - (C) Critical incident reporting procedures; and
 - (D) How to contact a supervisor or emergency on-call staff.
- (3) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)
- (A) Whether the individual has a guardian, and how to contact the guardian;
 - (B) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;
 - (C) Health and safety needs of the individual;
 - (D) Methods of communication used by the individual including tools, technology and effective partner support strategies; and
 - (E) The individual's ISA, including the amount of supervision the individual requires.
- (4) Values:
- (A) Individual rights, as specified in 18 V.S.A. § 8728 and as outlined in the federal CMS HCBS rules;
 - (B) Confidentiality;
 - (C) Respectful interactions with individuals and their families; and
 - (D) Principles of service contained in the Developmental Disabilities Act of 1996.
 - (E) Respecting that people can make decisions for themselves, with support when needed.
 - (F) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand.
- (5) How to access additional support, training, or information.

(e) In-service training

(1) Within three months of being hired or entering into a contract, workers must be trained in and demonstrate the knowledge and skills necessary to support individuals in 7.100.10(e)(1)(A) and (B). Workers must be trained in or demonstrate knowledge and skills necessary to support individuals, in 7.100.10(e)(1)(C) and (D). The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

- (A) The worker's role in developing and implementing the ISA, including the role and

Disability Services – Developmental Disabilities

purpose of the ISA, and working as part of a support team;

(B) The skills necessary to implement the recipient’s ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support methods of communication used by the recipient, and supporting decision making). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite, the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

(C) 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

(D) Basic first aid.

(2) Workers must be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

(f) Exception for emergencies

(1) For the purposes of this section, “emergency” means an extraordinary and unanticipated situation of fewer than 72 consecutive hours.

(2) In an emergency, if the unavailability of a trained worker creates a health or safety risk for the individual, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 72 hours after the worker first begins to work with the individual in response to the emergency, as long as essential information about the individual is communicated to the worker and he or she has immediate access to all the documents and information covering all areas of Pre-service training (see 7.100.10 (d)).

(3) This exception does not apply to workers performing special care procedures. All requirements in 7.100.8 of these regulations must be met prior to staff performing special care procedures.

7.100.11 Certification of Providers

(a) Purpose of certification

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

(b) Certification status

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

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

(B) Meet the Department’s *Quality Standards for Services* (7.100.11(e)); and

(C) Provide services and supports that foster and adhere to the Principles of Service (See 18

Disability Services – Developmental Disabilities

V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728) and the rights outlined in the federal CMS HCBS rules.

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

(3) New provider. A new provider that wishes to be certified by the Department must first establish that it meets the standards for designation. Upon being designated, an organization must apply in writing to the Department for certification. The application must include policies, procedures, and other documentation demonstrating that the organization is able to meet the quality standards for certification contained in 7.100.11(e) 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).

(4) Providers that are not designated will not be certified.

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

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

(c) Monitoring of certification

The Department will monitor certified providers through a variety of methods including quality reviews, other on-site visits, review of critical incident reports and mortality reviews, investigation of complaints from recipients and the public, input from Department staff and staff or employees of other departments of AHS.

(d) Services available regardless of funding source

(1) Any services or supports which are provided to people who are eligible for Medicaid must be made available on the same basis to people who are able to pay for the services or who have other sources of payment.

(2) The rate charged to recipients who are able to pay for services or who have payment sources other than Medicaid must 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 must 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.

(3) Any services not funded by Medicaid may be made available in accordance with a sliding fee schedule.

(e) Quality standards for services

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

(1) Respect: Individuals feel that they are treated with dignity and respect.

Disability Services – Developmental Disabilities

(2) Self Determination: Individuals direct their own lives and receive support in decision making when needed.

(3) Person Centered: Individuals' needs are met, and their strengths and preferences are honored.

(4) Independent Living: Individuals live and work as independently and interdependently as they choose.

(5) Relationships: Individuals experience positive relationships, including connections with family and their natural supports.

(6) Participation: Individuals participate in their local communities.

(7) Well-being: Individuals experience optimal health and well-being.

(8) Communication: Individuals communicate effectively with others.

(9) System Outcomes.

(f) Status of non-designated providers

(1) 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.

(2) The Department quality service reviews will be responsible for including people served by subcontracted providers to verify that they meet quality review standards.

(3) Any subcontract must contain provision for operations in accordance with all applicable state and federal policies, rules, guidelines, and regulations that are required of agencies.

(4) Agencies must 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.

(5) 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 Provider Agreement with the Department are carried out by their subcontractors.

7.100.12 Evaluation and Assessment of the Success of Programs

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

(1) 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*;

(2) The designation process for DA and SSAs as outlined in the *Administrative Rules on Agency*

Disability Services – Developmental Disabilities

Designation;

(3) Review of the data reported by agencies on required performance measures and monitoring of programs, as described in the agencies' Provider Agreements with the Department; and

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

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

