Summary of proposed changes to the Developmental Disabilities Services Regulations filed with the Secretary of State's Office

General:

This summary is provided as a companion document to the proposed HCAR 7.100 Disability Services – Developmental Disabilities - Annotated Rule which shows all the proposed changes to the *Regulations Implementing the Developmental Disabilities Act of 1996 (effective 10.1.17).*

Overall, the format of the *Regulations* is being changed to conform to the Vermont's Health Care Administration Rules formatting guidance. Many changes are simply numbering and lettering changes. These rules also require use of the terms "will" and "must" rather than "shall" for enhanced clarity.

The Developmental Disabilities Services Division has drafted the proposed rule changes primarily in Part 2: Criteria for Determining Developmental Disability, Part 4.7 Available Program and Funding Sources and Part 8: Grievance, Internal Appeal and Fair Hearing. The primary reason for making changes to Part 2 which describes who is eligible to receive DD services, relates to a 2019 VT Supreme Court decision indicating a lack of clarity in the regulations related to consideration of the standard error of measurement in IQ test scores. The proposed changes are to create greater clarity in this regard.

Section 4.7 includes a description of available programs and the funding sources for those programs. It also includes the eligibility and access criteria for each program. In 2022 the Legislature passed Act 186 which eliminated the requirement in 18 V.S.A. § 8725 that certain categories of the Developmental Services System of Care Plan be adopted by rule. Two of those categories were the criteria for receiving services or funding and the type of services provided. Section 4.7 covers those categories. Since they are no longer required to be adopted by rule, the Department proposes to remove them from the rule and only including them in the System of Care Plan. There is a robust input process for changes to the System of Care Plan and the State is currently in the process of updating the plan.

Part 8, which deals with grievance and appeals, is being changed to comply with updated federal regulations related to grievance and appeals in Medicaid (42

C.F.R Part 438, Subpart F). The Department of Vermont Health Access (DVHA) updated the regulations for grievance and appeals for all VT Medicaid services on 6/1/18 (after publication of the 10.1.17 DDS regulations) to comply with the federal requirements (see HCAR 8.100 and HBEE Part 7 & 8). DDSD has been following these rules since that time. The proposed change eliminates the current DDS regulations for grievance and appeals which are out of date and refers to the current VT rules which have been used since 2018. DDS, as a Medicaid program, is required to follow these new rules.

Below is a summary of changes and the rationale for the changes. This list includes only those changes in language, not the formatting changes. Item numbers in red are new items that are being proposed to be added. The item numbers in black refer to the item numbers in the current regulations.

This version of proposed changes to the Regulations is as filed with the Secretary of State's Office on September 1, 2022. This version reflects changes from the version submitted to the State Program Standing Committee in March 2022. Changes were made based upon feedback from stakeholders and the Interagency Committee on Administrative Rules (ICAR).

Item	**Proposed change and rationale**
7.100.1*	Adding an introduction to the rule and citing the authority under which the DDS program operates.
1.3	Definition of "appeal" removed due to HCAR 8.100 replacing current DDS rules related to grievance and appeals.
1.5	"Fiscal Employer/Agent" (FE/A) is removed from list of items which are not included in the authorized funding limit. The funds for the FE/A have been removed from individual Home and Community-based Services (HCBS) budgets as they are now being billed directly to Medicaid by the FE/A. These funds were not part of the AFL and have no impact funds available for individual services. "Employment program base" is added to the list of items not included in the authorized funding limit. These funds are provided to agencies to support the existence of their supported employment programs and are not part of an individual's budget.

7.100.2(e) 1.15	1.15 - Definition of "designated representative" removed due to HCAR 8.100 replacing current DDS rules related to grievance and appeals. Replacing with the term "authorized representative" (7.100.2(e)) which is in HCAR 8.100.
1.10	Added language to clarify that transportation is a part of community supports.
7.100.2(hh)	Added definition of school age child in relation to change in definition of "young child" (1.47).
1.47	Change definition of "young child" to mean child under age six from "not yet old enough to enter first grade" to align with VT special education rules for Early Childhood Special Education (ESCE) which provides services to children ages 3-5 and Children's Integrated Service – Early Intervention (CIS-EI) which serves children birth-2.11. Aligning with ESCE and CIS-EI allows intake staff at provider agencies to utilize existing assessment information from those programs. This alleviates the need, time, and expense of having new testing completed which is more efficient and less burden on the children and families. Specifying a specific age (under six) is clearer than "not yet old enough to enter first grade".
2.1(a)	Align language with regulations for ECSE and CIS-EI. Multisystem developmental disorder is not a medical diagnosis listed in the current versions of diagnostic manuals (Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD)).
2.1(b) (c)	Relabeling the developmental areas to align with those used in regulations for ECSE and CIS-EI.
2.2(a)	The diagnoses listed in 2.1(a) are made by physicians not psychologists. This is a technical correction.
2.2(b)	Aligning language with 2.1 (b-c). Explored changes to criteria for young children to define the terms "significant, observable and measurable". Met with staff from Agency of Education and reviewed their regulations for eligibility for ECSE and CIS-EI to consider aligning eligibility criteria. Consulted with 2 psychologists in VT. After exploration, decided not to add definitions. The criteria for ECSE and CIS-EI are different from each other. The criteria used is more inclusive of disabilities

	beyond ID and ASD. It is also not the Division's intention to narrow the criteria for eligibility for young children.
2.2(b)(1)	Updating terms and adding typical team members for young children.
2.4(a)	Clarifies that the standard error of measurement (which is approximately +/- 5 points) for IQ tests can be considered when making a diagnosis of intellectual disability. This is based on a 2019 VT Supreme Court case ruling. DDSD has been following this practice since the 2019 ruling when making eligibility decisions. DDSD monitored the number of individuals who came into services with IQs between 70 and 75 since that time and there has not been a substantial increase in the number of people who have been found eligible with scores in that range.
2.6(h)	Moved to section 2.5. Reiterating that the criteria for determining whether a person has an "intellectual disability" is as described in these regulations and not the definition in the DSM. The criteria in these regulations align with the DSM but the regulations include more specific cutoff scores from testing and more details for the assessment process. This allows for more clarity in making and supporting determinations of eligibility.
2.6(a)(2)	Language added to specify that both current and past test results should be reviewed and integrated when making a determination about whether a person has an intellectual disability.
2.6(d)	Added language to specify that the licensed psychologist should include their clinical opinion about which test scores are the best estimate of a person's cognitive ability and his/her rationale in the written evaluation. This will help in making eligibility determinations when there are varying test scores over time.
2.8	Specifying that people who were found eligible prior to 10.1.17 (the effective date of the current regulations) would continue to be eligible is found eligible based on previous versions of the DSM which were in effect at that time. As noted in 2.10, new applicants must be assessed using the DSM criteria in effect at the time of application.
2.11	Although not addressed in the Supreme Court case specifically, it seems logical that the standard error of measurement for adaptive behavior scores should also be considered in

	determining eligibility. The standard error of measurement is not the same for all assessment tools, so a specific point range was not included. For the commonly used ABAS assessment, the standard error of measurement is +/- 3 points. It is also proposed to drop the requirement of having adaptive behavior deficits in at least 2 of the areas listed. The consulting psychologists indicate that statistically that criteria would rarely be used as almost all people who have a score below 70 would have deficits in more than one area. The Division has not been using the standard error of measurement in making eligibility determinations since the Supreme Court case, so this change would represent an expansion of people who could potentially be eligible.
2.12(b)	Proposed adding language to ensure that assessments of adaptive behavior are conducted according to the protocols outlined in the manual. Generally, if an assessment is not completed according to the protocols, the results cannot be considered valid.
4.1(a)	Adds “authorized representative” to those who can apply for services. “Authorized representative” is inclusive of guardians and other individuals (See 7.100.2(3).)
4.7 (a-o)	The description of available programs and the eligibility criteria for these programs are no longer required to be adopted by rule due to the changes to the DD Act passed in Act 186 in 2022. Therefore, these will now only appear in the DDS System of Care Plan as required by the revised DD Act.
4.9(b)	The proposed changes regarding the content of notices of decision are made to be consistent with the current rules related to grievances and appeals.
4.11(b)	Adding language regarding when an initial ISA must be in place. In 2021, the Department modified the method that providers use for billing for services. This change in billing practice could have resulted in agencies having less than 30 days from when services were authorized by the state to develop the ISA. Therefore, the additional language was added to allow sufficient planning time.
4.16	The proposed changes in this section are made to be consistent with the current rules related to grievances and appeals.

Part 5 introduction	The proposed added language is to help clarify the criteria to be used by the Supportive ISO in making a determination about whether someone is capable of fulfilling the responsibilities of self/family management.
5.2(b)	Adding language to specify that ISAs must be in place according to the timelines outlines in the ISA guidelines. The federal Centers for Medicare and Medicaid Services (CMS) rules require that there is a current, signed plan in place in order to bill for services.
5.2(d)	The *Guide for People who are Self- Family-Managing* is being renamed and will be updated to be consistent with all the changes to the regulations once approved.
5.2 (m)	Deletes this requirement as the Housing Safety and Accessibility Review Process does not apply to settings where people who self/family manage services live. This requirement is a remnant of when a few families who were managing services in a 24-hour care setting at the beginning of self/family management who were "grandfathered" in. Those arrangements no longer exist, and the current rule allows for only 8 hours a day of home supports.
5.2(p) and 5.7(j)	Adds language for the submission of requests for reimbursement for non-payroll goods and services to ensure that they are accurate and represent services received. This language is added to emphasize the need for accuracy and to avoid inappropriate or fraudulent payments.
5.4(c)	Adds the responsibility of the QDDP to review and sign off on Critical Incident Reports. This is to be consistent with what is currently required in the Department's *Critical Incident Reporting Guidelines.*
5.5(g)	The additional language provides authority to the Supportive ISO to suspend billing for services if a current, signed ISA is not in place. Federal CMS rules require that there is a current, signed plan in place in order to bill for services.
5.6(a-b)	Adds clarifying language regarding how the Supportive ISO makes a determination about whether a person/family is able to self/family-manage services.

5.6(c)	Adds language clarifying the process for appealing a decision that a person/family is not able to self/family- manage services. The decision is appealable but goes through a different process than those outlined in HCAR 8.100 or HBEE 68 rules.
Part 8	As noted in the introduction, the grievance and appeals section of the regulations is being deleted in its entirety and replaced by the HCAR 8.100 and HBEE Part 7 & 8 which are the current regulations regarding all VT Medicaid grievance and appeals.
9.2	Adds language to indicate that the minimum standards are as outlined in 9.3-9.6.
9.4(c)(4)	Adds language to ensure that pre-service training is provided regarding how to communicate with a person, including those that require additional supports such as tools, technology and effective partner support strategies.
9.4(d)(1)	Adds reference to the individual rights specified in the DD Act.
9.4(d)	Adds a preservice training on the value regarding respecting that people can make decisions for themselves, with support as needed.
9.5(a)(2)	Language added to emphasize in-service training in supporting communication and decision making.
10.5(b)	Adding language to emphasize supported decision making as part of the quality standards for services.