Provider Standards for Supportive Intermediary Service Organization for Self/Family-Management of Developmental Disabilities Home and Community-Based Services
Effective 9/1/23

1. Requirements. Provider shall operate in compliance with the current version of the following:
   - Medicaid Provider Procedures (as promulgated by the State of Vermont, Agency of Human Services, Department of VT Health Access (DVHA) through its agent Gainwell.
   - In accordance with DVHA General Provider Agreement (General_Provider_Agreement.pdf (vtmedicaid.com)) as it applies to the services noted in #2 below. The Provider provides only those services listed and does not provide direct medical care or Home and Community-Based Services, other than QDDP services.
   - The Centers for Medicare and Medicaid Services (CMS) approved Global Commitment1115 Waiver .
   - *Developmental Disabilities Services Regulations (DDS Regulations) – HCAR 7.100 – Disability Services – Developmental Disabilities*.
   - Vermont State System of Care Plan (SOCP) for DD Services
   - *Guide to Self/Family Management* and all required regulations, policies and guidelines listed in the *Guide.*
   - *DDSD Medicaid Claim Codes & Reimbursement Rates*
   - Applicable state and federal regulations.
   - DDS HCBS Spreadsheet Manual for TII
   - The Provider Standards listed below.

Provider shall diligently and promptly correct any violation of the above requirements. Repeat or serious violations, as deemed by the State, may lead to cancellation of continued provider status, suspension of admissions, inability to claim Medicaid reimbursement, or other action by State. Provider shall fully participate in quality assurance and quality improvement activities as determined by the State.

2. Services. Provider shall provide all the following authorized services:
   - Supportive Intermediary Service Organization (Supportive ISO) and Qualified Developmental Disability Professional (QDDP) services for individuals who are enrolled in self/family-management of their Developmental Disabilities Home and Community-Based Services (HCBS).
   - The Provider shall provide Supportive ISO services to Vermonters who participate in the Self/ Family Management option of Developmental Disabilities Services in all regions of the State.
   - Provider is required to provide all services described in the Provider Standards. All services shall be provided as defined in the Requirements and Provider Standards.

3. Rate of Reimbursement. In consideration of the services to be performed by Provider, the State agrees to pay Provider as follows:

- Operating expenses shall be paid from the following sources:
  1. In the first year an individual is enrolled in self or family managing Developmental Disabilities Services HCBS
     i. The individual shall have available to them 3.5% of their Authorized Funding Limit for administrative services. The Provider shall have available the Administrative Rate of the agency that formerly served the individual minus the amount available to the individual for administrative services.
     ii. From individual budgets, an amount not to exceed the difference between the current HCBS Service Coordination hourly rate for DA/SSAs and the HCBS Service Coordination hourly rate set for people self/family managing. The rates will be published in the current *DDSD Medicaid Claim Codes & Reimbursement Rates*. The funds are moved from the Service Coordinator line to the Supportive ISO administration line. The HCBS Service Coordinator hourly rate for people self/family managing must be made available to the individual. Any additional amount within the service coordination line will be available to the Provider. Provider may not increase the services coordination line item for the sole benefit of making additional revenue available to the Provider without approval from the State.
  2. In each subsequent year that the individual in enrolled in self or family-management, the Provider shall have an Administrative Rate set by standard procedures of the Department for Disabilities, Aging and Independent Living (DAIL). The individual shall have available to them 3.5% of their Authorized Funding Limit for administrative services.
  3. The Provider is authorized to deduct from individual budgets the amounts or percentages above. The provider may not withhold from the individual's HCBS budget any additional funds for the Provider's operating expenses.
  4. Provider shall collect all applicable fees for providing QDDP services. The fee for the Supportive ISO's QDDP services will be published in the current *DDSD Medicaid Claim Codes & Reimbursement Rates*. The State sets the annual fee after consultation with the Provider.

4. Amendment. These standards may only be changed, modified, or amended if reduced to writing by the duly authorized representatives of the State. The Provider may recommend changes to the Developmental Disabilities Services Division (DDSD).

5. Termination. The Provider shall follow 8.1-8.3 of the DVHA General Provider Agreement regarding termination as a provider. In the event of termination, Provider must notify both DVHA and DDSD and agrees to work with both DDSD and the responsible Designated Agencies to ensure a smooth transition for the individuals enrolled in self/family management.

Provider Standards

Definitions:

Individual: the person who is authorized to receive the DDS Home and Community-Based Services.

Family: A group of people that includes an individual with a developmental disability and that is related by blood, marriage, or adoption or that considers itself a family based upon bonds of affection, which means enduring ties that do not depend upon the existence of an economic relationship. As used in this document, "family" or "family member" refers to the person who is managing services on behalf of the individual.

Employer of Record (EOR)/employer: An individual or family member who employs a support worker to provide HCBS for the individual. An employer is responsible for selecting, scheduling, training, supervising, and terminating a worker. An employer determines the wages to be paid and the hours of employment of the support worker. The employer approves and signs the worker's timesheets.

A. Communication with Individuals/Families

1. The Provider shall adapt its procedures to reflect the fact that individuals/families are not professionals and will need support, patience, and clear instructions to carry out their responsibilities.
2. The Provider shall provide prompt and accessible assistance to individuals/families through a toll-free phone line with convenient hours, FAX, Internet access, and clear written instructions. The capacity for face-to-face assistance is available and will be furnished when necessary.
3. Provider will make services, communications, and written materials accessible to and usable by individuals/families, for example, providing appeal information in an accessible format and information in plain language.
4. The Provider shall in its practices and policies support self/family management.

B. Enrollment

1. For those people who are newly opting for Self/Family Management, initial contact will be made within three (3) working days of receiving the referral.
2. The Provider shall have the capacity to meet face-to-face within 10 business days but may go beyond that time limit if the individual/family so requests. This meeting will occur at a time and location convenient to the individual/family, but generally will occur in the individual's home.
3. If after the orientation to Self/Family Management and the initial assessment noted in C below, the Provider agrees that the individual or family member is capable of self/family managing, the Provider and the individual or family member will sign the Self/Family Management Agreement that sets out the responsibilities of the individual or family member and the responsibilities of the Supportive ISO.
4. DDSD reviews and approves the form for Self/Family Management Agreements.

C. Orientation to Self/Family Managed Services

The Provider shall provide an orientation to all individuals/families. The orientation will include a discussion of the philosophy of self/family-managed services; determination of training needs; an explanation of the roles and responsibilities of the individual/family, QDDP, Supportive ISO, Designated Agency, and the State for self/family-management as delineated in the current version of the *DDS Regulations*; and completion of the essential paperwork to enroll with the Supportive ISO. The Provider will conduct an initial assessment to determine the individual or family member's ability to manage services and comply with all requirements. Additionally, the Provider will assist employers, as needed, to complete the essential paperwork to enroll with the Fiscal/Employer Agent (F/EA). The Provider will also provide information about the DDSD's crisis services to the individual/family.

D. Budgets and Authorized Funding Limits (AFL)

The Provider is responsible for assigning the Authorized Funding Limit (AFL) for individuals. The Provider works with the individual/family to develop the AFL within the budget approved by the DDSD. The AFL describes the type, amount, and cost of the services that have been approved for the individual, plus individual's share of administrative expenses. The Provider must provide the AFL in writing to the person, annually and any time there is a change in funding. Shifts of funding between already funded areas of support will be reflected on Spending Reports sent to the Employer of Record. The Provider will provide guidance to individuals/families in the management of the AFL and provide support and education in its allowable uses to be consistent with the *DDS Regulations* and guidance in the SOCP. The Provider will monitor the AFL and make adjustments, as necessary consistent with the DDS SOCP. The Provider must notify the person/guardian in writing of any change to the total AFL, along with their appeal rights. The Provider provides the F/EA each individual's AFL and updates when there are changes.

E. Pre-service/In-service Training for Employees

The Provider shall offer pre-service and in-service training as specified in the current *DDS Regulations* for the support workers of the individuals enrolled in self/family management. The pre-service and in-service training must cover all the topics specified in the *DDS Regulations.* The Provider shall assure that information regarding mandated reporting of suspected abuse, neglect or exploitation is included in training materials and explicitly provided to all individuals, families, and support workers. It is the responsibility of the individual and/or family to provide training specific to the needs of the individual. The individual/family is responsible for providing or arranging for pre-service and in-service training or ensuring that workers have knowledge and skills in the areas addressed by pre-service or in-service training. Individuals or families have the option of providing training for their workers themselves, arranging for training from others, including the pre-service training available on the F/EA website or receiving it from the Provider. The Provider is responsible for maintaining written verification in their files that the pre-service and in-service training was provided or that the worker has the knowledge and skills in the areas addressed by pre-service or in-service training.

F. Local Supportive ISO Funding Committee and Requests for Additional Funds

The Provider shall create and maintain a local funding committee that meets regularly and is comprised of a majority of individuals receiving services and/or family members, Provider staff, and one or more members who represent local community resources (such as HireAbility VT, schools, Area Agency on Aging) and other interested stakeholders. This committee will manage the shared funding pool. The shared funding pool is comprised of funding contributed from individuals' budget through deposits of funds not fully used at the end of the fiscal year or such other interim period determined by the committee. The local funding committee will develop funding procedures, with assistance from the Provider. The local funding committee will be responsible for one-time requests of up to $5,000, if funds exist in the shared funding pool. The Provider will follow the SOCP funding rules for use of One-Time funding in distributing these funds. The Provider will report the use of these funds according to the instructions for One-Time Funding.

For requests to increase annualized funding for individuals, the Provider shall be responsible to prepare and submit a funding proposal to the statewide Equity Committee for its review. Unlike designated and specialized services agencies, the Provider is not responsible to fund requests under $5,000. These requests may be submitted to the Equity Committee. The Provider must first conduct a Needs Assessment and make an

independent determination that the person has one or more significant unmet needs related to his/her developmental disability. In complex situations, the Provider may seek additional expertise in conducting an assessment of need, including requesting assistance from an independent clinician with relevant expertise, DAIL/DDSD or the responsible Designated Agency. The Provider may request permission from DDSD to cover extra costs for this purpose out of the shared funding pool. The Provider then drafts a funding proposal which is reviewed by the Supportive ISO's local funding committee prior to submission to the Equity Committee. The Supportive ISO's local funding committee determines if the request is appropriately supported by a recently conducted Needs Assessment, and that the identified needs meet a funding priority in accordance with the current version of the *State System of Care Plan for Developmental Disabilities Services*. Provider will present proposals to the Equity Committee along with the individual's service coordinator and/or QDDP. The Equity Committee makes a recommendation to DDSD regarding whether or not to fund the request and for how much. DDSD makes the final funding decision and forwards decisions to the Provider. The Provider is responsible to transmit the funding decision to the individual and/or family accompanied by information about the right to appeal, in accordance with the *DDS Regulations.*

G. Advisory Committee

The Provider shall have an Advisory Committee, comprised of a majority of individuals/families, which may be either a sub-committee of the organization's Board of Directors or the Board of Directors itself if it meets the majority requirement, to guide the Provider in their practices and implementation of their role as a Supportive ISO. The Provider may have one committee to serve developmental disabilities services and any other programs for which it provides services or it may have separate committees. If the Provider decides to have separate committees, the Committee for DDS shall be made up of a minimum of five (5) members. If the Provider decides to have one committee, it shall be made of up a minimum of seven (7) members. The Committee(s) meet as necessary to carry out its functions, but no less than quarterly. The Provider shall provide a copy of these Provider Standards to the Advisory Committee to assist them in their advisory role regarding the practices and implementation of the Provider's role as a Supportive ISO.

H. Qualified Developmental Disabilities Professional

The Provider shall have on staff at least one Qualified Developmental Disabilities Professional (QDDP), as defined in the State's QDDP policy, per every fifty people who are self or family-managing. The QDDP will be available to review and monitor individual support agreements if an individual wishes to purchase QDDP services from the Provider. When QDDP services are purchased from the Provider, the QDDP will perform the duties outlined in the *DDS Regulations* (Section 7.100.6(d)). The Provider may collect fees from individuals purchasing this service from the Provider. The Provider will submit requests for reimbursement for the fee directly to the F/EA.

I. Training in Employer Responsibilities

The Provider shall provide an orientation to the individuals/families regarding employer responsibilities, such as, recruitment, interviewing, hiring, training, evaluating, managing, and dismissing support staff, and compliance with state and federal law to avoid Medicaid fraud. The Provider shall provide training and technical assistance in the allowable uses of Medicaid funds. The Provider will inform individuals/families of their responsibilities as an employer to follow the Department of Labor Home Care rules, with a specific focus on the "Companionship Rule" that went into effect in October 2015. The Provider is not expected to interpret

the rules for employers but to direct individuals/families to resources to assist them in applying the rules to their circumstances. Training will be offered as part of the orientation, as requested by the employer and as determined to be needed by the Provider to ensure compliance with employer responsibilities. The individual/family member who is self/family managing services is responsible for carrying out their employer responsibilities. The Provider's responsibility is to provide orientation and technical assistance as needed to guide individuals and family members.

J. Reviewing Service/Budget Utilization

The Provider shall review service utilization and spending of the individuals' allocation in coordination with F/EA. This review is intended to alert individuals/families to potential issues or problems with the rate of spending. The Provider shall communicate with the individual/family member if the rate of spending may result in the individual/family over-spending the authorized funding limit. If there is significant under-spending, the Provider should communicate with the individual/family to explore the reasons for underutilization and whether the person continues to need the service. It is the responsibility of the individual/family to manage services within the approved allocation. The employer of record is responsible for any expenses in excess of the authorized funding limit. The Provider will offer guidance regarding any needed adjustments to the budget to ensure that assessed needs are being met.

A component of the service and budget review is for the Provider to monitor for the following: fraud, waste and abuse, inappropriate use of funds, inadequate oversight of the plan by QDDP, and capacity of individual/family to manage services. The Provider will address any issues discovered including providing additional training and support and reporting to the Medicaid Fraud Unit when warranted.

K. Monitoring of Non-Payroll Expenses

The Provider shall provide guidance to individuals/families regarding utilization of funding for non-payroll expenses to ensure that such expenditures are allowable under DDSD rules, SOCP and guidelines.

L. Ongoing Needs Assessment/Periodic Reviews

1. A QDDP employed by the Provider shall perform a reassessment or periodic review of needs for each individual enrolled in self/family management at least annually according to approved State guidelines. The review must include the person receiving services, the individual or family member who is self/family managing and the QDDP who is overseeing the plan, including the independent QDDP hired by the individual/family, if there is one. If the new assessment indicates a change in the individual's needs, the Provider shall work with the individual/family to develop a new budget and Authorized Funding Limit (AFL). These new budgets must be approved by designated state staff or local funding committee for increases in funding as described in Section F. State staff may request specific justification for changes in assessed need or request an independent reassessment. In complex situations, the Provider may seek additional expertise in conducting an assessment of need, including requesting assistance from an independent clinician with relevant expertise, DDSD or the Designated Agency. The Provider may request permission from DDSD to cover extra costs for this purpose out of the shared funding pool. If the periodic review in DDSD results in a reduction in the budget, funds should be returned to the appropriate fund. The agency HCBS spreadsheet should be adjusted accordingly, and the individual/family notified of their appeal rights.

2. The Provider shall annually complete the continued Medicaid HCBS eligibility of all individuals. This verification must be completed by the Provider's QDDP. The State will confirm the annual Medicaid HCBS eligibility.

M. Individual Service Agreement (ISA) Verification and Review

The Provider shall verify that an individual has a signed (or authorized via methods allowed by DDSD guidelines) ISA and that it matches the funded area(s) of support. The Provider may act as the QDDP in approving and monitoring the ISA, if the individual/family purchases the QDDP service from the Provider. The Provider shall also verify that the ISA has been reviewed and changed, as required. Additionally, the Provider shall verify that the individual's ISA addresses any known health and safety concerns as identified in the individual's needs assessment and for which the individual receives funding. The Provider will follow up with the individual/family to address any missing components of the ISA. The Provider will notify the individual/family that funding may need to be suspended if there is not a current signed ISA, according to the timelines outlined in the *ISA Guidelines*.

N. Reporting

1. The Provider shall provide the State, on a monthly basis, in an approved electronic format, all changes in demographic information (as defined by the State) for all those enrolled in the Supportive ISO.
2. The Provider shall submit, on a monthly basis, the required Medicaid HCBS spreadsheet with any changes to individual budgets or any other data on the spreadsheet. The initial spreadsheet for the FY shall be provided by the State.
3. Provider shall submit to the State quarterly financial reports which shall include details of revenue and expenditure by program.
4. The Provider will report, on a quarterly basis, the use of the shared funding pool created by unspent authorized funding according to the One-time funding reporting instructions.
5. The Provider will report units of QDDP services provided to each person via non-payroll reimbursement requests submitted to the F/EA, using the service coordination service category. The requests must be submitted to the F/EA in order for the F/EA to submit encounter claims to the MMIS according to the timely filing rules.

O. Critical Incident Reporting (Developmental Disabilities Services)

The Provider shall facilitate the reporting of all known critical incidents to the State in accordance with the State's *Critical Incident Reporting (CIR) Guidelines*. Individuals/families are required to report critical incidents, as defined and within the mandated timeframe in the *CIR Guidelines*. This requirement shall be communicated to the individual/family at enrollment. Provider shall periodically, at least annually, inform the individuals/families of their responsibilities to report critical incidents. The Provider will report CIRs to the State according to the timeframes in the *CIR Guidelines* once they have received information regarding a critical incident. The Provider is not responsible for submitting a CIR if they have not been provided information regarding a critical incident.

P. Annual Notification of Rights and Appeals

The Provider shall notify each individual of their rights and of the appeals and grievance processes as required and defined by appropriate State regulation and policies and using materials developed by the State. The

Provider shall have a written policy for individual notification of change in services, grievances and appeals, and fair hearings, and for the dissemination of information on dispute resolution to all those enrolled in self/family management. These policies shall be consistent with AHS, State and Medicaid required policies and regulations. When an individual enrolled with the Provider files a grievance, appeal, or request for fair hearing, the Provider shall provide all requested clinical records and other relevant documentation to State. When an individual files a request for fair hearing, the Provider, in addition to providing the above requested clinical records and documentation shall file a notice of appearance and attend the hearing, if requested.

Q. Confidentiality

The Provider shall comply with all state and federal laws and regulations relating to confidentiality of information, in accordance with Article VII of the DVHA General Provider Agreement General_Provider_Agreement.pdf (vtmedicaid.com).

R. Monitoring and Individual Case Record

The Provider shall monitor individuals which includes in-person contact with the individual and family, if family-managing, within three months of enrollment for people who are new to self or family managing their services and then two additional contacts in the first year, which can be in person, by video conferencing or by telephone. The Provider will have an in-person visit at least annually with the individual receiving services after the first year. All visits must be documented. The purpose of these contacts is to identify potential issues with regards to neglect, abuse, or exploitation, support the health and well-being of the individual, and ensure that the individual's identified needs are being met by self or family managing.

Additionally, the Provider shall keep a complete and up-to-date minimum case record for anyone self or family managing and that ensure the individual's records are maintained as required by the DDSD's *Guide to Self/Family Management.* The Provider shall take an active role in ensuring the individual/family provides them with the case record information, and that it is updated as needed. The Provider shall assist the individual or family in understanding the requirements for a complete case record.

The Provider will monitor the ability of the individual/family to self/family manage services. The Provider will follow the procedures in the current version of the *DDS Regulations* when determining an individual/family is unable to self/family-manage.

S. Quality Assurance Reviews/Audits

The Provider shall assist individuals/families in Quality Services Reviews conducted by the State. This shall include assisting State quality assurance staff in arranging for interviews with individuals, employers of record, the QDDP overseeing the plan, and guardians, if there is one, and reviewing individual records. The Provider shall assist and monitor individuals/families to assure that they adhere to the appropriate sections of DDSD Quality Services Reviews. The Provider will notify individuals/families of any issues that must be addressed as a result of a Quality Services Review and will provide guidance in addressing the issue and assist them in submitting a plan of correction, when needed. Individuals/families submit their plans of correction to the Supportive ISO who then submits them to the QSR team.

Provider shall participate and support individuals/families to participate in any Utilization/Service Documentation Audits conducted by the State.

T. Relationship with the Fiscal/Employer Agent (F/EA)

The Provider shall work collaboratively with the State-contracted F/EA, as needed, to assist individuals/families with managing their budgets and services and to resolve any disputes or conflicts related to individuals' budgets. The Provider agrees to assist individuals/families to utilize the services of the State-contracted F/EA. This includes, but may not be limited to:

1. Sharing with individuals/families information provided by the F/EA and/or the State on becoming an employer or other relevant topics.
2. Notifying the F/EA of approved purchases of non-payroll goods and services.
3. Notifying the F/EA of the individuals AFL and any changes to the individual's budget or AFL.
4. Making payment to the F/EA, upon receipt of acceptable bi-weekly invoices, within five (5) business days.
5. The State agrees to include provisions in F/EA contracts requiring the F/EA to retain documentation for no less than ten years related to all payments it makes, such as for payroll or goods. The State shall also require that the Provider shall have access to and/or free copies of such documentation and records if requested for the purpose of a payment review, auditor investigation relating to the Provider's payments to the F/EA.

U. No Internal Referrals

The Provider will offer Supportive ISO and QDDP services. The Provider may also explain the option of the Provider providing supported employment services including vocational assessment, job development, job placement, and post-placement follow-up. Long term job coaching is not included in this option. The option for the Provider to provide supported employment services must be presented along with information regarding other providers of this service.

V Peer and Family Networks

The Provider will support opportunities for peer support among individuals and separately for family members. This will include informing individuals and families of local peer and family support groups or resources. It may also include providing a meeting place, or other support upon request of people self/family managing.

W. Transfer to Another Provider

If an individual wishes to transfer to another designated provider (Designated Agency or Specialized Service Agency), the Provider shall participate in any needed transition planning and shall provide a copy of the individual's records (minimum case record elements noted in the *Guide to Self/Family Management)* to the new provider upon request. (See Transfer of Documents when Changing Providers: Guidelines for Agencies .) The Provider shall maintain records on participants who leave developmental disabilities services entirely for a period of no less than ten (10) years after the completion of the Provider's fiscal year. When an individual chooses to transfer to another provider, the full budget, including administration will be transferred to the new provider.

X. Billing for HCBS

The Provider will submit claims for HCBS according to the procedures outlined by the Division in the *HCBS Spreadsheet Manual,* the *Medicaid Manual for Developmental Disabilities Services* and the *DVHA General Provider Agreement*. Adjustments to individual budgets must follow the rules outlined in *DDS Regulations* and *System of Care Plan.*

Y. Submission of Encounter Data Claims

The Fiscal/Employer Agent will submit encounter data claims for all services paid for through F/EA on behalf of the Provider. The Supportive ISO and the F/EA will work together to resolve denied claims. The F/EA will resubmit the claims once resolved. The F/EA will submit encounter claims for QDDP services provided by the Provider. The Provider will provide the necessary information to the F/EA to allow them to submit the encounter claims for QDDP services.

Z. Responsibility for Fraudulent Claims

The roles and responsibilities of the Supportive ISO and the Employer of Record are outlined in the *DDS Regulations*, the *Guide to Self/Family Management* and the *Self/Family Management Agreement.* The Supportive ISO provides guidance, training, technical assistance and monitoring for Employers of Record (EOR) as outlined in these Provider Standards as it relates to State and Federal policies and guidelines. The EOR is responsible for decisions on the use of HCBS funding thar are not consistent with the appropriate use of HCBS Medicaid as outlined in state and federal policies. In the event the Supportive ISO becomes aware of a possible misuse of Medicaid funds, the Provider will report incidents of potential Medicaid Fraud to the Vermont Attorney General's Office for investigation.

AA. Cash Flow and Fund Balance

The current Provider acknowledges that the State has given it $85,000 for cash flow. This money shall be returned to the state in the event that the Provider no longer serves as a Supportive ISO. Any fund balance over $100,000 annually which arises from unspent funds for individuals receiving developmental disabilities services shall be returned to the State. Any remaining fund balance shall be spent, as necessary, on emergency or one-time funding for DDSD individuals.