Vermont

State System of Care Plan

for Developmental Disabilities Services

FY 2023 – FY 2025
Three Year Plan
Effective: January 1, 2023
Technical correction May 1, 2023

Vermont State System of Care Plan for Developmental Disabilities Services

FY 2023 – FY 2025 Three Year Plan

Effective: January 1, 2023

Developmental Disabilities Services Division
Department of Disabilities, Aging and Independent Living
Agency of Human Services
State of Vermont

This document is available online at: Vermont State System of Care Plan
(https://ddsd.vermont.gov/sites/ddsd/files/documents/SSCP_FY23-25_final.pdf)
For additional information, or to obtain copies of this document in this or other formats, please contact:

Developmental Disabilities Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-2030
Phone: 802-241-0304
Fax: 802-241-0410
www.ddsd.vermont.gov

TABLE OF CONTENTS

SECTION ONE
INTRODUCTION

I. Background

A. History

The closure of Brandon Training School in 1993 was a significant milestone in the history of Vermont's system of care for individuals with developmental disabilities.[1] It marked the end of reliance on an institutional model of care and underscored the commitment to create those supports and services necessary for people to live with dignity, respect and independence outside of institutions. Community-based services and supports are provided through ten Designated Agencies and five Specialized Services Agencies (DA/SSAs) or are self or family managed with the assistance of a Supportive Intermediary Service Organization (Supportive ISO).

In 1996, the Vermont State Legislature embedded in law the process by which the State continues its commitment to community-based services. The *Developmental Disabilities Act of 1996* (DD Act) requires the Department of Disabilities, Aging and Independent Living (DAIL), through the Developmental Disabilities Services Division (DDSD), to adopt a plan known as the *State System of Care Plan* that describes the nature, extent, allocation and timing of services that will be provided to people with developmental disabilities and their families. The *State System of Care Plan*, (from here on called the "*Plan"*), along with the *Developmental Disabilities Services Regulations* (previously titled *Regulations Implementing the Developmental Disabilities Act of 1996 from here on called the ("DDS Regulations")* and the *Developmental Disabilities Services Annual Report*, cover all requirements outlined in the DD Act.

In 2014, the Legislature passed Act 140 amending the DD Act. It included a new requirement that the department adopt certain categories of the *Plan* through the State rulemaking process. This means that they had to be included in the department's *DDS Regulations*. Those categories include:

1. Priorities for continuation of existing programs or development of new programs;
2. Criteria for receiving services or funding;
3. Type of services provided; and
4. A process for evaluating and assessing the success of programs.

[1] The definition of developmental disability and other frequently used terms is included a glossary of terms in Attachment E.

In 2022, the Legislature passed Act 186 which further amended the DD Act. They removed the requirement that the above categories of the *Plan* be adopted through the rulemaking process. Therefore, the Department proposed to remove these categories from the *DDS Regulations* in their next amendment, which was happening concurrent to the development of the new *Plan,* and to include them only in the *Plan.* This change was approved in the *DDS Regulations* effective March 1, 2023.

A draft *Plan* must be submitted to the State Program Standing Committee (SPSC) for Developmental Disabilities Services for advice and recommendations at least 60 days prior their adoption. A draft was submitted to the SPSC on 10/13/22 for a review at the 10/20/22 SPSC monthly meeting. Once the *Plan* priorities were determined, the Commissioner of the department considered funds available to the department in allocating resources.

Some sections of the *Plan* include language that is included in the *DDS Regulations*. Proposed changes to the *DDS Regulations* were being reviewed at the same time as this *Plan* was being drafted and finalized. Because of the timing, the draft *Plan* was based upon the proposed *DDS Regulations* that were submitted for review and public comment. Some changes to the proposed *DDS Regulations* were made after receiving public comment and a new version was sent to the Legislative Committee on Rules (LCAR) for review. The Department was awaiting final review and approval of the *DDS Regulations* when the *Plan* was first published for an effective date of 1/1/23. Where there was language in the *Plan* that overlapped with the *DDS Regulations,* updates to the *Plan* were made to be consistent with the language in the proposed *DDS Regulations* that were submitted to LCAR. See attachment A for link to the proposed *DDS Regulations.* It was anticipated that some adjustments would be made to the final version of the *Plan* based on the finalized *DDS Regulations* when any changed language to the *DDS Regulations* was referenced in the *Plan.* Those final adjustments to the *Plan* are not subject to further review by the SPSC. This technical correction of the *Plan* reflects those updates based on the final approved *DDS Regulations* which became effective on March 1, 2023. This version also fixes some of the links in the 1.1.23 version that linked to older versions of documents. These corrections do not change the content of the *Plan.*

The *Plan* reflects the Division's commitment to the health, safety and well-being of people with developmental disabilities and their families as well as to its principles and values. The principles, which can be found The *Developmental Disabilities Act of 1996*, emphasize the Division's commitment to maximizing individual choice and control in designing and implementing this *Plan*. Act 186

added language to the DD Act that further emphasizes that individuals and families need to receive full information regarding their options for services, as well as the need to ensure that they are respected and active participants in system change initiatives and the development of new services.

B. Creation of the *Plan*

Gathering information about the needs of people with developmental disabilities in Vermont and the effectiveness of our services and supports is an ongoing endeavor. The *Plan* builds on experience gained through previous plans and is developed every three years and updated annually, as needed, with input from a variety of individuals and organizations interested in services and supports for people with developmental disabilities. Input was obtained by the State through a process of gathering information from conversations with stakeholders, the State Program Standing Committee, a dedicated email box for sending input and comments, public forums and hearings and written comments for the *DDS Regulations* and the *Plan*, and an online stakeholder survey (see Section Six for more details). Due to the Public Health Emergency related to the COVID-19 pandemic, the FY2018-FY2020 Plan was extended until 12/31/22. Also, due to the pandemic, Local System of Care Plans were not required to be completed by provider agencies. There was a request from stakeholders and legislators for the Division to focus on three priority areas in developing the new *Plan.* These included:

- Expanding housing options for people with developmental disabilities
- Paying parents to provide services to their children
- Services to individuals with autism spectrum disorders.

Multiple public forums were held to gather input on these 3 topics. Additional forums were scheduled to gather input on the *Plan* as a whole. An online survey to gather input into the development of the *Plan* was also sent to stakeholders. The survey was added to provide an additional vehicle for providing input in light of not completing the Local System of Care Plans. The Division also reviewed existing information regarding the system and input gathered in other previous forums.

The department also considered changes to the *DDS Regulations* and the *Plan* based upon changes in state and federal regulations, policies and agreements. These include the rules for Home and Community-Based Services (HCBS) that have been issued by the federal Centers for Medicare and Medicaid Services (CMS); and the Global Commitment to Health 1115 Demonstration Waiver which is Vermont's agreement with CMS for operating its Medicaid program.

One of the key groups consulted during the development of this *Plan* is the State Program Standing Committee for Developmental Disabilities Services. In accordance with the Developmental Disabilities Act, specifically 18 V.S.A. §8733, this Governor appointed body is charged with advising DAIL on the status and needs of people with developmental disabilities and their families and advising the Commissioner on the development of the *Plan*. All these methods of input provide the perspective of a wide range of individuals.

It should be noted that there are considerable systems changes on the near horizon for Developmental Disabilities Services (DDS). These include the development of a new payment model for DDS and complying with the federal HCBS rules to separate the delivery of case management services from the delivery of other direct services. The work to develop a new payment model has been happening for several years, but it is not yet at the stage to recommend changes to the system. The State has submitted a plan to the CMS to address separating case management services from direct services by working with stakeholders to redesign the system. This work will be happening over the next several years. Act 186 also directs the Department to hire a Housing Specialist and form an Advisory Committee to work on developing additional housing and support options for people with developmental disabilities. After these planning processes have occurred, any changes that impact the *Plan* will be proposed for future updates and are not incorporated in this three-year *Plan* at this time. Updates to the *Plan* can be made annually or sooner if needed, as long as proposed changes are submitted to the DDS State Program Standing Committee for advice and recommendations at least 60 days prior their adoption. It is anticipated that changes to the *Plan* will be required, to reflect changes in accordance with Federal requirements and/or special initiatives as outlined herein.

C. Intention of the *Plan*

The *Plan* is intended to help people with developmental disabilities, their families, advocates, service providers and policy makers understand how resources for individuals with developmental disabilities and their families are managed. It lays out criteria for determining who is eligible for developmental disabilities services and prioritizes the use of resources. It is specifically intended to spell out how legislatively appropriated funding will be allocated to serve individuals with significant developmental disabilities. The *Plan* guides the appropriate use of this funding to help people achieve their personal goals and to continuously improve the system of supports for individuals with developmental disabilities within available resources.

This *Plan* does not substitute for the State of Vermont's Medicaid State Plan. It does not guide or direct the allocation of resources for all Medicaid State Plan services, or other services administered by the Agency of Human Services or other state agencies.

This three-year *Plan* is effective as of January 1, 2023 and will be updated on a yearly basis, as needed. The guidance provided in the *Plan* reflects the expectations for service delivery and documentation during usual operation of the program. The Department granted some flexibilities, as outlined in the December 4, 2020 memo to providers (DDSD_COVID_Flexibilities_FAQ_Nov_2020.pdf (vermont.gov)) to respond the Public Health Emergency due to COVID-19. The flexibilities will remain in place and take precedence over the guidance in the *Plan* until the Department provides notification that a flexibility has been ended. Advance notice will be provided unless the State is directed by CMS to make an immediate change. This includes any notices sent to providers between December 4, 2020 and January 1, 2023 regarding the ending of a specific flexibility.

Feedback on the *Plan* is welcome at any time.

II. Guiding Documents

The development of the *Plan* is guided by the *Department of Disabilities, Aging and Independent Living (DAIL)* *Mission Statement and Core Principles* as well as the *Principles of Service* outlined in the Developmental Disabilities (DD) Act of 1996.

The DAIL Mission Statement can be found at: *DAIL Mission Statement and Core Principles*

The Principles of Service outlined in the DD Act can be found in Section 8724 of the *Developmental Disabilities Act of 1996*.

SECTION TWO
ELIGIBILITY

I. Overview

Using national prevalence rates, it is likely that roughly 16,077 of the state's 643,077[2] citizens have a developmental disability as defined in the Vermont *Developmental Disabilities Act*. Given the birth rate in Vermont of about 4,953 live births per year[3], it is expected that approximately 124 children will be born with a developmental disability in Vermont annually[4]. In FY 21, 29% of Vermonters with a developmental disability are estimated to meet clinical eligibility and receive DDS based on the 4,634 individuals who received services.

Not everyone with developmental disabilities needs or wants services. Most individuals with developmental disabilities in Vermont are actively involved in home and community life, working and living along with everyone else. Of those who do need support, many people have only moderate needs. Those with more intense needs usually require long term, often life-long support. Services are determined through an individual planning process and designed to be based on the needs and strengths of the individual, the individual's goals and the availability of naturally occurring supports.

In enacting the Developmental Disabilities Act, the Legislature made clear its intention that developmental disabilities services would be provided to some, but not all, of the state's citizens with developmental disabilities. It gave responsibility for defining which individuals would have priority for funding and supports to the Division through the *DDS Regulations* and the *Plan*.

II. Eligibility Determination

Individuals with developmental disabilities who wish to receive services must first be found eligible. There are three parts to determining eligibility.

1. Financial eligibility

[2] National census figures obtained from the U.S. Census Bureau's 2020 Population Estimates Program and national prevalence rates of 1.5% for intellectual disability and 1.0% for autism spectrum disorders.

[3] This calculation is based on CY 20 data from the Vermont Department of Health Vital Statistics System.

[4] This calculation is based on prevalence rates of 1.5% for intellectual disability and 1.0% for autism spectrum disorders, understanding that there is an overlap between the two diagnoses.

2. Clinical eligibility
3. Funding eligibility

Financial Eligibility: In order to receive developmental disabilities services funding, an individual must be determined by the Department of Vermont Health Access to be financially eligible for Vermont Medicaid. (Applications for Medicaid can be found at: Medicaid | Department of Vermont Health Access)

Clinical Eligibility: Having a developmental disability means to have a diagnosis of one of the following based on a formal, professional evaluation:

- Intellectual Disability (IQ of 70 or below, or up to 75 or below when taking into account the standard error of measurement), or
- Autism Spectrum Disorder;

and have both of the following:

- Significant deficits in adaptive function (such as, daily living skills, communication, and/or motor development), and
- Onset of the disability prior to age 18.

Funding Eligibility: Each program and funding source has its own criteria to access funding.

The *DDS Regulations* provide more detail on clinical eligibility (Health Care Administrative Rules (HCAR) 7.100.3), recipient criteria (HCAR 7.100.4)), and financial requirements and responsibilities (HCAR 7.100.7)). Section Four of this *Plan* describes the eligibility and access criteria as well as limitations of each program. The clinical and financial eligibility criteria above apply to most programs but for a few programs it is different.

III. Intake Process and Choice of Provider

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. Any other person may refer a person who may need services, supports, or benefits. 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[5].

DAIL has agreements with ten Designated Agencies (DA) and five Special Services Agencies (SSA) to provide Developmental Disabilities Services. These agreements establish their status as certified providers. There is also an agreement with a Supportive Intermediary Service Organization (Supportive ISO) to assist individuals and families who wish to manage their own services. An application for Developmental Disabilities Services is filed at the DA for the geographic region where the individual with the developmental disability lives. Any disputes regarding which DA is the person's responsible DA can be resolved by the DDSD Director.

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 (DA) must document those in the individual's record. Information should be provided both verbally and in writing. 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[6] 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.

During the screening process, a DA must inform the person or his/her right to file an application, have a full assessment, and be given a formal notice of decision regarding eligibility.

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

a. Receive services and supports through any certified provider (DA/SSAs) in the region;

[5] See HCAR *7.100.5(a)* Who may apply. Link to final approved HCAR 7.100 (DDS Regulations) is included in Attachment A.

[6] See HCAR 7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings.

b. Share the management of those services with the DA or SSA; or
c. Self/family-manage their services through the Supportive ISO.[7]

The DA shall help a recipient learn about service options, including the option of self/family-managed services[8]. The option to choose designated providers (DA/SSAs) other than the DA and to self/family-manage or share-manage services applies only to Home and Community-Based Services described in Section Four (G).

It is the DA's responsibility to ensure the individual is informed of his or her choice of all services options listed below so that the individual can make an informed decision when choosing between and among management options/service providers. The DA must document options discussed and information shared as part of this process[9], including a signed acknowledgement by the applicant that they understand their options. 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[10].

The DA shall provide the choices in an unbiased manner to reduce the potential for conflict of interest[11]. The Designated Agency will clearly explain and provide contact information for the applicant to learn about each of the following options.

- **Agency-Managed Services**: Agency-managed services are when a Designated Agency or Specialized Service Agency (DA/SSA) manages all services and supports provided to the individual. Even when the DA/SSA contracts through another entity, such as a shared living provider or other service organization that hires or contracts for support workers, the DA/SSA remains responsible for management and quality oversight of all developmental disabilities services.
- **Shared-Managed Services**: Shared-managed services are when a Designated Agency or Specialized Services Agency (DA/SSA) manages some, but not all, of the services and is responsible for the quality oversight of those services, and the individual or a family member manages some of the services. For example, a DA/SSA may provide service planning and coordination and arrange for other services, such as home supports, while the individual or a family member manages supports such as respite or community supports. Shared-managed services is not defined as a DA/SSA

[7] See HCAR 7.100.5(d) Screening.
[8] See HCAR 7.100.5(j) Choice of Providers.
[9] Ibid.
[10] See HCAR 7.100.5(d) Screening.
[11] See HCAR 7.100.5(j) Choice of Providers.

contracting with a shared living provider and/or other service organization who hires support workers because in those situations the DA/SSA is still responsible for the management and quality oversight of those services.

- **Self-Managed**[12]**:** Self-managed services are when an individual manages all of his or her developmental disabilities services. The individual is responsible for hiring his or her own staff, administrative responsibilities and quality oversight associated with receiving developmental disabilities services funding. An individual may manage up to 12 hours per day of In-home Family Supports or Supervised Living, but may not self-manage Staffed Living, Group Living or Shared Living. 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.[13]
- **Family-Managed Services**[14]: Family-managed services are when a family member manages all of an individual's developmental disabilities services. The family member is responsible for hiring staff, administrative responsibilities and quality oversight associated with receiving developmental disabilities services funding. A family member may manage up to 12 hours per day of In-home Family Supports or Supervised Living, but may not family manage Staffed Living, Group Living or Shared Living. 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.[15]

When an individual or family chooses to self/family-manage services, the individual or family member is also responsible for ensuring that the approved funding is used in compliance with the *Plan*, the *DDS Regulations* and all other relevant policies and guidelines. The Supportive Intermediary Service Organization (Supportive ISO) must be used by individuals and family members who self/family-manage their services to help them understand their roles and responsibilities for self/family-management, including assuring workers are trained, supervised and monitored, following all Division policies and guidelines and managing funding. The DA/SSA assumes this role when services are shared-

[12] For more information, see the *Guide to Self/Family Management* for a comprehensive guide for people who are self/family-managing their developmental disabilities services funded through Medicaid.
[13] See HCAR 7.100.6 Self/Family-Managed Services.
[14] For more information, see the *Guide to Self/Family Management* for a comprehensive guide for people who are self/family-managing their developmental disabilities services funded through Medicaid.
[15] See HCAR 7.100.6 Self/Family-Managed Services.

managed. The Fiscal/Employer Agent (F/EA) must be used by employers of record, including individuals who self/family-manage or share-manage and shared living providers who hire workers, to assist with many of the bookkeeping and reporting responsibilities of the employer. The F/EA also conducts background checks for prospective employees and processes payroll for the employer.

Services from Providers other than the Responsible DA

An applicant may choose to receive services from the DA in the county where he or she lives or may choose to receive services from a Specialized Service Agency (SSA), or another DA. Specialized Service Agencies are organizations that provide a distinctive approach to services and/or services that are designed to meet the needs of individuals with distinctive needs. There are five SSAs who provide services in select regions around the state. The other DA/SSAs have the option to decline to provide services in which case the individual may receive services from their DA or choose to self-manage or family-manage their services.

The recipient or family may choose to receive services from an agency (DA/SSA) in the state, if the agency (other DA/SSA) agrees to provide the authorized services at or below the amount of funding authorized for the DA to provide services.

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

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

A recipient or family may request that an agency (DA/SSA) sub-contract with a non-agency (non-DA/SSA) provider to provide some or all of the authorized services, however, the decision to do so is at the discretion of the agency (DA/SSA)[16].

[16] See HCAR 7.100.5(j) Choice of Provider

IV. Authorization of Services and Funding and Notification

The DA is responsible for verifying that the applicant has met the criteria for financial eligibility. The DA must conduct or arrange for an assessment that will be used to determine clinical eligibility. It is the Division's responsibility to determine clinical eligibility for HCBS. If an applicant has been found financially and clinically eligible, an Individual Needs Assessment must be completed to determine whether the applicant meets criteria to access any of the services or funding listed in Section Four of this *Plan*. Individuals applying for HCBS must participate in the needs assessment process established by the State. Agencies must conduct or arrange for the needs assessment according to this process.

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 services or funding, if any, which the applicant will receive. 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.[17] Failure to act in a timely manner according to state rules is appealable. For an individual who is authorized to receive Home and Community-Based Services, notification will specify the amount, types and costs for these services in the form of the individual's Authorized Funding Limit (AFL).

Within 30 days of written notification of approval for services and/or funding, the chosen DA/SSA will begin funded services. During this period, the DA/SSA will work with the applicant to initiate person-centered planning and the Person's Story and develop an Individual Support Agreement (ISA). The DA/SSA may begin some or all services before the 30-day timeframe depending on individual circumstances. However, there must be a signed ISA within 30 days of the first day of billable services or authorized start date for HCBS. If the authorized services are not going to start within 30 days of notification of approval, the chosen DA/SSA will notify the applicant in writing of the estimated start date of services. For individuals or families who choose to self/family-manage their services, the DA will transfer the authorized funding and required records (Transfer of Documents when Changing Providers: Guidelines for Agencies) to the Supportive ISO. The individual or family may then arrange to implement services with the assistance of the Supportive ISO and F/EA.

[17] See HCAR 7.100.5(i) Notification of Decision on Application.

If the applicant is found ineligible for services, the DA is responsible to provide the individual information and referrals to other services. If the applicant is found ineligible to receive funding for some or all services, the DA will, as soon as possible, notify the applicant and provide information to the individual about the basis for the decision, the process for appeal and where to obtain legal assistance.

Applicants' names will be placed on a waiting list maintained by the DA as specified in the *DDS Regulations* (HCAR 7.100.5(q). The applicant will be informed when his or her name has been placed on the waiting list and will be given information about the periodic review of the waiting list. (See HCAR 7.100.5(i) for more information on notification of decisions and HCAR 8.100 on the appeal process.)

SECTION THREE
FUNDING AUTHORITY AND SOURCES

I. Overview

The authority to offer and fund services for people with developmental disabilities is outlined in the special terms and conditions of Vermont's Global Commitment to Health Section 1115 Demonstration, an agreement between the Vermont Agency of Human Services and the federal Centers for Medicare and Medicaid Services (CMS) regarding the administration of the State's Medicaid program. The agreement allows for the provision of "special programs" for individuals who would have been eligible under separate 1915 (c) waivers previously. Developmental Disability Services is one of these special programs.

The agreement indicates that "Vermont's specialized programs rely on person-centered planning to develop individualized plans of care. Specialized programs support a continuum of care from short term crisis or family support to intensive 24/7 home and community-based wraparound services. These programs include both State Plan recognized and specialized non-State Plan services and providers to support enrollees in home and/or community settings. The state may require: additional provider agreements, certifications or training not found in the State plan; specific assessment tools, level of care or other planning processes; and/or prior authorizations to support these programs." It provides a summary of the services available but specifies that "complete service definitions, approved provider types, applicant rules, prior authorizations, limitations and exclusions can be found in Vermont statute, rule and policy."

Below is a list of the additional Vermont statutes, rules and policies that provide authority and guidance regarding the use of funding and service delivery for people with developmental disabilities:

- *The Vermont State System of Care Plan for Developmental Disabilities Services,* this *Plan*
- *The Developmental Disabilities Act of 1996*
- The *DDS Regulations* - Disability Services – Developmental Services,
- *Administrative Rules on Agency Designation*
- *DDSD Medicaid Claim Codes and Reimbursement Rates*
- *Individual Support Agreement Guidelines*
- *Behavior Support Guidelines for Support Workers Paid with Developmental Services Funds*

- *Guidelines for the Quality Review Process of Developmental Disabilities Services*
- *Medicaid Manual for Developmental Disabilities Services*
- *Vermont State Medicaid regulations* – Health Care Rules | Agency of Human Services (vermont.gov)
- *DDSD Encounter Data Submission Guidance*

Each year, the Legislature appropriates funding for the provision of Developmental Disabilities Services. DAIL is committed to providing high quality, cost-effective services to support Vermonters with developmental disabilities within the funding available and to obtain good value for funding appropriated by the Legislature. To help achieve this goal, the Developmental Disabilities Services Division allocates these appropriated funds to its network of Designated Agencies and Specialized Service Agencies (DA/SSAs) as well as the Supportive Intermediary Service Organization (Supportive ISO) on behalf of people self/family-managing services. DAIL has Provider Agreements with all DA/SSAs that outline the requirements for service provision and include the amount of funding allocated for each available program and funding source. There are separate provider standards which outline the requirements for the Supportive ISO. The appropriation includes a base allocation used by DA/SSAs and the Supportive ISO for individuals currently receiving services. The appropriation may also include additional funding for individuals who are new to services or who currently receive services and have an increase in needs. A summary of the funding available in FY 2023 is shown in *Attachment C*. The Division as well as the DA/SSAs and the Supportive ISO each have roles in the allocation of funding to recipients.

II. Role of the Division in Funding

The Division maintains an active role in the allocation, review and approval of developmental disabilities services funding. The Division will:

A. Prepare budget recommendations for the Administration's review, including analysis of emerging trends, changes in best practices, new federal requirements, pressures, and opportunities for cost-reduction and system-delivery improvements.

B. Allocate base funding for each program specified in each agency's Provider Agreement.

C. Issue instructions for any budgetary rescissions or increases, as directed by the Legislature. In the absence of specific instructions from the Legislature, the Department will consult with DA/SSAs and Supportive ISO as well as the DDS State Program Standing Committee for recommendations regarding how to implement budgetary rescissions or increases. Then the Department will issue instructions.

D. Provide funding guidelines and technical assistance to DA/SSAs, Supportive ISO and local funding committees.

E. Lead the Equity and Public Safety Funding Committees (see Section Five, III); establish operating procedures for each committee; take recommendations from the committees; assure that each funding proposal is in compliance with this *Plan*, the *DDS Regulations*, and all other relevant policies and guidelines; make final funding decisions, track funding requests for current and new recipients and monitor caseload expenditures.

F. Verify clinical eligibility of those funded for Home and Community-Based Services.

G. Review representative samples of individuals' services to determine whether the supports currently funded are of high quality, cost effective, meet people's needs and achieve their desired goals.

H. Review Medicaid Management Information System paid and denied claims, and encounter data, service documentation, time records or Electronic Medical Records (EMR) equivalent documentations to determine adherence with state/federal rules and utilization/funding guidelines and inform the process of working to ensure compliance.

I. Approve all Unified Service Plans. Unified Service Plans blend different funding sources (such as developmental disabilities Home and Community-Based Services funding, Children's Personal Care Services and/or Medically Complex Nursing Services[18]) into a unified funding approach with one coordinated service plan for individuals with complex and intensive medical and/or behavioral support needs.

[18] Children's Personal Care Services and Medically Complex Nursing Services for children are managed by Vermont Department of Health/Children with Special Health Needs. Medically Complex Nursing Services for adults are managed by Department of Disabilities, Aging and Independent Living/Adult Services Division.

J. Assist DA/SSAs to fill vacancies in group homes/residential settings that are considered statewide resources. These are settings operated by DA/SSAs and considered by DAIL as statewide resources available to eligible individuals in VT. DA/SSAs must notify DDSD of a group home/residential setting opening. The Division then sends a notice to the statewide provider network. DA/SSAs receive referrals and consult with DDSD staff to review viable candidates and come to a mutual agreement as to the best match for the home. In the event that a mutual agreement cannot be reached, the DA/SSA will make the final decision.

K. Approve increases in funding for group homes/residential settings that are agreed upon by the provider and DDSD to be considered statewide resources.

L. Assist DA/SSAs to negotiate and facilitate arrangements for eligible individuals when the Department for Children and Families (DCF), Department of Mental Health (DMH), Department of Corrections (DOC) or other state agencies and/or organizations are contributing payment for an individual's Home and Community-Based Services. Provide final funding approval in conjunction with other departments, agencies or organizations.

M. Prior authorize requests for any out-of-home placements supported by developmental disabilities funding for children under age 18.

N. Resolve the issue of which agency is the Designated Agency when it is not clear which agency has the Designated Agency responsibilities for a particular individual in accordance with DDSD guidance.

O. Manage the DDSD budget within available funding.

P. Ensure use of HCBS funds are consistent with the federal HCBS rules.

III. Role of Designated Agency

A. Verify financial eligibility.

B. Conduct or arrange for an assessment that will be used to determine clinical eligibility.

C. Conduct or arrange for needs assessments for all new applicants or existing recipients, according to the process established by the Division.

D. Conduct periodic reviews of needs or new needs assessment for existing recipients as needs change or at least annually.

E. Seek or authorize funding based upon assessed needs of individuals and families.

F. Review service and individual budget utilization and assist individuals and families in understanding the funding rules and management of their budget.

G. Manage base allocation by shifting funds within and across individual budgets as needs change.

H. Follow all Division rules and guidance in requesting and managing funds as outlined in the Provider Agreement, *the Plan*, the *DDS Regulations* and the *Medicaid Manual for Developmental Disability Services.*

I. Operate a Local Funding Committee (see Section Five, III.A).

J. Submit requests for funding involving Unified Services Plans, DMH, and DCF or other in-state or out-of-state organizations to the Division for approval.

K. Submit requests for out-of-home placements supported by developmental disabilities services funding for children under age 18 to the Division for approval.

L. Notify Division of openings in group homes/residential settings that are considered statewide resources as soon as an opening occurs.

M. Recalculate service and support costs annually and update individuals' budgets accordingly by reallocating (known as "re-spreading") costs across individuals' budgets, as appropriate.

N. Address gaps in services identified in the Local System of Care Plans with available funds.

IV. Role of Specialized Service Agency

A. Conduct periodic reviews of needs or new needs assessment for existing recipients as needs change or at least annually.

B. Conduct or arrange for needs assessments for existing recipients, according to the process established by the Division.

C. Seek or authorize funding based upon assessed needs of individuals and families.

D. Review service and individual budget utilization and assist individuals and families in understanding the funding rules and management of their budget.

E. Manage base allocation by shifting funds within and across individual budgets as needs change.

F. Follow all Division rules and guidance in requesting and managing funds as outlined in the Provider Agreement, *the Plan*, the *DDS Regulations* and the *Medicaid Manual for Developmental Disability Services.*

G. Participate in the Local Funding Committee. Submit requests for increased HCBS funding for an individual to the individual's DA. Present on those requests for HCBS funding at Local Funding Committee.

H. Submit requests for funding involving Unified Services Plans, DMH, and DCF or other in-state or out-of-state organizations to the Division for approval.

I. Submit requests for out-of-home placements supported by developmental disabilities services funding for children under age 18 to the Division for approval.

J. Notify Division of openings in group homes/residential settings that are considered statewide resources as soon as an opening occurs.

K. Recalculate service and support costs annually and update individuals' budgets accordingly by reallocating (known as "re-spreading") costs across individuals' budgets, as appropriate.

L. Address gaps in services identified in the Local System of Care Plans with available funds.

V. Role of Supportive ISO

A. Conduct periodic reviews of needs or new needs assessment for existing recipients as needs change or at least annually.

B. Conduct or arrange for needs assessments for existing recipients, according to the process established by the Division.

C. Seek or authorize funding based upon assessed needs of individuals and families.

D. Review service and individual budget utilization and assist individuals and families in understanding the funding rules and management of their budget.

E. Follow all Division rules and guidance in requesting and managing funds as outlined in the Provider Standards for Supportive ISO for Self/Family Management of Developmental Disabilities Services, *the Plan*, the *Rules* and the *Medicaid Manual for Developmental Disability Services*.

F. Operate a Local Funding Committee. Authorize up to $5,000 per person annually for short-term needs from the shared funding pool in accordance with the One-Time Funding guidelines (Section Four, I(I)). Submit requests for increases to annualized HCBS funding to the Local Funding Committee for review prior to submitting them to the Equity or Public Safety Funding Committees.

G. Submit requests for funding involving Unified Services Plans, DMH, and DCF or other in-state or out-of-state organizations to the Division for approval.

H. Recalculate service and support costs annually and update individuals' budgets accordingly by reallocating (known as "re-spreading") costs across individuals' budgets, as appropriate.

I. When a new person transfers from a DA/SSA to self/family-management, the Supportive ISO assists the person/family to plan how best to provide the services using the approved budget to meet the assessed needs.

SECTION FOUR
AVAILABLE PROGRAMS and FUNDING SOURCES

I. Description of Available Programs

Below is a description of the available programs for developmental disabilities services. Each description includes information about the funding source, the intent of the program, the eligibility and access criteria; limitations and process for authorizing the services.

The Department's programs reflect its current priorities for providing services for Vermont residents with developmental disabilities. The availability of the Department's current programs, which are described below, is subject to the limits of the funding appropriated by the Legislature on an annual basis. The nature, extent, allocation and timing of services are addressed in this *Plan*, as specified in the DD Act. Additional details, eligibility criteria, limitations and requirements for each program are included in 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.[19]

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

The Bridge Program is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) service that provides support to families in need of care coordination to help them access and/or coordinate medical, educational, social or other services for their children with developmental disabilities. As an EPSDT service, children who meet the eligibility criteria below are entitled to receive this service and may not be placed on a waiting list. Agencies may use Targeted Case Management funding to meet the needs of some young adults between 18-22 when appropriate. Agencies should notify the department if they exhaust their Bridge funding and are in need of additional funds to serve those eligible for the Bridge Program.

[19] See HCAR 7.100.5(g) Available Programs and Funding Sources.

On an annual basis, the Division negotiates and approves funding allocations for Developmental Disabilities Services Providers for the Bridge Program. The DAs will determine clinical and financial eligibility and approve individuals to receive this service. *The Bridge Program Guidelines*.
provide details regarding eligibility, scope of service provision and overall management of services.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

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

(c) Access Criteria:
Individual must be under the age of 22. Care coordination is available in all counties either through the Bridge Program or through an Integrating Family Services (IFS) program administered by the Department of Mental Health. Children who are receiving care coordination, case management or service coordination from another AHS-funded source listed in the *Bridge Program Guidelines* are not eligible to receive Bridge Program Care Coordination.

(2) **Limitations**

(a) Funds must be used in accordance with *Medicaid Manual for Developmental Disabilities Services*.

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

(c) DA/SSAs should use Bridge Funding for children in need of case management/care coordination rather than Targeted Case Management, except for some young adults age 18-22 for whom TCM is determined to be the more appropriate service.

(B) Clinical Services-Non-HCBS

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

- Diagnosis and Evaluation (D & E)
- individual therapy
- group therapy
- family therapy
- emergency care
- Medication and Medical Support and Consulting Services (e.g., chemotherapy, med-check)

(1) Eligibility

(a) Clinical:
Individuals who meet the criteria for developmental disabilities as defined in the *DDS Regulations*, except for as specified in the Medicaid Manual for initial D & E and emergency care.

(b) Financial:[20]
Individual has a method of payment for services including:

- Private Insurance
- Medicare
- Vermont Medicaid eligible as determined by Department of Vermont Health Access or other arrangements specified in agency policy

(c) Access Criteria:
Access to these services is determined by the agencies (DA/SSA) based upon need and available resources.

(2) Limitations

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

[20] There are exceptions to the financial eligibility criteria for initial emergency care.

(b) An agency may not bill for these services and HCBS on the same day.

(C) Developmental Disabilities Specialized Services Fund

This fund pays for dental services for adults and adaptive equipment and other one-time ancillary services needs that individuals and families cannot meet or are not covered by other funding sources. Requests for Special Services Funds can be made to the Division by DA/SSAs, the Supportive ISO, individuals, families or other interested parties.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

(b) Financial:
None.

(c) Access Criteria:
The goods and services requested must be related to the person's disability.

(2) **Limitations**

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

(b) Dental for adults has a maximum limit of $1,000 per person per fiscal year.

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

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

(e) The fund shall not be used to pay for services covered by Medicaid State Plan, HCBS funding, Medicare, or private insurance.

(f) Funds are provided based on the funds available for this program at the Division.

(D) Employment Supports - Conversion of Community Supports Funding

The Employment Support Conversion allows for re-allocation of Community Support funding to Employment Support funding to gain or maintain employment. The HCBS limitations related to moving funds within an individual's budget do not apply to this initiative. The $5,000 threshold for Equity/Public Safety committee funding requests is not required for these requests.

Adults who have graduated from high school and have Community Supports funded in their HCBS budget may transfer their Community Supports, up to a maximum of $5,000, to receive Employment Supports in order to obtain an employer paid job. Employment Supports to obtain employment include Employment Assessment and Employer and Job Development.

Upon job hire, Community Support funds may be converted to Supported Employment for Job Training and Ongoing Support to Maintain Employment as needed. Once an adult has determined how many Community Support hours to convert to employment, the DA/SSAs may submit *Community Support Conversion Funding Requests* to Equity or Public Safety Funding Committees for additional funding, up to $5,000, to offset any increased cost of the Employment Support for Job Training and/or Ongoing Support to Maintain Employment. The increased cost is the difference in hourly rate between Community Supports and Employment Supports.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disabilities as defined in the *DDS Regulations*.

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

(c) Access Criteria:
Individuals with HCBS funding who must have transferred

some or all of their existing community supports funding to work supports.

(2) **Limitations**

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

(b) The maximum amount of Community Supports to convert for Employment Assessment and Employer and Job Development is $5,000.

(E) Family Managed Respite

Family Managed Respite (FMR) funding is allocated by DAs to provide families with a break from caring for their child with a disability, up to age 21. Respite can be used as needed, either planned or in response to a crisis. It may be used to allow the caregiver to attend to his or her own needs or the needs of other family members. Respite may also be used to create a break from the normal routine for the child with a disability. It is intended to promote the health and well-being of a family by providing a temporary break. Eligibility for FMR, determined through a needs assessment with a Designated Agency, is defined in the *Family Managed Respite Guidelines*. Families are given an allocation of respite funds that they will manage. Families are responsible for recruiting, hiring, training and supervising the respite workers. DAs may provide assistance with these responsibilities. The workers are paid through the Fiscal/Employer Agent (F/EA) who processes the payroll and conducts background checks for these employees.

(1) **Eligibility**

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

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

(c) Access Criteria:
FMR is available to children up to, but not including age 21 living with their biological/adoptive families or legal guardian.

(2) **Limitation**

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

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

(c) The maximum allocation per year per individual is set by the Department and is listed on the *Family Managed Respite Guidelines*

(F) Flexible Family Funding

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

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

(b) Financial:
Income-based on sliding fee scale outlined in *Flexible Family Funding Guidelines.*

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

(2) **Limitations**

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

(b) Flexible Family Funding is limited to a maximum of $1,000 per person per year, including when using one-time dollars for FFF and when FFF that is carried over by DAs into the next fiscal year.

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

(d) Availability of these funds is limited to the amount allocated to the DA for this program and available one-time funds.

(G) Home and Community-Based Services (HCBS)

Developmental Disabilities HCBS are long term services and supports provided throughout the state by private, non-profit developmental disabilities services providers, or through self/family-management, to adults and children with developmental disabilities with the most intensive needs. Individual HCBS service plans are based on all applicable services and supports provided to the individual in accordance with their assessed needs. Services and supports may include: Service Coordination, Community Supports, Employment Supports, Respite Supports, Clinical Services, Supportive Services, Crisis Services, Home Supports and Transportation Services. A link to the definitions of these services is included in Attachment A. HCBS are applied for through the local DA for new applicants. Current recipients can request increased services or funding through their current DA/SSA or the Supportive ISO if they are self/family-managing.

The provision of HCBS must be consistent with federal HCBS rules. This includes providing choice regarding living arrangements, providing supports that are integrated in the community, and in alignment with the person's culture. A person's home where these services are provided must honor and support the person's cultural preferences and rights to free association and privacy. Services must be integrated in the community in a manner that does not inhibit the person receiving services from knowing and being known by others in the community and forming enduring relationships. HCBS must accommodate the person's culture and support connections to communities of the person's choice.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

(b) Financial:
Vermont Medicaid-eligible as determined by Department of Vermont Health Access.

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

1. Individual would otherwise be eligible for Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD) level of care;

2. The individual has an unmet need related to their developmental disability; and

3. The individual's unmet need meets one of the following six funding priorities for HCBS.

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

    a. "Imminent" means presently occurring or expected to occur within 45 days.

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

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

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

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

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

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

(2) **Public Safety Funding Criteria**
The following describes the criteria to access HCBS under the Public Safety funding priority:

(a) Criteria for Eligibility for Public Safety Funding:

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

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

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

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

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

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

account.

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

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

(5) Not charged with or convicted of a crime, but the individual's risk assessment contains evidence that the individual has committed an illegal act and still poses a substantial risk of committing a sexual or violent offense.

(6) Convicted of a crime and under supervision of the Department of Corrections (DOC) (e.g., probation, parole, pre-approved furlough, conditional re-entry) and DOC is actively taking responsibility for supervision of the individual for public safety. Public Safety Funding only pays for supports needed because of the individual's developmental disability. Offense-related specialized support needs, such as sex offender therapy, cannot be funded by the Department for an individual who is under the supervision of DOC.

(b) Access Restrictions:

(i) It is not a priority to use Division funding to prevent an individual who has been charged with or convicted of a crime from going to or staying in jail or to prevent charges from being filed.

(ii) Public Safety Funding shall not be used to fund services for individuals believed to be dangerous to others but for

whom there is no clear evidence they pose a risk to public safety, and who have not committed an act that is a crime in Vermont. These individuals may be funded if the individual meets another funding priority.

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

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

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

(3) **Limitations**

(a) HCBS funds must be used according to the guidance in this *Plan* in Section Five, Management of Home and Community-Based Services Funding. This section describes the availability and limitations of HCBS funding.

(b) HCBS funds must be used in accordance with the *Medicaid Manual for Developmental Disabilities Services.*

(H) Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD)

An ICF/DD residence provides comprehensive and individualized health care and habilitation services to individuals, as an alternative to HCBS, to promote their functional status and independence. There are currently no ICF/DD facilities operating in Vermont. DAIL intends to develop a new ICF/DD.

(1) **Eligibility**

(a) Clinical:

(i) Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

(ii) Individual must have significant medical needs.

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

(b) Financial:
Vermont Medicaid eligible as determined by Department of Vermont Health Access

(c) Access Criteria:
Access to an ICF/DD is limited to those who meet the clinical and financial eligibility criteria.

(2) **Limitations**

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

(b) Placement in an ICF/DD must be authorized by the Division.

(c) HCBS and ICF/DD services cannot be billed on the same date of service.

(I) One-Time Funding

One-time funds are generated from the new and returned caseload dollars for the Equity and Public Safety funding pools. When new funding is approved, 100% of the annualized amount needed to support a full fiscal year of services for the individual is committed. This assures that funds to pay for a full fiscal year of services are built into the DA/SSA's base budget. When 365 days of funding are not required because the individual's newly funded services began after the start of the fiscal year (July 1st), the unused balance creates one-time funding.

One-time funds are used to address short term needs and cannot be used for long term needs. The Division may use one-time funding to support specific activities, pilot projects and special initiatives. When there are one-time funds available, a portion of those funds shall be distributed to agencies. The amount and timing of distribution is at the discretion of the Department. The Department will report on the use of one-time funds distributed to DA/SSAs and for specific activities, pilots and initiatives to the State Program Standing Committee through the DDS Annual Report.

Any one-time funding distributed to DA/SSAs must be allocated according to one-time funding guidance listed in item (2) below and reported to the Division. If there is a question about an allowable use of one-time funding, the Division makes the final decision. One-time funds should be used only after exploring other sources of funding such as Medicaid State Plan, Medicare, private insurance, or other available community resources. One-time funds are accessed through DA/SSAs and Supportive ISO. The Supportive ISO has one-time funds generated from unused funds from individuals' budgets, which creates a reserved funding pool.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disabilities as defined in the *DDS Regulations*.

(b) Financial:
Vermont Medicaid eligible as determined by Department of Vermont Health Access, except when used for individuals for Flexible Family Funding, who must meet financial eligibility for that service.

(c) Access Criteria:
Current recipients of DDS services or funding and individuals who meet clinical and financial eligibility who are not current recipients of funding to meet one of the needs listed below:

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

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

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

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

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

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

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

(g) Small grants to self-advocates, families and others that promote the Principles of Developmental Disabilities Services in the the *Developmental Disabilities Act of 1996*; for innovative programs that increase a consumer's ability to make informed choices, promote independent living, and offer mentorship or career building opportunities.

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

(i) Funding to cover the cost of installing a lock that complies with the HCBS settings rule for people in shared living homes who are in service in FY23. In the future, the cost would be an expectation of all new home providers.

(3) **Limitations**

(a) Maximum annual amount per person is $5,000 and only for allowable uses described.

(b) Cannot be used to pay for room and board, rent or utility subsidies.

(J) Peer Growth and Lifelong Learning

These Department approved programs provide lifelong learning and teaching experiences to adults with developmental disabilities and increases the individual's ability to become an expert in topics of interest through supported research, inquiry, community networking and full examination of a topic. The experience empowers individuals as role models and results in improved confidence, self-direction, interpersonal skills, organization, and executive functioning skills.

(1) Eligibility

(a) Clinical:
Individuals who meet the criteria for developmental disabilities as defined in the *DDS Regulations*.

(b) Financial:
Vermont Medicaid-eligible as determined by Department of Vermont Health Access.

(c) Access Criteria: Access is limited to the geographic area where the approved program is provided.

(2) Limitations

The Department determines the amount of funding allocated to a DA or SSA for this program.

(K) Post-Secondary Education Initiative

The Post-Secondary Education Initiative (PSEI) is a program funded through a combination of grants and HCBS funding that assists transition age youth 18 to 30 with developmental disabilities to engage in typical college experiences through self-designed education plans that lead to marketable careers in competitive employment and independent living. Supports are arranged with the Department's approved PSEI college support organizations to provide academic, career and independent living skill development through a peer mentoring model.

(1) Eligibility

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

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

(c) Access criteria:
This program prioritizes adults under 30 who have graduated from high school or have a GED who have been accepted for enrollment in post-secondary programs facilitated by the PSEI support programs. If space allows, adults 30 and older who have graduated may apply to the program on a case-by-case basis. The individual must also have access to resources that are needed to participate beyond what is provided by the PSEI program.

(2) **Limitations**

(a) Access to the PSEI is limited to the geographic area of partnering colleges, the capacity of the PSEI program to support additional students and the PSEI funds available at the DA/SSA**.**

(b) The individual's existing service budget, as appropriate, must be utilized prior to using funds from the PSEI allocations in the Provider Agreements. Upon an individual's completion of the program, PSEI funding is returned to the DA/SSA for re-allocation to new students.

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

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

PASRR Specialized Day Services are available to individuals living in a nursing facility and who need additional services related to their

developmental disability (e.g., social, behavior, communication) that are beyond the scope of the nursing facility.

These services are prior-authorized on an individual basis by the Division. The Division authorizes funding for those individuals who have been determined through a PASRR evaluation to be in need of this service. If the individual's needs change, a request can be made to the Division for a re-assessment. Adjustments to the individual allocation are made based on the assessed needs.

(1) **Eligibility**

(a) Clinical:
Individual with a developmental disability or related condition as defined by Federal PASRR regulations.

(b) Financial:
Vermont Medicaid eligible as determined by Department of Vermont Health Access.[21]

(c) Access Criteria:
Individual over 18 years of age living in a nursing facility and having been determined to be in need of Specialized Day Services through PASRR evaluation.

(2) **Limitations**

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

(b) Services must be provided in accordance with the *Medicaid Manual for Developmental Disabilities Services.*

(M) Projects for Transition Support

These Department approved projects prepare student-interns who are in their last year of high school or adults up to age 30 with technical skills through internship rotations at a host business location. The cornerstone of these projects is immersion in a single business for the entire school year where

[21] For individuals who are not eligible for Vermont Medicaid, the Division can assist in exploring alternative payment arrangements.

students learn career development skills through job coaching and direct guidance provided by the business' department managers. This support is accessed through DA/SSAs with Department approved programs.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations* (see exceptions below in Access Criteria (M)(1)(C).

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

(c) Access Criteria:
This program prioritizes students in their last year of high school who have been determined to have developmental disabilities. If space allows, adults under 30 who have graduated may apply to the program on a case-by-case basis. Those that have graduated would need to have funding available in their HCBS budget to pay for their participation. In addition, if space allows, students who receive special education and do not have developmental disabilities, but do have other challenges that are supported by an Individual Education Plan (IEP), may apply on a case-by-case basis.

(2) **Limitations**

Access to these Department approved projects is limited to the geographic area where they are provided.

(N) Public Guardianship Fund

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

(O) Targeted Case Management for Persons with Developmental Disabilities

Targeted Case Management (TCM) is a Medicaid State Plan service that provides assessment, care planning, referral, and monitoring. Case Management is provided by the agencies (DA/SSA) and designed to assist adults to gain access to needed services. Units of service to be provided are based upon assessed need.

(1) **Eligibility**

(a) Clinical:
Individuals who meet the criteria for developmental disability as defined in the *DDS Regulations*.

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

(c) Access Criteria:
TCM is available for adults age 22 and over, and young adults between 18-22 when appropriate. An agency may not bill for TCM and HCBS, Bridge Care Coordination or other Medicaid funded case management services on the same day.

(2) **Limitations**
Funds must be used in accordance with the
Medicaid Manual for Developmental Disabilities Services.

II. 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 enhance choice and control by people in services and increase opportunities them and their families. The timing and amount of funding for any initiative will be identified in the *Plan*. For all special initiatives, specific outcome measures will be required and results will be reported by DDSD.[22] The ability to take on an initiative will depend upon

[22] See HCAR 7.100.5(h) Special Initiatives.
[23] See Attachment B for further guidance on *Moving Funds in Individualized Budgets*.

financial resources available to the Division and staff capacity to manage projects in collaboration with service providers, self and family advocates, and other stakeholders. The Division's intent is to be transparent and accountable, and it will develop and maintain more detailed workplans that include benchmarks and timelines for the work on these initiatives. The Division will seek input from the DDS State Program Standing Committee regarding prioritization and timing of these initiatives. The Division will update these detailed workplans no less than every six months and post them on the Division website.

Based upon stakeholder input, the Division will select initiatives that support the following areas:

1. Increase the variety of supported living options that address the needs of a variety of age groups, support needs, and maximizes choice and independence.
    - Leverage aspects of Act 186 to assist the Division to identify current gaps in system related to housing options and desired alternatives:
        - The Division will work with the Vermont Developmental Disabilities Council and Green Mountain Self-Advocates to study statewide:
            - Effective housing and residential models for individuals with intellectual and developmental disabilities from across the United States that align with the CMS Settings Rules and the Principles of Services for Vermont Developmental Disabilities Services, and
            - The number of individuals who would benefit and choose to live in alternative housing options
    - Develop a request for proposal to develop housing and residential service pilot planning grants in at least three regions of the State, in partnership with designated and specialized services agencies, for individuals with developmental disabilities and their families.
    - Solicit guidance and advice from the Act 186 Steering Committee related to the expansion of housing and residential options for individuals with developmental disabilities and their families, as well as their stated role as laid out in Act 186.
    - Review current State rules and limitations in the *Plan* that may pose barriers to innovative housing options. Seek stakeholder

input on possible changes to rules and limitations. Make decisions regarding changes and initiate work to amend rules and the *Plan* as needed.

- Access earmarked funding for a limited-services *Residential Program Director* position. This position will lead the work:
  - Related expanding housing and residential services options for individuals with developmental disabilities,
  - Assist individuals with developmental disabilities and their families to navigate publicly and privately funded housing and residential services options,
  - Develop requests for proposals for pilot-planning grants for different regions of the State focused on the housing needs identified in those regions, and
  - Work with the appropriate providers to implement the selected pilots.
- Partner with stakeholders including but not limited to individuals receiving services, family groups, providers, related to the development and implementation of potential housing models and options in addition to the pilot planning grant opportunities. This includes:
  - Illustrating the flexibilities inherent within the options included in the System of Care plan.
  - Exploring local, state, and federal funding options for capital expansion and renovation.
  - Determining the feasibility and sustainability of models proposed based on compliance with state and federal rules and regulations, and funding.

2. Develop an ICF/DD that provides nursing and supportive services for up to six people with developmental disabilities.

3. Strengthen the direct support professional workforce through targeted efforts in recruitment, training, supervision and mentoring, skill development, and retention.
   - Convene a stakeholder workgroup focused on exclusively DD services
     - Identify approaches for strengthening the workforce on topics such as wages and benefits, training, and professionalization of the workforce.

- Leverage existing work under the DA/SSA Workforce group as appropriate
- Provide recommendations to the Division, provider network and State Program Standing Committee.

- With the assistance of the workgroup, research and, if necessary, develop resources required to implement recommendations.
- Identify and leverage local, state, and federal funds available for this initiative.
- Ensure coordination of efforts with the Statewide workforce workgroup.

4. Explore the option of paying parents to provide services to their adult children using DS HCBS dollars.

- Assemble a workgroup consisting of key stakeholders, including individuals receiving supports, families, and provider representatives, to work with the Division to:
  - Identify necessary safeguards related to oversight, quality, accountability, and individual choice to pay parents.
  - Design administrative structure for paying parents, as needed.
  - Provide recommendations to the Division Director and Commissioner of Disabilities, Aging and Independent Living on whether to pay parents, and under what conditions.
- If appropriate, the Department will seek approval from CMS.

5. Develop training resources for understanding the needs of individuals with autism spectrum disorders and designing individualized person-centered supports. Include people with ASD in the design and delivery of training.

- Develop a workgroup consisting of key stakeholders, including individuals receiving supports, and provider representatives, to work with the Division to:
  - Identify the gaps in service delivery.
  - Determine areas of importance for training for direct support professionals, clinical staff, medical personnel, etc.,

        - Identify best practices related to person-centered supports.
    - Identify and leverage state, local, and federal funds available for this initiative.

6. Systemically incorporate Supported Decision Making into the service delivery system.
    - Work with the state's Community of Practice (CoP) on Supported Decision Making to coordinate efforts related to the development and implementation of:
        - Individual Support Agreement guidelines.
        - Training for individuals, families, guardians, and the court system.
        - Guidance to providers regarding their role in Supported Decision Making.
    - Leverage the CoP to learn about Supported Decision Making approaches in other states.

7. Explore creation of an ombuds program for DD services in partnership with key stakeholder, including exploring a pilot grant.

    - Solicit input from stakeholder groups such as individuals receiving services and guardians, families, and providers.
    - Leverage earmarked federal funding for pilot grant.
    - Expand ombuds supports to include DD population to include:
        - Determining a region of the state for pilot.
        - Development of a monitoring visit plan.
        - Development of policies and procedures.
        - Creation of website, intake, and dedicated phone line.
    - Explore ongoing funding and expansion of services through Department of Disabilities, Aging and Independent Living appropriations.

8. Conduct fiscal impact studies of making the suggested changes to expand access to Employment Supports.
    - Assess financial implications of:
        - Raising the allowable age of the Employment Support funding priority from 26 to 65.

        - Increasing the allowable number of hours per week of employment supports funded from 25 hour per week to 30 hours per week.
    - Explore resources to implement recommended changes.
    - Report findings to State Program Standing Committee.
    - Solicit stakeholder input, if appropriate, on priorities of potential changes that could be implemented.

9. Develop a plain language document that outlines people's rights described in the DD Act and the HCBS rules, disseminate and provide training on rights.
    - Convene a stakeholder workgroup to develop the document.
    - Distribute widely to stakeholders.
    - Assure that providers share with all applicants and recipients.
    - Work with partners (e.g., Green Mountain Self-Advocates, VT Developmental Disabilities Council, service providers) to develop and provide training to individuals and families on their rights.

SECTION FIVE
MANAGEMENT of HOME and COMMUNITY-BASED SERVICES FUNDING

I. Base Allocation

As noted previously, the Legislature appropriates the funding for DDS, including HCBS funding. The appropriation includes a base allocation used by DA/SSAs and the Supportive ISO for individuals currently receiving services. The appropriation may also include additional funding for individuals who are new to services or who currently receive services and have an increase in needs. This funding is known as New Caseload Funding and is allocated to the Equity and Public Safety Fund. DA/SSAs manage their base allocations for HCBS as follows:

Funds from the DA/SSAs and the Supportive ISO base allocation that are no longer needed are reallocated in two ways:

1. Agencies (DA/SSA) reassign funding to individuals who meet the funding priorities.
2. Funds are returned to the Division to be used as a statewide resource. These funds are known as Returned Caseload Funding. See Section Five, IV.A.1 and Section Five, IV.B.5 for when funds must be returned to the Division. The priority use of the Returned Caseload Funding is for the Equity/Public Safety Fund for New Caseload needs.

To ensure the highest value is obtained from funding, services must be of high quality and cost effective. To that end, the Division requires DA/SSAs to continually reassess the use of developmental disabilities HCBS funding to assure funding is used to:

1. Address unmet needs of individuals who apply for, or are currently receiving, developmental disabilities services when those needs meet a funding priority.
2. Provide services and supports using the most cost-effective option to meet the individual's assessed needs. Consider an individual's strengths and personal goals, and the prevention of a need for more costly services when developing the plan for services and support.
3. Meet outcomes identified in Individual Support Agreements.
4. Provide services based on current Individual Needs Assessment or periodic review. A periodic review of needs is conducted at least annually for all individuals receiving services. The intent of this process is to reallocate

funding to where it is most needed. Funding is adjusted on an individual basis so that services are reduced where they are no longer needed and increased where there are new needs, as funds are available[23].

Before requesting New Caseload Funding, DA/SSAs must reallocate their base allocation funding that is no longer needed by individuals currently receiving services. When base allocation funds are not available, DA/SSAs may request New Caseload Funds from the Division.

The Supportive ISO must also conduct annual periodic reviews and adjust budgets accordingly. They do not shift base allocation funding between individuals. Base allocation funding that is not needed for ongoing needs must be returned to the Division. Funding that continues to be needed, but is not utilized, goes into a reserved shared funding pool. Short-term needs up to $5,000 can be accessed from the Supportive ISO from the reserved shared funding pool. When there are increased needs for ongoing funding, the Supportive ISO may request New Caseload Funding from the Division through the Equity/Public Safety process.

II. New Caseload Funding

New Caseload Funding, when available, may be accessed for eligible individuals who are new to services or existing recipients who have increased needs, who meet a funding priority listed in Section Four (G)(1)(c)(3), when base allocation funds are not available. The determination of meeting a funding priority is based upon the Individual Needs Assessment and takes into consideration the specific level of support needed, natural supports and other resources available to meet the individual's needs. Services and supports are then designed using the most cost-effective option to meet the individual's assessed needs. An individual's strengths and personal goals should be considered when developing the plan for services and support. The proposed plan must be developed in accordance with the all the rules in the *Plan* (Section Five, IV) and the *Medicaid Manual for Developmental Disabilities Services* and Federal HCBS Rules.

For new applicants, if the individual is found to meet a funding priority, the DA is responsible for preparing a funding proposal requesting specific types and amounts of service based upon the individual's needs. The DA then presents it to the Local Funding Committee for approval and then the appropriate Statewide Funding Committee (Equity or Public Safety) for final review and

[23] See Attachment B for further guidance on *Moving Funds in Individualized Budgets*.

recommendation to DAIL for a final decision as described in Section Three II.E. For individuals currently receiving services from a SSA who have new assessed needs, the SSA prepares a funding proposal and submits it to the individual's DA prior to review by the Local Funding Committee. For individuals receiving support from the Supportive ISO, the Supportive ISO prepares the funding proposal and submits it to Supportive ISO funding committee. After review by the Supportive ISO's Local Funding Committee, if appropriate, proposals are then sent to the Equity or Public Safety Funding Committee.

Funding priorities focus on an individual's unmet needs and circumstances that require support from the developmental disabilities services system to address. The funding priorities are listed in Section Four (G)(1)(c)(3). Circumstances that may result in an individual meeting a funding priority may include the loss of a caregiver; aging caregiver or inability of caregiver to provide care due to mental or physical limitations; caregiver unable to work without support; homelessness of the individual; or abuse, neglect or exploitation.

Although an individual may have needs that meet more than one funding priority, it is only necessary to meet one of the funding priorities to access funding. However, the type and level of service may be dependent on the funding priority or priorities the individual meets.

The Equity Funding Committee and Public Safety Funding Committee will make funding recommendations for both new applicants and individuals with new needs in accordance with the roles of the Equity and Public Safety funding committees described in below. The Division makes the final decisions. The Division will also verify that the individual is clinically eligible. When there is conflicting information regarding clinical eligibility, the Division may request a new assessment or review by an independent evaluator.

Division decisions will be sent to agencies as soon as possible after the funding committee meetings. The Division will establish monthly funding targets and will use the targets as a guide to manage the annual Caseload and Returned Caseload funding.

III. Role of the Funding Committees

The Local and Statewide Funding Committees for Home and Community-Based Services and their respective roles and responsibilities are outlined below.

Funding Committee	Decision-making Authority
Local Funding Committees	Review requests to be submitted to Equity and Public Safety Funding Committees
Statewide Equity Funding Committee	Review requests for New Caseload Fund and Returned Caseload Fund – Division makes final decisions
Statewide Public Safety Funding Committee	Review requests for New Caseload Fund and Returned Caseload Funds for those who meet criteria under Public Safety funding priority – Division makes final decisions

A. Local Funding Committees

Each Designated Agency must maintain a local funding committee that meets at least monthly and consists of staff from the Designated Agency, representatives from local Specialized Service Agencies, people receiving services and/or family members or guardians. Members must also include one or more individuals representing local community resources (e.g., HireAbility, schools, Department of Corrections, Area Agency on Aging, Department for Children and Families) and other interested stakeholders.

The Supportive Intermediary Service Organization (Supportive ISO) for people who choose to self/family-manage services must maintain a local funding committee that meets on a regular basis and consists of staff from the Supportive ISO and people receiving services and/or family members. Members must also include one or more individuals representing local community resources (e.g., HireAbility, schools, Area Agencies on Aging) and other interested stakeholders.

The local funding committee will review proposals for all new funding on behalf of individuals for whom they are the Designated Agency. The same expectations pertain to the Supportive ISO funding committee. The committee will:

1. Confirm documentation that the individual meets clinical and financial (Medicaid) eligibility criteria for developmental disabilities services;
2. Determine whether the individual's needs meet a funding priority;
3. Determine if the supports and services described are needed by the

individual and are the most cost-effective option to meet the individual's assessed needs. Consider the individual's strengths and personal goals when making recommendations regarding the plan for services and support;

4. Ensure all other funding options and resources have been explored, including available naturally occurring supports or unpaid supports; and,
5. Confirm that each individual funding proposal is in compliance with this *Plan*, the *DDS Regulations* and all other relevant policies and guidelines; and revise the proposal as necessary prior to sending it onto the relevant statewide funding committee.

If the committee determines that all criteria are met, the proposal is submitted to either the Equity Funding Committee or Public Safety Funding Committee, as appropriate, for funding consideration.

B. Equity Funding Committee

The Equity Funding Committee will follow the membership, management, and operating procedures established by the Division. The committee consists of the following membership.

# of Members	Representation	Selected by
2	Developmental Disabilities Services Division	Developmental Disabilities Services Division
3	Designated Agency and/or Specialized Service Agency	Designated Agencies and Specialized Service Agencies
2	Individual(s) receiving services, family member(s) or advocate	Recommendations from DA/SSAs, Green Mountain Self-Advocates, Vermont Family Network, and other advocacy organizations – Division makes final decisions

The Equity Funding Committee will confirm:

1. The individual's needs meet a funding priority;
2. The supports and services described are needed by the individual and are the most cost-effective option to meet the individual's assessed needs. Consider the individual's strengths and personal goals when making recommendations regarding the plan for services and support;
3. All other funding options and resources have been explored, including available naturally occurring supports or unpaid supports; and,
4. Each individual funding proposal is in compliance with this *Plan*, the *DDS Regulations* and all other relevant policies and guidelines.

The Equity Funding Committee will make recommendations to the Division regarding the amount of service and funding to be approved for each applicant.

C. Public Safety Funding Committee

The Public Safety Funding Committee will follow the membership, management, and operating procedures established by the Division. The committee consists of the following membership, preferably those with knowledge and expertise in supporting individuals who pose a public safety risk.

Number of Members	Representation	Selected by
2	Developmental Disabilities Services Division	Developmental Disabilities Services Division
2	Designated Agency and/or Specialized Service Agency	Designated Agencies and Specialized Service Agencies
2	Other interested individuals (e.g., people receiving services/family members; Department of Corrections staff, public safety professionals)	Recommendations from DA/SSAs, Green Mountain Self-Advocates and other advocacy organizations – Division makes final decisions

The Public Safety Funding Committee will confirm:

1. The individual's needs meet the Public Safety funding priority,
2. The supports and services described are needed by the individual and are the most cost-effective option to meet the individual's assessed needs. Consider the individual's strengths and personal goals when making recommendations regarding the plan for services and support;
3. All other funding options and resources have been explored, including available naturally occurring supports or unpaid supports, when appropriate; and,
4. Each individual funding proposal is in compliance with this *Plan*, the *DDS Regulations* and all other relevant policies and guidelines.

The Public Safety Funding Committee will make recommendations to the Division regarding the amount of service and funding to be approved for each applicant.

IV. Guidance for Management of HCBS Funding

A. Timeframes for Funding

1. New funding must be used to meet an individual's needs and goals related to the identified funding priority. Changes in a funded area of support must continue to meet the needs related to the identified funding priority. For up to one calendar year after approval of new funding, any reductions to an individual's budget, including both existing and new funding, up to the amount newly funded must be returned to the Equity/Public Safety Fund. After one calendar year, these funds are available to the DA/SSA to reallocate. For reductions to budgets for those self/family managing, the Supportive ISO will return the funds to Equity/Public Safety Fund.
2. An individual's Home and Community-Based Services funding may be suspended for up to a maximum of 6 months. If a suspension exceeds 6 months, services must be terminated, and the funding returned to the Equity/ Public Safety Fund. A notification of termination must be sent to the individual informing him or her of the right of appeal, according to timeframes identified in Health Care Administrative Rules 8.100 *Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services*. The same provision applies to services approved and funded, but not implemented within 6 months of receiving funding approval. The Division may grant additional time for exceptional circumstances. Services must be terminated rather than suspended when it is reasonable to conclude from available information that the individual will not be resuming services within 6 months. Services, in whole or in part, must be suspended for the following reasons:

    - Incarceration – When an individual enters a correctional facility (pre- or post-sentencing) and is expected to stay no more than 6 months – all HCBS must be suspended.
    - Nursing Facility – When an individual enters a nursing facility and is expected to stay no more than 6 months – all HCBS must be suspended.
    - ICF/DD – When an individual is admitted to an ICF/DD (in state or out of state) and is expected to stay no more than 6 months – all HCBS must be suspended.
    - Psychiatric Hospitalization – Level 1: When an individual is admitted to a Level 1 psychiatric bed – all HCBS must be suspended[24].

[24] Vermont facilities that provide Level 1 inpatient psychiatric care are the Brattleboro Retreat, Rutland Regional Medical Center and Vermont Psychiatric Care Hospital. Note that not all "beds" used for

- Other Hospitalization – When an individual is temporarily hospitalized in other than an inpatient Level 1 psychiatric bed[25], HCBS funding can be used to provide personal care type services. DA/SSAs/Supportive ISO can be reimbursed for an individual's daily rate for home supports, service coordination and administration for up to 30 days of hospitalization.
- Gap in Service Provision – When there is a gap in the provision of any of an individual's authorized HCBS that exceeds 14 days – billing for those HCBS services that are not being delivered must be suspended until services are resumed. Services that are provided on an intermittent basis (service coordination, respite, individual crisis and transportation for a van payment only), that can be expected to be used within the fiscal year, may continue without suspension for gaps over 14 days. Billing for shared living may continue when an individual is temporarily away from home for no more than 30 days, such as when visiting family, on vacation, at respite or at camp. In most instances, a shared living provider is considered to be on-call and may be expected to be available in the event of an emergency. It is at the discretion of the DA/SSA to determine under what circumstances they continue to pay a shared living provider. Services do not need to be suspended when a person is in an agency's local crisis bed, an Intensive Transition Services Bed or accessing Vermont Crisis Intervention Network (VCIN) level III statewide crisis bed) services.
- Visits outside of Vermont – When an individual leaves Vermont temporarily but continues to need services, Home and Community-Based Services funding may be continued for a period not to exceed 6 months[26]. Those services that are not being delivered during this time must be suspended.
- Leaves Services – When an individual drops out of services without notice and is unable to be contacted, all HCBS must be suspended.
- Other circumstances – When an individual is not expected to receive services within a 6-month period, all HCBS must be suspended.

3. An individual's Home and Community-Based Services funding must be terminated for the following reasons.

psychiatric care in the Brattleboro Retreat and Rutland Regional Medical Center are considered Level 1.

[25] Ibid.

[26] For further information about the impact on Medicaid funding and Social Security Benefits when leaving the State of Vermont on a temporary or permanent basis, see Maintaining Medicaid Eligibility when in Shared Living Out-of-State Guidelines.

- Incarceration – When an individual's stay in a correctional facility exceeds, or is expected to exceed, 6 months.
- Nursing Facility – When an individual's stay in a nursing facility exceeds, or is expected to exceed, 6 months.
- ICF/DD – When an individual's stay in an ICF/DD (in or out of state) exceeds, or is expected to exceed, 6 months.
- Extended Visit Out-of-State – When an individual's temporary visit out-of-state exceeds, or is expected to exceed, 6 months[27].
- Moved Out-of-State – When an individual makes a permanent move out-of-state. Exceptions for people who are living out-of-state for the purposes of receiving treatment as authorized by the State, or in shared living in a NH, MA or NY border town.[28]
- Declines Services – When an individual voluntarily chooses to no longer receive services.
- Prolonged Suspension – When a suspension exceeds 6 months.
- Death – When an individual dies. Termination of funding date is the day after the individual died.

4. The Division may conduct reviews or audits to ensure compliance with requirements related to suspensions and terminations. Data to be used in a review may include paid and encounter claims, utilization data from the F/EA or agency records.
5. If an individual's HCBS funding is terminated, including an individual whose eligibility is based upon HCAR 7.100.4(d) of the *DDS Regulations* (referring to individuals who were receiving services on July 1, 1996), the individual retains clinical eligibility for services for up to one year, but must reapply for funding and have needs that meet the funding priorities in order to receive services.
6. If an individual's HCBS funding has been terminated for more than one year, the individual must complete the full application process, which includes determination of clinical eligibility, financial eligibility and if needs meet a funding priority.
7. If the start date for newly approved HCBS (in whole or in part) is delayed, the start date for each delayed service must reflect (or, if previously submitted to DAIL, be amended to) the actual date services were started.

[27] For further information about the impact on Medicaid funding and Social Security Benefits when leaving the State of Vermont on a temporary or permanent basis, see Maintaining Medicaid Eligibility when in Shared Living Out-of-State Guidelines. See also definition of a Vermont resident in the *DDS Regulations, 7.100.2(ff) and 7.100.4(b) and Vermont Health Benefits Eligibility and Enrollment Rules* §21 (part-three-clean-scrubbed-18-062.pdf (vermont.gov))

[28] Ibid.

Billing for each service must coincide with the actual start date of each service.

8. If an individual in a licensed group living situation that is considered a statewide resource operated by DA/SSA moves out or dies, the funding allocated to that individual may be spread across the budgets for the remaining people in the home for up to 30 days with prior approval from Division. Requests to extend the funding beyond 30 days must be made to the Equity Funding Committee or Public Safety Funding Committee and cannot extend beyond 90 days in total. If there is more than 1 vacancy at a time in the home, the amount of funding to be respread across the remaining individuals is subject to the Division Director's approval.

B. Administrative Guidance for Funding

1. Services and supports must be the most cost-effective option to meet the individual's assessed needs.
2. Funds must be used in accordance with the *DDS Regulations*, *the Plan* and the *Medicaid Manual for the Developmental Disabilities Services* and Federal HCBS Rules.
3. Each individual receiving services must receive at least an Annual Periodic Review of existing services by the DA/SSA providing services, or the Supportive ISO, to assure the level of funding is consistent with the individual's needs. A more frequent review is required if there is a significant change in the individual's needs. The Periodic Review must include an examination of the actual utilization of services in the past year as compared to the authorized funding limit.
4. Movement of funding within an individual's budget:
    a. Moving of funds between already funded areas of support within an individual's budget is allowable without an updated needs assessment.
    b. Moving funding to a currently unfunded area of support is allowable if a new needs assessment reveals a serious unmet need in that new area (see Attachment B). However, within the first year of being funded, movement of funds to a previously unfunded area of support is allowable only if it continues to meet the needs related to the originally identified funding priority (see Section Five, IV.A.1.).
5. Funds are returned as Returned Caseload Funding when an individual has:
    a. Had their services terminated (see Section Five, IV.A.3).

b. Moved into a group home/residential setting that is considered a statewide resource.

c. Received new funding and there are any reductions to an individual's budget during the 12 months after receiving funding, including both existing and new funding, up to the amount newly funded. Any amount reduced that is more than the newly funded amount is retained by the DA/SSA and is reallocated to others who have a new or increased need.

d. Moved to self/family-management and services cost less than Authorized Funding that was transferred from the DA/SSA.

e. Reduced budget upon periodic review when self/family managing. Savings are returned as Returned Caseload Funding.

6. In the event of service and/or funding allocation reductions, DA/SSAs and Supportive ISO must inform individuals **in writing** of the reduction and their rights to the Grievance and Appeal process **prior** to reducing individual budgets or services as required by Health Care Administrative Rules 8.100 *Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services*. Individuals, families, and guardians must be included in the budget reduction decision-making process.
7. Costs for broad-based services, as approved by the Division, include local and statewide crisis capacity (Vermont Crisis Intervention Network and Intensive Transition Services) and employment program base funding, and are spread across all individuals' Home and Community-Based Services budgets. These are not included in the person's Authorized Funding Limit.
8. Payroll taxes such as Social Security and Medicare (FICA), State unemployment taxes (SUTA) and worker's compensation insurance costs must be calculated for payments to direct caregivers. DA/SSAs and Supportive ISO may adjust for rate changes according to the *DDS Regulations* (HCAR 7.100.5(l)(2)(C)).
9. All service rates in individuals' budgets must be set at the actual cost to deliver or the prevailing DAIL-set rate[29], whichever is lower. Services must be billed at no more than the rate authorized by the Department. The budgets submitted to the Department for authorization should reflect the cost of actual services delivered except as allowable under rules noted in Section Five IV.A.2.

[29] *DDSD Medicaid Claim Codes Reimbursement Rates*

10. Joint funding arrangements for Home and Community-Based Services involving other state agencies (e.g., VDH, DCF, DMH, and/or out-of-state organizations must involve DDSD in negotiation and receipt of funding. The Division does not contract with local schools; however, schools may contract directly with DA/SSAs. These contracts do not involve DDS funding and are not managed by the Division.
11. Daily respite can be used for respite provided for a 24-hour period of which up to 8 hours of sleep time is excluded. The exclusion of payment for sleep time must be consistent with the Federal Department of Labor Home Care rules[30] regarding payment for sleep time.
12. All existing and new budgets over $300,000 shall be reviewed by the Division annually in order to verify that the services authorized are provided and appropriate to meet the assessed needs. Budgets over $300,000 may be time limited and renewed based on review. Need for review of the overall support needs, as well as timeframe, shall be established by the Division as appropriate. If the review process does not result in a finding that the continued level of need is verified, the Division shall make a final decision regarding the ongoing amount of authorized funding.
13. When utilizing shared living provider arrangements for home supports, DA/SSAs must follow all applicable state and federal tax and labor laws.
14. HCBS funding at a DA/SSA may be converted to increase Targeted Case Management allocations with prior approval from the Department. This may also be done when an individual's whole HCBS budget has been suspended, to provide transition services for the individual when he or she is moving back to community-based services. Providers should access available TCM funds prior to requesting a transfer of HCBS funds to TCM allocations.

C. Guidance for Requesting New Caseload Funds

1. Before requesting new funding:
   a. DA/SSAs must reallocate their base allocation funding that is no longer needed by individuals currently receiving services.
   b. DA/SSA/Supportive ISO must explore all other funding options and resources, including those noted in D.1, D.2 and D.4 below.
   c. The cost of services to meet the individual's new or increased needs must exceed $5,000 (except those already self/family-managing and under the employment supports conversion option described in

[30] *https://www.dol.gov/whd/homecare/sleep_time.htm*

Section Four, I (D)).

d. For individuals who are already receiving services, the DA/SSA and Supportive ISO must complete a new needs assessment to verify a change in need.

2. Administration is authorized at 5% for all newly authorized funding rather than at the DA/SSA or Supportive ISO administration rate.
3. When requesting new funding, if an individual chooses to receive services from an agency (DA/SSA) other than the DA, or an agency (DA/SSA) agrees to subcontract with a provider, the provider shall submit a budget to the DA and the DA shall determine its costs to serve the individual and shall submit the lower of the two budgets to the funding committee. If an alternative provider is not able to provide the services at the lower approved budget, the DA must do so at the amount of funding authorized for the DA to provide services.[31]
4. For new applicants who choose to self/family-manage their services, the Designated Agency determines its costs to serve the individual, and the individual self/family-managing works with the Supportive ISO to plan how best to provide the services using the approved budget to meet the assessed needs. While funds may be used flexibly, the plan must be based upon the assessed needs as noted in A.1 above, not expand services beyond addressing those needs. The Supportive ISO works with the person, with input from the team, to determine reasonable rates to provide services as noted in D.20. The number of hours of service and hourly rates determined by the Supportive ISO become the authorized amounts to be reflected on the person's budget. Any savings are returned to the Equity Fund.
5. For individuals' already self/family-managing services who have new needs as determined by a new needs assessment, the Supportive ISO develops and submits proposals to the Supportive ISO funding committee and then to the appropriate statewide funding committee.
6. When developing a proposal for an individual already receiving funding, the DA/SSA or Supportive ISO must consider the existing funds in all categories of the individual's budget to determine the most cost-effective means of meeting the individual's needs. The individual's whole budget should be considered by the local and statewide funding committees and the Division in determining the best way to meet the individual's new needs.

[31] See HCAR 7.100.5(j) Choice of Provider.

D. Limitations for Funding

1. All services that can be funded under Medicare, Medicaid State Plan and/or private insurance must be accessed before using developmental disabilities HCBS funding. This includes, but is not limited to, Children's Personal Care Services; clinical services; durable medical equipment; nutrition; Medically Complex Nursing Services; Early Periodic Screening, Diagnosis and Treatment; Medicaid transportation and interpreter services when used for accessing Medicaid funded services. Private insurance may be available for children and young adults up to age 26. Providers must follow the established Medicaid procedures for coordination of benefits when submitting claims for an individual who has other insurance coverage.
2. Home and Community-Based Services funding may not duplicate or substitute for services and supports that are the responsibility of other publicly funded support systems. Other support systems may include HireAbility, DCF, DOC, educational services, etc.
3. Funded services shall not duplicate or substitute for available naturally occurring supports or unpaid supports.
4. New funding may be authorized for a time-limited period, when appropriate, with the intention to reduce funding based on a review of needs.
5. The maximum cost for service coordination managed through a DA/SSA shall be published in the *DDSD Medicaid Claim Codes and Reimbursement Rates*[32]. If actual costs are less than the published rate, the actual cost must be used. The maximum cost for service coordination for individuals who self/family-manage shall also be published by DAIL in the *DDSD Medicaid Claim Codes and Reimbursement Rates*. When an individual transfers from a DA/SSA to self/family-managed, the difference between the DA/SSA's service coordination rate and the rate for individuals who self/family-manage is transferred to the Supportive ISO to pay their administrative costs.
6. Funding for Vehicle Modifications for accessible transportation for an individual living with a home provider or family member is available. The maximum per person payment for accessible vehicles shall be published in the *DDSD Medicaid Claim Codes and Reimbursement Rates*[33] The cost of reimbursement for mileage is included in service rates where appropriate. For individuals self/family or shared managing,

[32] DDSD Medicaid Claim Codes and Reimbursement Rates

[33] Ibid.

a portion of the authorized rate may be used for mileage reimbursement for employees paid through the F/EA for community and employment supports.

7. A DA/SSA may not bill HCBS for an individual on the same day as Clinical Services, Bridge Program, Targeted Case Management, PASRR Specialized Day Services, Flexible Family Funding, Family Managed Respite or ICF/DD services.
8. Home and Community-Based Services can only be billed through one HCBS program on the same day (e.g., DDSD, Brain Injury Program, Choices for Care, DMH). If an individual qualifies for more than one HCBS program, the individual can be evaluated to determine the package of supports available and then make an informed decision about which program to choose. Where services administered by either DMH and/or DDSD are concerned, funding from one department may be transferred for use under one HCBS program according to the current interdepartmental agreement between DMH and DAIL.
9. Home and Community-Based Services funding may not pay for room and board costs, rent or utility subsidies. These costs are typically paid for through the individual's SSI/SSDI and other sources[34]. HCBS also may not pay for the costs of vacations. Home and Community-Based Services funding may be used, however, to cover costs incurred by a paid caregiver to support an individual on vacation (e.g., hotel and food expenses). HCBS funding may be used to attend camp, when going to camp serves the function of respite. The amount of funding that can be used is up to the typical daily rate for respite for the individual for each day of attendance.
10. Shared living homes, including short term arrangements, must meet the standards outlined in the *Housing Safety and Accessibility Review Process.* The shared living provider, or homeowner, is responsible for the costs to be incompliance with the housing safety standards.
11. Home Modifications
    (a) Home and Community-Based Services funding may help pay for home modifications for physical accessibility in shared living, the family home that is the individual's primary residence or individual's own home or apartment, not to exceed a $10,000 cap. The costs of ramps, widening doorways, accessibility modifications to bathrooms, visual fire alarm, and plexiglass windows or alarm systems for safety may be appropriate costs to

[34] Sources of funding other than SSI/SSDI to assist with room and board costs include Section 8 subsidies, wages, and public assistance (e.g., fuel assistance program, General Assistance vouchers, 3Squares VT).

reimburse.

i. Physical accessibility modifications that do not add to the value of the home may be paid for, when necessary, using DA/SSA base allocation, new funding, or one-time funding. Once a modification is paid for, the additional allocation must be deducted from the individual's budget.
ii. Modifications that improve the value of the home that are made to meet the physical accessibility needs of an individual may only be funded up to 50% of the cost, not to exceed the $10,000 cap. For example, if a new bedroom is needed to allow the individual to live in the home, the shared living provider must pay for the addition of the bedroom. However, additional cost to make that bedroom accessible may be paid for with HCBS funding.
iii. Two or more bids are required when construction work is needed to provide the modification. Funding is allocated based on the most cost-effective bid.
iv. Home modifications that cost from $5,000 to $10,000 will be paid on a monthly payment basis which ends if the individual moves.

(b) HCBS funding may be used for other 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[35]. This would be in circumstances in which the technology substitutes for paid staff. Examples include remote monitoring systems for the home, visual fire alarm systems for person who is deaf, medical alert systems, etc. Costs may be covered using DA/SSA base allocation, new funding, or one-time funding. Once a modification is paid for, the funding for the modification must be deducted from the individual's budget. Costs for systems that require an ongoing service fee may continue to be included in the HCBS budget.

12. Funding for work supports is to maintain an employer-paid job. The following limits apply to new funding for community supports and work supports:
    a. Community supports and work supports are limited to individuals who are not enrolled in high school who are age 18 and older.
    b. Individuals receiving work supports only: work support hours may not exceed 25 hours per week, including transportation hours. Developing and executing a transportation plan is part of work

[35] See HCAR 7.100.2(v). Home Supports.

supports. Individuals should be assisted, as needed, in learning to use public transportation or in working out rides from natural supports, including co-workers.

c. Individuals receiving community supports only: community support hours may not exceed 25 hours per week (including transportation time).
d. Individuals receiving both work supports and community supports: may not exceed a total of 25 hours per week of community supports and work supports (including transportation time). Individuals are not eligible for new funding for community supports if they are already receiving 25 hours per week of work supports.

13. Individuals who choose to self/family-manage or share-manage cannot manage 24-hour home supports including Shared Living, Staffed Living, Group Living.
14. Individuals may self/family-manage up to 12 hours per day of paid home supports, specifically In-Home Family Support or Supervised Living. However, individuals who need 24-hour home supports may receive them from their local DA, or an SSA who agrees to serve them.
15. Developmental disabilities HCBS services funding cannot be used to:
    a. Increase the availability of residential settings that provide supports to more than four adults with developmental disabilities (age 18 and over). Any exceptions to this limitation must be approved by the Division and comply with HCBS setting rules.
    b. Fund residential settings that provide supports to three or more children (under the age of 18). Any exceptions to this limitation must be approved by the Division and comply with HCBS setting rules.
    c. Fund placements in residential schools or treatment centers; or in-state or out-of-state nursing facilities, correctional facilities, psychiatric hospitals, or ICF/DDs.
    d. Fund out-of-state placements for adults unless they pose a risk to public safety and there are no appropriate treatment options in Vermont and the cost is less than the cost of community-based supports in Vermont. Involvement and approval by the Division is required.
    e. Fund sheltered workshops or enclaves (segregated work environments within an employer's worksite).
    f. Make incentive payments, subsidies, or unrelated vocational training expenses for Supported Employment such as the following:

(1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
(2) Payments that are passed through to users of supported employment programs.
(3) Payments for vocational training that are not directly related to individuals' supported employment program.

g. Fund settings that are not consistent with the federal HCBS Rules.

16. For requests for new funding for clinical and supportive services the follow limits apply:
    (i) The maximum number of visits for psychiatry is four per year for those individuals who are stable on their medications and up to a maximum of 12 per year for those who are not stable on medications.
    (ii) The maximum number of visits for individual, group or family therapy is 48 visits per year or a total of 96 visits per year for those needing a combination of those therapies.
    (iii) The maximum number of visits for behavioral support, assessment, planning and consultation is 96 visits per year.
    (iv) All other supportive services are limited to 48 visits per year or a total of 96 visits per year for those needing a combination of supportive services (not including behavior consultation).

    If a needs assessment justifies additional services, one-time or internal DA/SSA or Supportive ISO funds may be utilized to increase visits beyond these limits. When requesting new caseload funding, exceptions beyond these limits for psychiatry and individual, group or family therapy will be considered when the DA/SSA or Supportive ISO provides written documentation from the treating clinician that additional services are necessary.
17. Facilitated Communication shall only be funded when it is used consistent with the *DDSD Facilitated Communication Guidelines*.
18. Behavior Support, Assessment, Planning and Consultation shall only be funded when it is used consistent with the DDSD *Behavior Support Guidelines*. HCBS funding cannot be used for behavior interventions that restrict an individual's basic human rights and their rights guaranteed by the DD Act.
19. The maximum amount of funding for the Parenting funding priority listed in Section Four (G)(1)(c)(3) is $10,000 per person per year.
20. When authorizing hourly rates for services for workers who are paid through the F/EA, the lowest rate must be at least the minimum hourly wage negotiated through the Collective Bargaining Agreement for those

workers (or VT minimum wage, if higher), plus employer taxes. The rates should be based upon the level of support needed by the individual. DDSD approves rates for new requests to Equity and Public Safety Funding committees. The DA/SSA or Supportive ISO determines the authorized rates for existing recipients. While there is no established maximum rate for services paid through the F/EA, DDSD provides a benchmark rate to the F/EA above which the F/EA is required to check in with the DA/SSA or Supportive ISO to verify that the hourly rate is reasonable and needed for the individual. The F/EA will pay the rate authorized by the DA/SSA or Supportive ISO or at or below the benchmark as directed by the employer.

E. Guidance for Transfers between DA/SSA/Supportive ISO or Methods of Management

1. If the individual decides to move to a different DA/SSA or method of management (self/family or shared management or home provider hiring workers) within a calendar year from receiving new funding, savings must be returned to the appropriate caseload fund (Equity and Public Safety). After one calendar year, if services cost less to meet an individual's assessed needs when transferring to a new DA/SSA or the Supportive ISO, the savings should be reallocated through internal adjustments by the new DA/SSA or returned to the Equity Fund by the Supportive ISO for those who are self/family-managing. After one calendar year, for those moving to a new method of management within the same DA/SSA, savings should be reallocated through internal adjustments.
2. When a person chooses to change from having agency hired staff to hiring his/her own workers to deliver a specific service, the person's authorized hours of that service should remain the same. The agency works with the person and the team to determine the new hourly rate for the service as noted above in D.20. Any savings are returned to the agency for internal adjustments. This applies to agency and shared-management arrangements. See C.4 above for the process for self/family management.
3. If a person transfers from the Supportive ISO to a DA/SSA, a periodic review should be done by the DA/SSA to determine current needs. If the cost of services is greater at a DA/SSA, the rates may be adjusted through internal adjustments or requests for additional funding can be made to the Equity or Public Safety Fund committees when the amount exceeds $5,000.

4. If at any time a recipient chooses or consents to receive some or all authorized services or supports from a different agency (DA/SSA or Supportive ISO), the agency (DA/SSA or Supportive ISO) currently serving the recipient shall promptly transfer the individual's authorized funding limit to the agency (DA/SSA or Supportive ISO) selected according to the procedures outlined in Division guidelines.[36] This includes the administration amount specified in division policy. Funding for local and state crisis services, employment program base and statewide communication resources (through Howard Center and Washington County Mental Health) are not transferred.
5. When an individual chooses to transfer to another agency (DA/SSA) or to self/family-manage, the receiving agency (DA/SSA) or Supportive ISO must fully inform the recipient and the individual's designated representative, if applicable, prior to the transfer, of the impact on the amount of services that can be provided within the approved budget based upon the agency (DA/SSA) or Supportive ISO's costs for services.
6. When a person transfers to another DA/SSA or the Supportive ISO, the budget is prorated for the days remaining in the FY, regardless of the amount of service utilized for the FY. If there is an allocation to the F/EA, the receiving organization will send prorated allocations, based on the new approved budget, to the F/EA.
7. Any disputes about the amount of funding to be transferred will be resolved by the director of the Division.[37]

F. Managing Home and Community-Based Services Funding if There are Insufficient Funds

The Developmental Disabilities Act provides the authority for the Commissioner to consider funds available to the Department in allocating resources. In the event of fiscal pressures (e.g., an appropriation less than projected need, rescission), the Commissioner may adjust funding allocations to DA/SSAs and Supportive ISO. The Department may reduce DA/SSAs and Supportive ISO base allocations. The Division will issue instructions and provide guidance regarding any reductions. If services are reduced, individuals and guardians will be provided with notice of the right to appeal[38] the reduction.

[36] See HCAR 7.100.5(j)Choice of Provider.
[37] Ibid.
[38] See HCAR 8.100 Internal Appeals, Grievances, Notices, and State Fair Hearings.

.

Any proposed change that relates to the nature, extent, allocation, and timing of services for the prioritized programs will be sent to the State Program Standing Committee for advice and recommendations 60 days prior to implementing the change. The proposed change will be presented at the earliest scheduled full committee meeting.

G. 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 individuals when they have been placed on a waiting list and review needs of all people 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:

1. When there are changes in the funding priorities or funds available; or
2. When notified of significant changes in the individual's life situation.[39]

Each Designated Agency must submit waiting list data according to instructions established by the Division. The waiting list for Flexible Family Funding and Family Managed Respite are reviewed by the Division annually. Information regarding the utilization of each DA's allocation and waiting lists for the FFF and FMR programs is used in determining the following fiscal year allocations.

Information regarding waiting lists will be included in the DDSD annual report and will be reviewed annually by the DDS State Program Standing Committee.

[39] See HCAR 7.100.5(q) Waiting List.

SECTION SIX
PLAN DEVELOPMENT

This section highlights the contributors to the *Plan*. Preparation of the State System of Care Plan typically includes the following:

1. Review of local system of care plans from DAs,
2. Input received from public forums and hearings,
3. Discussion and input from the State Program Standing Committee for Developmental Disabilities Services,
4. Analysis of trends in the quality review process and satisfaction surveys,
5. Review of adherence to the principles of service in Developmental Disabilities Act of 1996 as reported in the DDS Annual Report, and
6. Review of ongoing input and feedback provided to the Department by various stakeholders (individuals, families, providers, advocacy organizations, etc.) over the past several years.

Due to COVID 19 pandemic related extenuating circumstances and workforce crisis in the system, there were some changes to the typical method of developing the *Plan.* The Division did not require agencies to develop local system of care plans to contribute to the development of this *Plan.* Because the local system of care plans were not being done, the Division created an on-line survey that was disseminated widely to seek input from stakeholders across the state. In addition, the Division held seventeen stakeholder specific and general forums to seek input on the development of the *Plan.*

Until recently, the Division contracted for satisfaction surveys conducted using the National Core Indicators In-Person Survey. The Department put the survey on hold to respond to other priorities during the pandemic. The last survey completed was in 2018-19. This data is unlikely to reflect the current level of satisfaction with services which have been significantly impacted by the pandemic and workforce challenges. Therefore, satisfaction survey information was not considered in the development of this *Plan.*

For this renewal of the *Plan*, the following sources of input and information were gathered and reviewed:

1. Input received from public forums,
2. Input received from an online survey,
3. Input received via Division email box set up for stakeholder input on *Plan,*
4. Discussion and input from the State Program Standing Committee for Developmental Disabilities Services,

5. Analysis of trends in the quality review process,
6. Review of adherence to the principles of service in Developmental Disabilities Act of 1996 as reported in the DDS Annual Report,
7. Review of ongoing input and feedback provided to the Department by various stakeholders (individuals, families, providers, advocacy organizations, etc.) over the past several years,
8. Review of input from the DDS Innovation Think Tank – 2018, and
9. Public comments on draft *Plan.*

A draft of the *Plan* was developed considering sources of input in 1-8 above. The final *Plan* incorporates changes made in response to public comments on the draft. More information regarding each of these sources of input is included below.

I. Public Input Forums

Prior to developing a draft *Plan,* the Division held a series of forums to seek stakeholder input on the development of the *Plan.* General forums were held to seek input on the entire plan. In addition, there was a request from stakeholders and legislators for the Division to focus on three priority areas in developing the new *Plan.* These included:

A. Expanding housing options for people with developmental disabilities
B. Exploring options to allow for paying parents to provide services to their children
C. Services to individuals with autism spectrum disorders.

Between late spring and early fall of 2022, DDSD held 17 forums to obtain stakeholder feedback and input. In response to input from the State Program Standing Committee, advocates, and families regarding the composition and structure of public forums, the State held specific targeted forums to create safe spaces for individuals to express their thoughts, make comments and ask questions. DDSD met with:

- Provider Agencies/Vermont Care Partners,
- Members of the Developmental Disabilities Services State Program Standing Committee,
- Green Mountain Self-Advocates,
- Vermont Developmental Disabilities Council,
- Vermont Family Network and other family members,
- The Vermont Developmental Disabilities Housing Initiative,
- The Vermont Communication Task Force,
- Guardianship and Supported Decision Making Group and
- People who are Deaf or Hard of Hearing.

The result is a collection of ideas, concerns, and recommendations from many

different voices. DDSD staff compiled all the comments shared at these forums, as well as through the online survey, the Division email box and the State Program Standing Committee. Central themes that emerged from all the input were summarized. A link to the summaries of the input provided is included in Appendix A.

II. Online Survey

DDSD posted an online survey to the DAIL website to gather input on the development of the *Plan* on August 1, 2022. The link to the survey was sent to key stakeholder groups with the request to disseminate it to people who may have been interested in responding. People were asked to provide input on:

- what was working well in the system,
- what was not working well
- recommendations for improvements and changes in the system
- changes to any rules or limitations in the current *Plan*
- what is needed to help people live in a home of their choice
- what would they like to see changed or improved to supports for adults with autism spectrum disorders
- what specific rules or safeguards should there be if parents were able to be paid with Medicaid funds to care for their children with developmental disabilities

The survey was open until August 18, 2022. 237 people responded to the on-line survey. The responses were compiled with the input from the public forums and are incorporated into the summaries of major themes. Links to the summaries are included in Appendix A.

III. Division email box set up for stakeholder input on *Plan*

The Division set up an email box for stakeholders to provide input and comments on either the *Plan* or the *DDS Regulations* which are being renewed and updated concurrently. The email address to send input or comments to the Division was shared at all public forums and hearings. It was also posted on the DDSD website. The input provided via that mailbox was compiled with the input from the public forums and is incorporated into the summaries of major themes. Links to the summaries are included in Appendix A.

IV. State Program Standing Committee for Developmental Disabilities Services

The State Program Standing Committee (SPSC) for Developmental Disabilities Services is the advisory board to the Division regarding the DDS system. The SPSC provided input into the development of the *Plan* at their August 18, 2022 meeting. This input was compiled with the input from the public forums and is incorporated into the summaries of major themes. Links to the summaries are included in Appendix A.

The SPSC reviewed the draft *Plan* on October 20, 2022 at their regularly scheduled meeting. The minutes from that meeting reflect the input provided. This meeting was one of the two public hearings held on the draft.

V. Quality Reviews

The Division's Quality Management Reviewers conduct bi-annual on-site reviews to assess the quality of services provided by DA/SSAs and services that are self/ family-managed. Due to the COVID-19 pandemic, the bi-annual onsite review process was suspended for two months from mid-March to mid-May 2020. This suspension of the review process along with safety protocols to prevent the spread of COVID-19 required the Quality Management Review team to make some changes to the review process itself. The decision was made to restart the review cycle performing the interviews with individuals receiving services, family/guardians, shared living providers, direct support staff and service coordinators virtually via video calls. Additionally, the sample size was reduced back to the previous 10% of individuals receiving HCBS funded supports in order to accommodate the reduced staffing at the provider agencies while maintaining the ability of the review team to gather the required information and fulfill its oversight responsibilities. Two, two-year review cycles occurred since the last update of the *Plan,* first from July 2018 through June 2020 with a total of services for 382 individuals being reviewed. The second review cycle was from July 2020 through June 2022, with a total of services for 347 individuals being reviewed. The lower total number of individuals whose services were reviewed is a result of returning the sample size in general back to 10%. The goal going forward is to return it to a minimum of 15% of individuals receiving HCBS funded services with the next review cycle as well as a return to face to face, in person interviews.

Areas of Strength – The following trends were noted as areas of strength during these review cycles:

- Creative opportunities for individuals to remain safe while being connected to their

peers through on-line video classes, group meetings/interactions with individuals wearing masks and other protective equipment and maintaining social distancing, etc.
- Communication among the individual's team members.
- Individualized supports across all funded areas.
- Knowledgeable and well-trained service coordination staff.
- Successful, creative employment supports – individualized to meet needs and increased support for consumer businesses and self-employment.
- People experiencing post-secondary education opportunities at local colleges and universities.
- Well trained direct service staff, including shared living providers.
- Positive family supports.
- Individuals supported to make healthy meal choices & exercise regularly.
- Clinical supports available and used as appropriate.

Areas of Importance to Improve the Quality of Services – The majority of DA/SSAs had no areas of importance noted during this review cycle. Of those that did have areas identified, the following trends were noted. Agencies have submitted plans of correction to address these areas.
- Service Coordinator training to ensure consistency in quality and depth of Individual Support Agreements, person centered planning processes, and following the Health & Wellness Guidelines and Needs Assessment & use of services to identify needs and allocate funds to meet these needs across individuals.
- Special Care Procedure training, monitoring and support.
- Recognizing the need for, developing, writing, implementing and monitoring comprehensive Behavior Support Plans.
- Need to establish or expand availability of clinical and therapy supports.
- Lack of consistency and thoroughness in the ISA documents (e.g., no clear method for documenting or tracking progress toward accomplishing the outcomes).

VI. Review of other existing information

The Division also reviewed other existing information and input provided since the development of the last *Plan.* This included reviews of:

- Adherence to the principles of service in Developmental Disabilities Act of 1996 as reported in the DDS Annual Report
- Ongoing input and feedback provided to the Department by various stakeholders (individuals, families, providers, advocacy organizations, etc.) over the past several years.
- Input and recommendations from the DDS Innovation Think Tank – 2018 (Retreat_Summary_of_Key_Topics.pdf (vermont.gov)

VII. Public Hearings and Comments

The draft *Plan* , notice of public hearings, including the teleconference links to join the hearings, and request for comments was posted on the DAIL website on October 13, 2022. The request for comment was also sent to key stakeholder groups. A public hearing on the DRAFT Developmental Disabilities Service State System of Care Plan was held on October 20, 2022, from 10:00 a.m.-12:30 p.m. during the State Program Standing Committee meeting. All comments were recorded. A second public hearing was held on October 26, 2022, from 4:00-6:00 pm. The public hearings were conducted via teleconference. Stakeholders were invited to send written comments via email or regular mail to the Department.

All comments were reviewed and considered prior to finalizing the *Plan.* Any changes made in response to comments have been incorporated into the final version.

ATTACHMENTS

[Page intentionally left blank.]

ATTACHMENT A
LINKS TO IMPORTANT DOCUMENTS

Developmental Disabilities Services Codes and Definitions for Home and Community-based Services

(DDSD_Service_Definitions.pdf (vermont.gov))

Summary of Input from System of Care Plan forums

Proposed Changes to the Vermont State System of Care Plan (SOCP) for DDS | Developmental Disabilities Services Division

Proposed Changes to *Regulations Implementing the DD Act of 1996* now referred to as the *DDS Regulations* or HCAR 7.100 Disability Services- Developmental Services

Disability Services - Developmental Services Rules Sent to Legislative Committee on Rules for Approval | Disabilities Aging and Independent Living (vermont.gov)

Final Approved Developmental Disabilities Services Regulations or HCAR 7.100 Disability Services- Developmental Services

DDS Regulations

Act 186 – An act amending the Developmental Disabilities Act

ATTACHMENT B
MOVING FUNDS IN INDIVIDUALIZED BUDGETS

Applies to ALL
Self-Managed / Family-Managed / Shared-Managed/ Agency-Managed
Services and Supports

Moving funds between funded areas of support is allowable without an updated needs assessment. A move to an unfunded area is allowable if a new needs assessment reveals a serious unmet need in that area. Only individuals and/or their guardians and the agency may make decisions to move funds between funded areas. Home providers or other employers may not move funds. Moving funds requires a team decision. In all cases the agency or Supportive ISO must be notified of the decision. Moving funds must comply with the DDS State System of Care Plan.

Applies to
Self-Managed and
Family-Managed Services

The individual/family:
- Makes the decision to move funds within funded areas of support with his or her team
- Notifies the Supportive ISO prior to implementing any change
- Is responsible for any overspending in the funded areas of support/authorized funding limits
- Must personally pay their employee(s) or other bills if the overall authorized funding limit is exceeded

The Supportive ISO:
- May or may not be part of the team
- Notifies the Fiscal/Employer Agent of any changes in the budget/authorized funding limits
- May determine the individual or family cannot manage services if overspending is repeated

The Fiscal/Employer Agent:
- Will enforce the limits on funded areas of support/authorized funding limits
- Will not pay the employee(s) or bills if overall authorized funding limit is exceeded

Applies to
Shared-Managed Services

The individual/family:
- With the agency, discuss moving funds; come to agreement prior to moving the funds between funded areas of support and before implementing any change
- Is responsible for any over-spending in the funded areas for those services that they manage

The Agency:
- Notifies the Fiscal/Employer Agent of any changes in the budget
- Is responsible for any overspending in the funded areas it manages
- May determine the individual/family cannot manage services if overspending is repeated

The Fiscal/Employer Agent:
- Will enforce the limits on funded areas of support and the authorized funding limits
- Will not pay the employee(s) or bills if overall authorized funding limit is exceeded

Applies to
Agency-Managed
Services

The individual/family:
- Is involved in the team decision about moving funds between funded areas of support

The Agency:
- Manages the individualized budget and is responsible for any overspending in funded areas of support/ authorized funding limits.
- Does not use the Fiscal/Employer Agent for their employees

OVERSPENDING IN FUNDED AREAS OF SUPPORT AUTHORIZED FUNDING LIMITS

Applies to Self-Managed / Family-Managed and Shared-Managed Services and Supports

If an individual or family exceeds the money available in a funded area of support, but there are still funds in another funded area of support, Employer of Record can direct the Fiscal/Employer Agent (F/EA) to pay the worker for that payroll period only. The F/EA will not continue to pay workers, unless directed by the agency or Supportive ISO. The team must address the issue before the next payroll period. The agency or Supportive ISO must notify the F/EA of any changes in the budget before the next payroll period. Otherwise, timesheet and requests for non-payroll payments will not be processed by the Fiscal/Employer Agent. Also, the F/EA will not process timesheets or requests for non-payroll payments that exceed the overall authorized funding limits for "goods" and services.

Applies to Self-Managed and Family-Managed Services	Applies to Shared-Managed Services
The Employer of Record: ▪ Notifies the Supportive ISO how to address the issue of overspending in a funded area of support and the necessary changes to existing funded areas of support to process the submitted timesheets or non-payroll requests ▪ Is responsible for personally paying their employee and other bills if the overall authorized funding limit is exceeded ***The Supportive ISO:*** ▪ Discusses how the issue will be addressed with the Employer of Record. The Supportive ISO may make contact if the Employer of Record does not contact them. ▪ Notifies the Fiscal/Employer Agent of the new changes in the funded areas of support ▪ Is not responsible for any overspending caused by the Employer of Record ▪ May determine the Employer of Record cannot manage services if overspending is repeated ***The Fiscal/Employer Agent:*** ▪ Enforces spending limits in each funded area of support ▪ Provides bi-weekly Employer Spending Reports, which notify employers of remaining balances in funded areas of support ▪ Pays the worker as directed, only after the employer works with the SISO to transfer unspent funds in another funded area of support ▪ Will not pay the worker if the funded area of support is exceeded	***The Employer of Record:*** • Is notified of spending throughout the fiscal year by the Fiscal/Employer Agent through bi-weekly Employer Spending Reports ▪ The team decides how to address the issue and whether any money can be shifted between funded areas of support when overspending occurs ▪ Is responsible for the services they manage ▪ Is personally responsible for paying their employee and other bills if funding cannot be moved or if overall authorized funding limit is exceeded ***The agency:*** ▪ Discusses how the issue will be addressed with the Employer of Record. The agency may make contact if the Employer of Record does not contact them. ▪ Notifies the Fiscal/Employer Agent of the new changes in the funded areas of support ▪ Is not responsible for overspending by the Employer of Record ▪ Is responsible for any overspending in the area it manages ▪ May determine the Employer of Record cannot manage services if overspending is repeated ***The Fiscal/Employer Agent:*** ▪ Enforces spending limits in each funded area of support ▪ Provides bi-weekly Employer Spending Reports, which notify employers of remaining balances in funded areas of support ▪ Pays the worker as directed, only after the Employer of Record works with the agency to transfer unspent funds in another funded area of support ▪ Will not pay the worker if the overall authorized funding limit is exceeded

ATTACHMENT C

DEVELOPMENTAL DISABILITIES SERVICES FUNDING APPROPRIATION FOR HCBS – FY 2023

New Caseload Projected Need (341 individuals (includes high school graduates) x $43,051 avg x 1% COLA)	$14,680,391
Minus Returned Caseload Estimate (3 year average)	(7,658.127)
Public Safety/Act 248 (13 individuals x $68,978 average x 1% COLA)	896,714
TOTAL FY '23 ESTIMATED NEW CASELOAD NEED	7,918,978

- Annualization of FY22 CBA increase $1,051,929
- FY23 CBA increase $1,896,917
- 8% DS/SSA rate increase $22,493,138

TOTAL DDS APPROPRIATION - AS PASSED FY 23
$282,169,830

[Page intentionally left blank.]

ATTACHMENT D

Vermont Council of
Developmental and Mental Health Services

NEEDS ASSESSMENT

Name:

D.O.B.:

Recorder (name & title):

Date:

Informant(s) (name(s) & relationship to consumer):

Supports requested:

☐ **Housing & Home Supports:** Supports related to current or needed living arrangements.

☐ **Community Supports:** Supports related to being an included and contributing member of the community such as volunteer, recreational, and self-advocacy activities, board member responsibilities, establishing/maintaining friendships.

☐ **Work Supports:** Supports related to obtaining or maintaining employment.

☐ **Service Planning & Coordination:** Supports related to coordination and monitoring of services.

☐ **Respite Care:** Supports to give breaks to caregivers in order to maintain living situation/placement.

☐ **Crisis Supports:** Supports that aid in the prevention of crisis and that assist people in crisis situations.

☐ **Clinical Interventions:** Supports needed to meet therapeutic needs such as individual and group therapy, occupational therapy, physical therapy, speech and language therapy, consultation, psychiatric, and team training.

☐ **Transportation:** Specialized transportation:

☐ **Other:** Please specify:

NEEDS ASSESSMENT

COMMUNICATION: Level of support needed to express wants and needs and to understand ideas from others (e.g., verbal prompts, cueing, communication devices, gesture dictionaries, sign language, interpreters).

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No support

Minimal. Some support

Moderate. Ongoing support and/or uses alternative means of communication and/or requires interpreter

Significant. Uses maximum level of support to understand communication or be understood

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

SELF-CARE: Level of support needed to complete self-care tasks such as bathing, dressing, toileting, eating, etc.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Some physical assistance and/or verbal prompting

Significant. Total physical assistance to complete most tasks

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

INDEPENDENT LIVING: Level of support needed to complete independent living tasks such as home care, budgeting, cooking, etc.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Some physical assistance and/or verbal prompting

Significant. Total physical assistance to complete most tasks

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

WORK: Level of support needed to obtain or maintain employment.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Some assistance and/or verbal prompting

Significant. Total assistance to complete most tasks

	Current Level of Support	Level of Support Needed
Job development:	Select Level	Select Level
On-the-job support & supervision:	Select Level	Select Level
Job follow-up:	Select Level	Select Level
Transportation:	Select Level	Select Level
Supports related to being safe:	Select Level	Select Level
Accessibility issues/adaptations:	Select Level	Select Level
Communication:	Select Level	Select Level
Legal concerns:	Select Level	Select Level
Health/physical needs:	Select Level	Select Level
Personal care needs:	Select Level	Select Level
Psychological/emotional/ behavioral:	Select Level	Select Level

NEEDS ASSESSMENT

RESPITE: Level of support needed to give breaks to caregivers in order to maintain living situation/placement.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No respite

Minimal. Occasional respite

Moderate. Consistent ongoing respite

Significant. Regular, frequent respite

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level

NEEDS ASSESSMENT

PARENTING: Level of support needed to provide training in parenting skills to help keep a child under 18 at home.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Regular intervention and support

Significant. Intense intervention and support

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

HEALTH CARE/MEDICAL/MOBILITY: Level of support needed in the following areas: taking medications; making and getting to medical/dental appointments; using special equipment such as a wheelchair, Hoyer lift, etc.; addressing chronic medical conditions such as diabetes, seizures, etc.; addressing special care procedures such as tube feedings, colostomy bag, etc.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring or periodic support / Routine health care; stable

conditions **Moderate.** Ongoing assistance / Serious and/or multiple conditions

Significant. Total assistance / Substantial health issues

	Current Level of Support	Level of Support Needed
Taking medication:	Select Level	Select Level
Making medical/ dental appointments:	Select Level	Select Level
Getting to medical/ dental appointments:	Select Level	Select Level
Using specialized equipment such as wheelchair, Hoyer lift, etc.:	Select Level	Select Level
Chronic medical conditions such as diabetes, seizures, etc.:	Select Level	Select Level
Special care procedures such as tube feedings, colostomy bag, etc.:	Select Level	Select Level
Other:	Select Level	Select Level

NEEDS ASSESSMENT

SLEEPING: Level of support needed as a result of sleep disruption during the night.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No intervention

Minimal. Occasional assistance; monitoring of medium or short duration

Moderate. Frequent assistance; monitoring of extended duration on an episodic basis

Significant. Nightly assistance of long duration

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level

NEEDS ASSESSMENT

BEHAVIORAL/MENTAL HEALTH: Level of support/supervision needed throughout the day to manage emotions and/or behavior.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Periodic or ongoing intervention

Moderate. Planned support and skilled intervention and/or 24-hour support and/or monitoring

Significant. Extensive skilled intervention and/or 24-hour supervision in close proximity

	Current Level of Support	Level of Support Needed
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

CLINICAL: Level of support needed to meet therapeutic needs.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No support

Minimal. Infrequent intervention

Moderate. Ongoing intervention

Significant. Intervention more than once a week

	Current Level of Support	Level of Support Needed
Psychotherapy:	Select Level	Select Level
Psychiatry:	Select Level	Select Level
Occupational Therapy:	Select Level	Select Level
Physical Therapy:	Select Level	Select Level
Speech Therapy:	Select Level	Select Level
Communication:	Select Level	Select Level
Behavior Consult/Support:	Select Level	Select Level
Offender Treatment:	Select Level	Select Level
Other:	Select Level	Select Level

NEEDS ASSESSMENT

Additional Comments:

ATTACHMENT E
GLOSSARY OF TERMS

Below is a glossary of terms used in the DDS State System of Care Plan

Terms in red are also found in the *Disabilities Services – Developmental Services Rules,* mostly in the definition section (HCAR 7.100.2)

PL means plain language version of definition

Link to more information is included when appropriate

Act 248: a law that authorizes a VT State criminal court to civilly commit a person with an intellectual disability who is a continuous risk of significant harm to others, into the custody of the Commissioner of the Department of Disabilities, Aging, and Independent Living (DAIL).
PL: a law that allows the state to have legal custody of people with intellectual disabilities who are at risk of causing serious harm to others.
https://ddsd.vermont.gov/sites/ddsd/files/documents/Act_248_Info.pdf

Administrative Rules on Agency Designation: rules and qualifications that agencies must follow and demonstrate in order to be designated by the Department to provide services for individuals with developmental disabilities.
PL: rules agencies must follow in order to receive funding from the Department to provide services to people with developmental disabilities.
https://ddsd.vermont.gov/sites/ddsd/files/documents/administrative-rules-on-agency-designation.pdf

Adult: means a person who is age eighteen or older. The term includes people who are age eighteen or older who attend school.
PL: a person who is 18 years old or older, even if they are in school.

Advisory groups: a group of individuals who advise the State on policy, projects, and special initiatives.
PL: a group of people who speak up and give their thoughts, ideas, and advice to the State about services.

Agency: means the responsible designated agency or specialized service agency (DA/SSA).
PL: the organization that the Department provides funding to and who is responsible for providing services for people with developmental disabilities. It could be a Designated Agency, also called a DA or a Specialized Agency, also called an SSA.

Agency Designation: process by which agencies are reviewed by the State on a multi-year cycle to assure that agencies meet the standards to be designated within the geographic areas identified by the Commissioner.
PL: a review that the State does to check and make sure that the agency is able to meet the needs of people in their community.
https://ddsd.vermont.gov/sites/ddsd/files/documents/administrative-rules-on-agency-designation.pdf

Annual Periodic Review: means an annual review of an individual's support needs to assure the individual's budget reflects current needs, strengths, and progress towards personal goals.
PL: a review of the amount of support needed by a person who is currently receiving services. This is done once each year with the person.

Annual Report: means the *Developmental Disabilities Services Annual Report* that highlights the work provided to individuals with developmental disabilities and their families in Vermont. It also reviews the extent to which the system is meeting their needs.
PL: a report that comes out each year that talks about services provided to people with developmental disabilities and their families in Vermont and how well services are meeting people's needs.
https://ddsd.vermont.gov/annual-report-dds

Appeal: means a request for an internal review (see HCAR 8.100) of an adverse benefit determination (see HCAR 1.101) by the Department or designated agency or specialized service agency.
PL: if a person or their authorized representative disagrees with a decision regarding their services, they can request that the Department or the agency that made the decision review that decision. Some of the decisions that can be appealed include: • Denial of a service that was asked for • Denial of the amount of service that was asked for

• Denial of the type of service that was asked for • Denial of who can provide the services • Decisions to reduce, put on hold or end services • Not getting approved services in a timely manner
11.101-hcar-definitions-adopted-rule.pdf (vermont.gov), hcar-8.100-ga-adopted-rule-7.6.18.pdf (vermont.gov)

Applicant: means a person who files a written application for services, supports or benefits in accordance with HCAR 7.100.5. If the applicant is a guardian or family member or a designated agency, the term "applicant" also includes the person with a developmental disability.
PL: means the person that fills out an application for services or the person who is applying for services.

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, employment program base and statewide communication resources.
PL: The amount of money in a person's individual service budget that they can use to pay for their supports. An AFL is based on the person's needs assessment and is reviewed each year. The AFL says how much money is available in each category of service such as Community Supports, Respite, Home Supports, etc.

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.
PL: means a person who is given permission by the person with a developmental disability or appointed by the State to help with applications, appeals, grievances or other issues regarding services.

Budgetary Recissions: means reductions to the budgets provided by the State to agencies to provide services to individuals. These reductions usually result in reductions to individual's service budgets.
PL: When the State does not have enough money to fund agencies, they may cut the agencies' budgets and then the agencies may cut individual budgets for people in services.

Caregiver: means a person who provides support and care to a person with developmental disabilities in their day-to-day life. A caregiver may be paid or unpaid.
PL: NA

Centers for Medicare and Medicaid Services: (CMS) federal agency that works with state governments to provide health insurance and related services to individuals who qualify based on specific criteria.
PL: Also called **CMS**. CMS is a federal agency that works with the State to provide Medicaid services.
Home - Centers for Medicare & Medicaid Services | CMS

Certification: means the process by which the Department determines whether a provider meets minimum standards for receiving funds administered by the Department to provide services or supports to people with developmental disabilities.
PL: means the process the State uses to make sure agencies are qualified to provide services.
See HCAR 7.100.11 7.100 final-clean.ddact-regulations-10-01-2017.pdf (vermont.gov)

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 HCAR 7.100.11.
PL: means a designated agency, specialized agency, or other organization that the State has determined to meet what is required to provide services to people with developmental disabilities.
See HCAR 7.100.11 7.100 final-clean.ddact-regulations-10-01-2017.pdf (vermont.gov)

Collective Bargaining Agreement (CBA): A CBA is generally a negotiated agreement between an employer and a union representing employees regarding conditions of employment such as wages, benefits, hours, etc. As referenced in this document it refers to the CBA between the State of VT and the union representing independent direct support workers who provide services to people with disabilities.
PL: The agreement between the State and the union for workers who are hired by people in services, their families or shared living providers regarding their wages and benefits.

Commissioner: means the Commissioner of the Department of Disabilities, Aging, and Independent Living (DAIL).
PL: The Commissioner is the person appointed by the Governor of VT to run the Department.

Conflict of Interest: a real or seeming incompatibility between the private interests and the official responsibilities of a person in trust. The CMS rule (42 CFR 441.301 (c)(1)) requires that Home and Community-Based Services (HCBS) programs use a person-centered planning process which includes ways to solve conflict or disagreement and that the guidelines around conflict of interest are clear to everyone in the process. The rule also requires that providers of HCBS, or those who have an interest in or are employed by a provider of HCBS may not provide case management to or develop the person-centered service plan for people receiving services.
PL: Conflict of Interest in this document mostly refers to a federal rule that says the agency who provides a person's case management services cannot also provide the rest of the person's Home and Community-Based Services.
hcbs-cfcm-summary-3.26.19.pdf (vermont.gov)

Day: day means calendar day, not working day, unless otherwise specified.
PL: calendar day means each of the 7 days of the week. Working day usually means Monday to Friday, not including holidays.

Department of Children and Families (DCF): a department within Vermont's Agency of Human Services that provides supports and services for children and families.
PL: NA
Vermont Department for Children and Families (DCF) | Department for Children and Families

Department of Mental Health (DMH)**:** a department within the Agency of Human Services that provides supports and services to Vermonters in the area of mental health.
PL: NA
https://mentalhealth.vermont.gov/about-us

Department of Corrections (DOC)**:** a department within the Agency of Human Services that provides services to support safe communities through leadership in crime prevention, reparations, addressing needs of crime victims, ensuring offender accountability for criminal acts, and managing risk posed by offenders.
PL: A department that provides services to people who have been victims of a crime or who have committed a crime.
https://doc.vermont.gov/about-us

Department: (DAIL) means the Department of Disabilities, Aging and Independent Living.
PL: the department within the Agency of Human Services that provides services and supports for people with disabilities. The Developmental Disabilities Services Division (DDSD) is a division within DAIL.
Home Page | Disabilities Aging and Independent Living (vermont.gov)

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.
PL: the agency responsible for making sure that needed developmental services are available in specific areas of the state. People go to the DA to apply for services. The DA provides direct supports to people as well as makes referrals to other agencies.
Vermont Laws, https://ddsd.vermont.gov/sites/ddsd/files/documents/administrative-rules-on-agency-designation.pdf

Developmental Disability: 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 HCAR 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.
PL: means a person who has been diagnosed with either an intellectual disability or an autism spectrum disorder, who also needs support around day-to-day tasks and their disability started prior to age 18.
See HCAR 7.100.3 for specifics on determining that a person has a developmental disability.

Direct Care/Direct Support: work, care, or support that is provided directly to an individual with a developmental disability.
PL: NA

Developmental Disabilities Services Division (DDSD): is a Division of the Department of Disabilities Aging and Independent Living that oversees services to individuals with developmental disabilities and their families.
PL: See definition of Division below.
Home Page | Developmental Disabilities Services Division (vermont.gov)

Direct support professional (DSP): someone who works directly with individuals with developmental disabilities to provide assistance and support for individuals to access the community, employment, and other services.
PL: Person who provides direct support to individuals with developmental disabilities so they can be as independent as possible and participate in their communities. Also called staff.

Division: means the Developmental Disabilities Services Division (DDSD) within the Department.
PL: DDSD is a Division within DAIL. DDSD provides funding for agencies to provide services for people with developmental disabilities. They also develop the rules for how services should be provided and oversee the agencies providing services. Sometimes people call the Division "the State" because the Division is part of the State government.
Home Page | Developmental Disabilities Services Division (vermont.gov)

Department of Vermont Health Access: (DVHA) a department within the Agency of Human Services that is responsible for administering the Vermont Medicaid health insurance program and Vermont's state-based insurance marketplace.
PL: The department at the State that oversees Medicaid services for Vermonters.
https://dvha.vermont.gov/

Early, Periodic, Diagnosis and Treatment (EPSDT): a Medicaid benefit that provides comprehensive and preventative health care services for children under age 21 who are enrolled in Medicaid.
PL: Medicaid services for children who are under age 21
https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Employer of record: (EOR) The organization or person who hires, trains and supervises employees. This includes setting wages for employees and being the one who signs employees' timesheets.
PL: NA

Equity Fund/Equity Funding Committee: The Equity Fund is funding made available by the Legislature to address the needs of current recipients with new needs or people newly applying for DDS Home and Community-Based Services. The Equity Funding Committee reviews requests and makes recommendations to the Division regarding authorizing funding from the Equity Fund.
PL: NA
https://ddsd.vermont.gov/boards-committees/equity-committee

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 the bonds of affection, which means enduring ties that do not depend upon the existence of an economic relationship**.**
PL: family related by blood includes people such as parent, grandparent, sister, brother, aunt or uncle. Being related by marriage would include people such as a husband or wife, or husbands or wives of people related by blood. Being related by adoption would include the person being adopted or other relatives who were adopted. Family also includes people the person considers to be family.

Federal HCBS rules: regulations from the Centers for Medicare and Medicaid Services (CMS) that support enhanced quality in HCBS programs, outlines person centered planning practices, separate case management from delivery of direct services, and that ensure individuals receiving services and supports that: • Are integrated in, and support full access to the greater community; • Ensure individual rights of privacy, dignity, and respect, and freedom from coercion and restraint; • Optimize individual autonomy and independence in making life choices; and • Facilitate choice regarding services and who provides them
PL: the federal regulations that the State and agencies must follow in providing Home and Community-Based Services (HCBS). They include: • Person must be at the center of planning their services • Service must be in and support access to the community • Ensure people's rights for privacy, dignity, respect • Support people in making choices about their life • Separating case management from delivery of other services
Click on this link for more information on the federal HCBS rule: § 441.530

Fee for service: means services that are billed for individually.
PL: The majority of developmental disability services (HCBS) in VT are paid for in a monthly bundle that includes multiple categories of services such as Home Supports, Employment Supports, Respite, Clinical Services, etc. Fee for service is when each service is paid for separately. Some services that are paid for by fee for service in DDS include Targeted Case Management, Individual Therapy, Family Managed Respite.

Fiscal/Employer Agent: 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 recipients or families who choose to self/family manage or share-manage services.
PL: means an organization that takes of care payroll and taxes for services provided by the independent direct support workers who are hired by individuals in service, family members or shared living providers. Currently, ARIS is the Fiscal/Employer Agent for those workers.

Funding Priorities: A list of situations delineated in the State System of Care Plan that a person must meet in order for the Division to authorize use of the Equity or Public Safety funds for Home and Community-Based Services. Funding priorities specify how the Division will allocate its limited caseload funds.
PL: The Division has a limited amount of money to meet the needs of people who are currently in services but have new needs or people newly applying for services. The funding priorities help the Division decide who can receive that funding.
See Section Four G(1)(c)(3) of this document for the funding priorities.

Global Commitment to Health 1115 Waiver: is the agreement that the state of Vermont has with the federal Centers for Medicare and Medicaid Services (CMS) regarding how VT operates its Medicaid program. The agreement includes all of the Medicaid funded developmental disabilities services. It provides flexibilities to strengthen the overall Vermont's health care system.
PL: The agreement that the State of Vermont has with the federal government regarding how it operates its Medicaid program. Most of the developmental disabilities services are funded by Medicaid under this agreement.
https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver/1115-waiver-documents

Goods: means tangible merchandise or supplies.
PL: Goods are things that can be bought.

Guardian: A guardian is a person with the legal responsibility to protect the well-being and rights of another. A guardian is a person appointed by the court to make certain legal decisions for the person, when they have been determined to be unable to do so for themself due to their disability.
PL: A person appointed by the court to supervise and protect the interests of another person who is found not able to make decisions on their own. A guardian may be a family member or friend or a public guardian.
https://ddsd.vermont.gov/sites/ddsd/files/documents/OPG%20handbook%20April%202016.pdf

HireAbility Vermont: previously called VocRehab, a network of employment and job skills specialists and counselors who assist Vermonters with disabilities to find employment and expand career paths.
PL: A division within DAIL that helps people find jobs and supports them to be successful and independent with their jobs. Hireability used to be called Voc Rehab.
https://www.hireabilityvt.com/

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.
PL: Services that are provided to people with developmental disabilities to help them live in and be part of their community. HCBS services can help a person in their home, work and community. Providers of HCBS must follow all the federal rules when providing services.
See Section Four G in this document for more information on the DDS HCBS program. Click on this link for more information on the federal HCBS rule: § 441.530

Intermediate Care Facility for Individuals with Developmental Disabilities: (ICF/DD) is a residence that provides comprehensive and individualized health care and habilitation services to individuals, as an alternative to HCBS, to promote their functional status and independence.
PL: Facilities that provide care for people with developmental disabilities who have specialized needs, such as unique medical care needs. Vermont had one ICF/DD that served people with high medical needs, but it closed. The Division is planning to open a new ICF/DD.
The requirements for operating an ICF/DD can be found at: (eCFR :: 42 CFR Part 483 Subpart– -- Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities).

Individual: means a young child, a school-age child or an adult with a developmental disability.
PL: A person who meets the eligibility criteria in the DDS *Rules* for having a developmental disability.

Individual Support Agreement: means the agreement between an individual and an agency or Supportive Intermediary Service Organization that describes the plan of services and supports.
PL: An agreement between the person, the person's guardian (if there is one), and the agency that describes the person's supports and services. Every person who receives DDS Medicaid services must have an ISA. The ISA includes how the person wishes to be supported, what will be different in the person's life because of services, and what the person and the agency's responsibilities are.
https://ddsd.vermont.gov/sites/ddsd/files/documents/ISA_Guidelines.pdf

Internal adjustments: the movement of funds in a person's individual service budget from one service category to another or moving funds no longer needed by one person to another person's budget within the same agency.
PL: Means moving funds from one area of a person's budget to another. For example, a person has community supports but they get a job. Money from their community supports can be moved to employment supports. It can also mean moving money between people's budgets within the same agency. If a service is no longer needed, the money for that service can be moved to another person's budget who has increased needs.
Information about moving funds within a person's budget is included in Appendix B in this document. More information regarding internal adjustments can be found in: https://ddsd.vermont.gov/sites/ddsd/files/documents/DDS_HCBS_Spreadsheet_Manual_FY 23_DA_SSA_FINAL.pdf

Intellectual Disability: (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 HCAR 7.100.3(e).

PL: An intellectual disability is one that develops in childhood and affects a person's ability to learn new information or skills and the ability to function in day-to-day life. The disability could be mild or severe.

Local Funding Committee: is a committee operated by the local Designated Agency or Supportive ISO in order to review requests for funding for people receiving Home and Community-Based Services (HCBS) who have new needs or for people newly applying for HCBS.
PL: NA
See Section Five III(A) for more information about the role of Local Funding Committees.

Local System of Care Plan: plans submitted by all designated agencies under contract with the Division that covers a three-year period. The plan assists in guiding the development of local services, including identifying priority areas of support, gaps in services and use of resources.
PL: Agencies ask people in services and their families, as well as other stakeholders and partners in the community about how well their services are meeting the needs of people with developmental disabilities in their region. This helps to know what is working well or not working well so they can make a plan to improve if needed. The information from all the agencies' local systems of care plans is used by the Division when developing the State System of Care Plan.

Medicaid Management Information System (MMIS): system used to process Medicaid claims and obtain information on utilization and eligibility for Medicaid members.
PL: An online system where agencies send their bills and information about what Medicaid services have been provided to people. The State can review the information in the system to see how much service is being provided to people.

Medicaid Manual for DDSD: a manual that provides guidance to provider agencies, the Supportive ISO, and the Fiscal/Employer Agent regarding eligible Medicaid service activity, procedures for billing and documentation requirements.
PL: a manual that explains Medicaid insurance benefits for developmental disabilities services. The manual tells agencies how to bill for services and explains the rules for using Medicaid funding.
https://ddsd.vermont.gov/sites/ddsd/files/documents/dds-medicaid-procedures.pdf

Natural supports: unpaid relationships and personal associations that occur in the everyday life of a person, including but not limited to: family relationships, friendships, community, fellowship, etc.
PL: means the people, communities, or organizations in someone's life that provides support. Examples of natural supports include family members, friends, or church groups. These people are not paid to provide support to the person.

Needs Assessment: a tool that is used to measure the level of need and support an individual with a developmental disability requires in a variety of areas of daily functioning.
PL: An assessment that is done when a person first applies for developmental services to see what kinds of support they need. The assessment is done each year to check and see if there are new or changed needs.

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.
PL: means the designated and specialized service agencies who the Department says can receiving funding to provide services to people with developmental disabilities.

Non-certified entity: a person, company, agency that is not certified by the Department to provide developmental disabilities services. (See definition of "certified provider" above.)
PL: NA

Pre-Admission Screening and Resident Review (PASRR): a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that all applicants are screened for serious mental illness and/or intellectual disability, are offered the most appropriate setting for their needs, and provide all applicants the services they need in those settings.
PL: a process for review of people who have a developmental disability and are at risk of being placed in a nursing home.
Preadmission Screening and Resident Review | Medicaid

Periodic review: See Annual Periodic Review above.
PL: NA

Person-centered planning/person-centered plan (PCP): a process by which a person's supports and services are selected and that is directed by the person who is receiving services. PCP approach identifies strengths, goals, medical needs, support services, and desired outcomes**.**
PL: means that the person who is receiving services is at the center of and an active participant in the creation of their plan or ISA.

Prior authorization: a process where prior approval by a physician, health care provider, insurer or the State is required before a service can occur and be paid for.
PL: When a doctor, health care provider, insurance company or the State must approve a service before it can happen and be paid for.

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.
PL: Means the agency that is providing developmental disabilities services. Other examples of providers are doctors, hospitals, dentists, speech and language therapists.

Provider Agreements: means agreements the State has with developmental disabilities service providers that outline the conditions and requirements for the services provided.
PL: An agreement the state has with agencies that outlines the rules they must follow in order to provide services.

Public Safety Funding Committee: a committee that reviews requests and makes recommendations to the Division regarding authorizing HCBS funding allocated by the Legislature to specifically address public safety issues posed by adults with developmental disabilities.
PL: a committee that makes recommendation to the Division about funding for people who have needs related to public safety. For example, a person who has committed a violent crime and has a developmental disability may be eligible for public safety funding.
https://ddsd.vermont.gov/boards-committees/public-safety-committee

Qualified Developmental Disabilities Professional: (QDDP) means a person who meets the Department's qualifications as specified in the Department policy for education, knowledge, training and experience in supporting people with developmental disabilities and their families.
PL: A person who has certain training and experience in providing developmental disabilities services. It is required that each person have a QDDP on their team to develop, review and monitor their plan for services (ISA).
Qualified Developmental Disability Professional (QDDP) | Developmental Disabilities Services Division (vermont.gov)

Recipient: means a person who meets the criteria contained in HCAR 7.100, and who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in HCAR 7.100.
PL: means a person with a developmental disability or their family who is approved to receive funding or services.

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.
PL: When an individual or family member chooses to manage all of their services. This means that the person or family member has the responsibility of hiring staff and overseeing the funding and other parts of their services. The Supportive ISO and the Fiscal/Employer Agent provide support for self/family management of services, but a provider agency is not involved.
Self and Family Management | Developmental Disabilities Services Division (vermont.gov)

Service: means a benefit: 1) covered under the 115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Centers for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the intergovernmental agreement (IGA) between the Office of Vermont Health Access and Agency (DVHA) and the Agency of Human Services (AHS), or DVHA and the Agency of Education for the administration and operation of the Global Commitment to Health Section 1115 Demonstration.
PL: means the assistance or help a person receives when they are approved for developmental disabilities services. Examples of services include: community support, work support, case management, and respite.

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.
PL: When an individual or family member chooses to manage some, but not all, of their services. For example, the agency may provide service coordination and home supports, but the person may choose to manage community and work supports. The Fiscal/Employer Agent provides payroll services for people share managing their services.

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.
PL: An agency similar to a designated agency that provides supports and services to people with developmental disabilities. The SSA does not do intake but takes referrals from other agencies. Unlike designated agencies, an SSA can say no to serving someone if they do not have the capacity to serve them.
Vermont Laws, https://ddsd.vermont.gov/sites/ddsd/files/documents/administrative-rules-on-agency-designation.pdf

Stakeholders: individuals or groups that have an interest in the decisions or activities of an organization.
PL: A group of people that have interest in the decisions and activities of the State or provider agencies. Stakeholders in DDS include people receiving services, family members, people who work at the State, people who work at agencies, people who work for other organizations with an interest in services for people with developmental disabilities.

State Plan: Vermont's plan for providing services to those who are eligible for Medicaid.
PL: The State Plan includes what Medicaid benefits are available to people who qualify and the rules around those benefits.

State Program Standing Committee: committee that advises the Developmental Disabilities Services Division (DDSD) on the performance of the DDS system, evaluation of quality and responsiveness of services, development of the State System of Care Plan, department policy, and complaints grievances and appeals and agency designation. Made up of 15 members, majority of whom are disclosed service recipients.
PL: A committee of stakeholders that advises the State about developmental disabilities services.
DS State Program Standing Committee | Developmental Disabilities Services Division (vermont.gov)

Supported decision making: (SDM) Supported decision-making (SDM) is a term used to describe a series of relationships, practices, arrangements, and agreements designed to assist an individual with a disability to make and communicate to others decisions about their life.
PL: a process that supports individuals with disabilities to make choices about their lives with support from a trusted person or team of people they choose.
Supported Decision Making (SDM) | Developmental Disabilities Services Division (vermont.gov)

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.
PL: An organization that helps people who are self or family managing their services. Transition II is currently the Supportive ISO under an agreement the State.