AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DAVE JONES, CHAIR

WEDNESDAY, MAY 5, 2010
STATE CAPITOL, ROOM 4202
UPON ADJOURNMENT OF G.O.

ITEMS TO BE HEARD

5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: IN-HOME SUPPORTIVE SERVICES – PROPOSED REDUCTIONS

This section will discuss the major proposals being put forth by the Administration for 2010-11 related to the In-Home Supportive Services (IHSS) program.

BACKGROUND

87% Service Elimination in IHSS (2010-11)

The Governor's budget proposes to eliminate, effective June 1, 2010, all services for recipients with a functional index (FI) score of less than 4. This cut would eliminate eligibility for 426,733 individuals (87 percent of the caseload) and is estimated to eliminate employment for 350,262 providers and county staff, for a total number of lives affected of 776,995.

GF savings vary by whether the federal government extends enhanced ARRA Federal Medical Assistance Percentage (FMAP) rates (61.6 versus 50 percent) past December 31, 2010. During ARRA, program costs are shared 62/25/13 at Federal/State/County levels. If ARRA is extended, proposed 2010-11 GF savings are $651 million. The state would forego about $2.4 billion federal funds. If ARRA is not extended, GF savings would increase to $1.1 billion, while federal funds foregone would be approximately $1.7 billion. The Administration is relying on a favorable court decision or increased federal flexibility to allow implementation of this proposal.

Expected Impact. According to the LAO, this proposal would likely lead to offsetting costs that more than outweigh potential savings. A recent study by Candace Howes, Ph. D. and published by the Institute for Women's Policy Research and the Paraprofessional Healthcare Institute asserts that more than 65% of current IHSS consumers will move into nursing homes if the IHSS program were eliminated, at a significantly increased cost to taxpayers.

The UCLA Center for Health Policy Research in a February 2010 report estimated that the vast majority of those with FI scores under 4.0 are severely disabled and suffer from cognitive impairments that make daily survival without assistance extremely difficult. UCLA also estimates that nursing homes and residential care facilities can absorb less than 10 percent of those who face losing their community-based benefits due to these cuts.

IHSS Reduction in State Participation in Wages (2010-11)

The Governor's budget again proposes, effective June 1, 2010, to reduce the state's participation in IHSS wages from the current ceiling of $12.10 per hour to a ceiling of the minimum wage of $8.00 per hour, plus $.60 in benefits costs. There are approximately 385,000 IHSS service providers providing services to 460,000 program recipients. IHSS providers organize and collectively bargain for wages and benefits on a county-by-county basis.

As of October 1, 2009, IHSS wages were above $8.60/hour in 45 California counties. In 24 counties, the wages were at or above $10.10/hour. To the extent that counties continue to pay wages above $8.60, they would have to backfill decreased state funds.

Expected Impact. Again, the Administration is relying on a favorable court decision or increased federal flexibility to allow implementation of this proposal. Budget bill provisions from February 2009 reduced the state's contribution to participation in wages up to $9.50 per hour plus $.60 for benefits (for a total of $10.10), effective July 1, 2009. However, a federal district court issued a preliminary injunction against this reduction. The Administration is appealing in the 9th Circuit.

Counties' ability to make up the difference between a current wage level and that which would be required if the state reduced participation in wages is unknown. County resources being strained as they are across program areas, with furloughs, layoffs, and program downsizing, may not be able to bridge this difference.

CONTEXT

The Legislature adopted, as part of the 2009-10 Budget, several changes to services and eligibility that were initially estimated to result in General Fund savings of about $73 million in 2009–10.

- **Reduction in Domestic and Related Care Services.** The first reduction targets domestic and related care services to the most impaired IHSS recipients, limiting these services to consumers with FI Ranks in this service category above 4.0. An estimated 85,000 would have been affected by this reduction.

- **Elimination of All Services for Consumers with FI Scores Under 2.0.** This second reduction eliminates all IHSS services for those who are considered least impaired. An estimated 39,000 elderly and/or disabled persons would have lost all services.

For both of these reductions, the Legislature adopted exceptions for certain recipients who meet specified criteria, but authorized the Governor to waive these exemptions under specified conditions if they put federal IHSS funding at risk. Ultimately, the Governor cited these conditions in vetoing an additional $28.9 million from the final budget package. In total, the savings from these proposals are estimated to be about $102 million in 2009–10.

The courts have halted both of these cuts and DSS will provide additional information regarding the litigation at the hearing.

- **Wage Reduction Adopted in February 2009 Trigger Budget Agreement.** In the February, 2009 budget package, the state reduced by $2 the level at which it will participate in paying in-home supportive services worker wages (from $12.10/hour to $10.10/hour). The courts have halted this reduction and DSS will provide additional information regarding the litigation at the hearing.

PANELISTS

- DSS – Please be prepared to address the following in your testimony:
    - A brief description of each of the reduction proposals in IHSS, with an overview of the trigger proposal.
    - A review of the current status of litigation, the success of which the administration is relying to make these proposals possible. The administration has been asked to provide a handout on this to the Subcommittee and to be prepared to walk through its content.
- Legislative Analyst's Office
- Department of Finance – Please provide a status of the receipt of federal funds received related to the Governor's trigger proposal.
- Janie Whiteford, IHSS Coalition
- Mark Beckwith, IHSS Consumer, Advocate with Northern California ADAPT, and Member, Advisory Board of Alameda County IHSS Public Authority
- Deborah Doctor, Legislative Advocate, Disability Rights California
- Jovan Agee, United Domestic Workers of America / AFSCME
- Representative, SEIU California
- Nancy Schulz, Napa County Public Authority Manager
- Supervisor Shirey Zane, Sonoma County
- Frank Mecca, County Welfare Directors Association of California
- Public Comment

Possible Questions

- How many IHSS consumers does the administration project would enter a nursing home if this cut is made in IHSS? What is the basis for that projection?

- How many in the caseload with an FI score below 4.0 suffer from cognitive impairments that would make them nursing home eligible in their current condition?

- What options exist for IHSS consumers and how are these affected by the administration's proposed cuts in other areas and programs?

Staff Recommendation:

Staff recommends that these proposals be held open pending May Revision.

ISSUE 2: IN-HOME SUPPORTIVE SERVICES – OVERSIGHT ON ADOPTED PROGRAM REFORMS

This section provides a review of implementation of various reforms adopted as part of the 2009-10 Budget for IHSS, summarizing issues and raising questions for the Administration.

ADOPTED REFORMS

The 2009-10 Budget made vast and significant changes in the IHSS program, including expansion of anti-fraud/program integrity activities. According to the Administration, these changes will cost $88.3 million ($34.2 million GF), discussed in more detail in the section below. The Administration arrives at an estimated $162 million GF savings by assuming a basic 10 percent of program costs. No further empirical basis for this assumption has been offered by the Administration.

The changes, which included requirements for stakeholder collaboration in their implementation, were:

- Criminal background checks and appeals processes for IHSS providers;
- The requirement for providers to attend an orientation;
- Authorization to send targeted mailings to providers and recipients and to conduct unannounced home visits, pursuant to developed protocols and in targeted cases, when there is cause for concern about program integrity;
- Limits on the use of P.O. boxes by providers to receive paychecks;
- Training for social workers on fraud prevention;
- Notification to providers about their clients' authorized hours and service levels;
- Fingerprinting of IHSS program recipients; and
- Changes to timesheets, including fingerprinting and certification after notice of possible criminal penalties for fraud.

The 2009-10 Budget additionally required the Department to convene a stakeholder group to develop a report, by December 31, 2010, to evaluate quality assurance and fraud prevention and detection activities implemented from 2004 to the present. The stakeholder group is required to review annual error reports, information regarding referrals of suspected fraud and subsequent investigations (including cost-benefit information), and information regarding final convictions for fraud. The resulting report must also provide recommendations for early detection and for prevention of errors and fraud.

COSTS OF AND REQUESTS FOR ADDITIONAL RESOURCES RELATED TO REFORMS

Request for New Positions. DSS requests $528,000 ($264,000 GF) for six permanent positions to carry out IHSS-related anti-fraud and program integrity activities, and $500,000 ($264,000 GF) for a contract with California State University (CSUS) to assist in the development of a required report to the Legislature. The Department has administratively established these six new positions in 2009-10, and is now seeking 2010-11 authority to continue them permanently. These six positions would be on top of the 42 new IHSS anti-fraud positions authorized by the 2009-10 budget (12 positions at DSS in 2009-10 and 30 positions at DHCS across 2009-10 and 2010-11).

Anti-Fraud Budget. The total budget for IHSS Quality Assurance and Anti-Fraud efforts by DSS and the Counties is $88.3 million ($34.2 million GF), with approximately $3.1 million ($1.6 million GF) for state operations and $85.1 million ($32.6 million GF) for local assistance. Of this total, $54.2 million ($21.9 million GF) were new funds in the 2009-10 budget, including $8.2 million ($4.4 million GF) for the costs of fingerprinting IHSS recipients. These figures do not include the additional costs of IHSS fraud investigations by DHCS, nor do they include the costs of fingerprinting for the Statewide Fingerprint Imaging System (SFIS), estimated now to be $10.5 million ($5.6 million GF) in 2009-10 and totaling $41.6 million ($21.6 million GF) over the eight-year life of the contract change order with the SFIS vendor.

These changes were anticipated to take effect at varying points in time over 2009-10 and 2010-11. This Subcommittee has held, jointly with the Senate Budget Subcommittee, three oversight hearings to address major challenges in the implementation of these changes to date. Background information on these hearings is available at the Assembly Budget Committee website.

Not including the requested positions and resources, DSS's total state operations staff for IHSS Quality Assurance and Anti-Fraud efforts consists of 28 positions. Twelve of these positions are new as of 2009-10. According to DSS, all of these 12 new positions have been filled. Six of these 12 staff members are assigned to a variety of program integrity activities (e.g., developing protocols for home visits and targeted mailings, social worker fraud training and data collection). The other six are assigned to the new provider enrollment appeals process.

Provider Enrollment Thus Far. As of April 21, 2010, there were 100,020 providers enrolled under the new enrollment procedures. Another 112,176 were in "pending" enrollment status. Finally, 206 had been denied eligibility to enroll in the program.

Also according to DSS, the six additional staff requested in 2010-11 would focus on program changes related to the inclusion of provider and recipient fingerprint information on timesheets.

This agenda recommends three issues for focus in this hearing:

1. The April 1, 2010 implementation of the fingerprinting requirement for IHSS recipients;

2. The July 1, 2010 date for provider enrollment under the reform-affected process; and,

3. Evaluation and assessment of anti-fraud and quality assurance efforts going forward.

1. APRIL 1 FINGERPRINTING

As a result of the 2009-10 Budget package, beginning April 1, 2010, finger imaging is required for new consumers, to be conducted in their homes at the time of initial assessment. Current consumers (between 460,000 and 490,000) will be finger imaged at their next reassessment, conducted annually and also in the home, with exemptions for minors and those physically unable to provide fingerprints due to amputation. The statute does not in any place require a picture image to be taken of the consumer. The statute requires DSS to consult with stakeholders to develop protocols to carry out these requirements. To date, this formal consultation toward protocol development has not occurred.

DSS has provided minimal information on its overall implementation plan for this new requirement. What DSS has provided is a Pilot timeline, showing generally when pilots are being conducted in five counties on use of ten finger imaging and photograph devices (five from each of two vendors), a notice to consumers on the voluntary nature of the Pilot, a consent form for IHSS recipients, and a recipient/social worker questionnaire to assess the experience.

Remaining questions for the Administration include:

Pilot Project

- What collaboration with stakeholders was conducted prior to the pilots commencing?
- DSS originally estimated that the fingerprinting interaction could occur with the consumer within 90 seconds. Does DSS continue to view that as reasonable?
- DSS asserts the pilot tests with consumers are "voluntary." How has this been communicated with consumers? When the government visits an elderly frail and/or disabled individual applying for public benefits, does that constitute a duress-free environment where one can freely give consent?
- How were the protocols and forms used in the pilot vetted with stakeholders?
- How were the counties in the pilot selected? Are the counties receiving special resources for the pilot?
- How many social workers are being utilized for the pilot in each?
- What are the exact dates of the beginning and endings of the pilot?
- When is the evaluation for the pilots due? What are the key questions and indicators around the evaluation?

$5,000 Cameras

- On what authority are you borrowing these devices? Under what arrangements or with what conditions were these loaned to the state? Is the state in a position to accept a gift of this kind?
- What are the two model devices being tested and how much does each one cost?

- Is a warranty provided on these? How long will they last? What are the expected repair or refresh costs for the cameras being considered?

- Through what process were the vendors being considered selected?

- How many cameras are expected to be purchased for statewide rollout? There are approximately 2,400 active IHSS caseworkers – how will the cameras be managed among them properly?

SFIS Readiness

- How did the administration and vendor arrive at its projected costs for the eight-year term of the changeover required by this, costing $41.6 million total?

- How might the cost figure fluctuate? How does the change order restrict additional refresh or inflationary costs?

- What is the spending authority in the current year for consumer fingerprinting? Is this for use of SFIS as it relates to IHSS?

- How many SFIS workstations are there? How long will it take to prepare them to be available for statewide implementation?

- Can information be processed prior to SFIS reprogramming? Is there a manual workaround being provided to the counties? Is this accounted for in your costs?

- How long will it take to reprogram SFIS in order to download information from the devices? What if there is a delay?

Costs

- How much of your current year authority has been expended and under what cost categories?

- What are the General Fund costs of the administration's proposal for finger imaging and picture-taking of consumers, counting for all costs, for current and budget years?

- What response has the state received from the federal government on its requests?

Statewide Implementation

- What is the plan for stakeholder collaboration to formulate the April 1, 2010 protocols for implementation of the consumer finger imaging policy?

- What is the specific timeline and plan for draft and final instructions, mailers, bulletin board postings, etc. for implementation of this policy?

- How will exemptions per the statute be determined? What conditions and expectations are being built around issues of linguistic and cultural sensitivity?

2. COMPLETION OF PROVIDER ENROLLMENT PROCESS

It is estimated that approximately 385,000 providers who were enrolled prior to November 1, 2009 are required to undergo most of the same requirements that new providers are subject to by a deadline of June 30, 2010. These requirements include the criminal background check, completion of orientation at the time of enrollment for new providers, and signed acknowledgement of receipt of orientation materials for current providers.

Remaining questions for the Administration include:

- What is the outlook and what are the challenges for meeting the requirements for current providers before the June deadline?
- What are the consequences for a current provider who has not met the requirements on July 1, 2010, the day after the deadline?
- What instructions will be provided to the counties in preparation for July 1, 2010 and on what timeline?
- What will happen to recipients' access to services on July 1, 2010 if there is a huge backlog of current providers who have not yet been able to complete all of the requirements?

3. EVALUATION AND ASSESSMENT

There are several areas in the IHSS reforms for which implementation has not yet begun or the implementation activities have not been shared with stakeholders. These include:

- The targeted mailing policy for providers and recipients;
- The unannounced home visit policy when there is cause for concern about program integrity;
- The policy limiting the use of P.O. boxes by providers to receive paychecks;
- Training for social workers on fraud prevention;
- Notification to providers about their clients' authorized hours and service levels; and,
- Changes to timesheets, including fingerprinting and certification after notice of possible criminal penalties for fraud.

There are many questions related to these proposal that have been outlined in prior agendas prepared for the three oversight hearings conducted in the Fall of 2009 and in January 2010. Some of the questions raised in those hearings that remain unanswered include:

- What is the plan for stakeholder collaboration, drafting, and approval of protocols for implementation of the home visit policy?

- What is the plan for stakeholder collaboration, drafting, and approval of protocols for the implementation of the targeted mailing policy? What is the specific timeframe for commencing targeted mailings?

PUBLIC AUTHORITY ADMINISTRATION

Public Authority Administration. In 2009–10, the Governor proposed $23.3 million General Fund for support of the public authorities. The Legislature reduced General Fund support for public authority administration by $4.7 million. The Governor subsequently vetoed an additional $8.6 million, for a total reduction of about $13.3 million. The IHSS public authorities essentially represent the county in provider wage negotiations. Besides collective bargaining, the primary responsibilities of public authorities include (1) establishing a registry of IHSS providers who have met various qualification requirements; (2) investigating the background of potential providers; (3) establishing a system to refer IHSS providers to recipients; and, (4) providing training for providers and recipients. While the 2009-10 budget agreement included manifold new, substantial requirements for current IHSS providers, numbering 385,000, as well as new providers, this reduction was taken in one of the areas of system supports for the program.

PANELISTS

- DSS – Please be prepared to address the questions listed in the agenda for each of the sections identified.

- Legislative Analyst's Office

- Department of Finance

- Janie Whiteford, IHSS Coalition

- Mark Beckwith, IHSS Consumer, Advocate with Northern California ADAPT, and Member, Advisory Board of Alameda County IHSS Public Authority

- Deborah Doctor, Legislative Advocate, Disability Rights California

- Jovan Agee, United Domestic Workers of America / AFSCME

- Representative, SEIU California

- Nancy Schulz, Napa County Public Authority Manager

- Supervisor Shirey Zane, Sonoma County

- Frank Mecca, County Welfare Directors Association of California

- Public Comment

Staff Recommendation:

Staff recommends consideration of the following actions (each recommendation may be taken as a separate motion):

1. Rejection of the Administration's proposal for six new positions and holding open the request for $500,000 in authority to contract for support in developing the required report. This is consistent with action taken in the Senate.

2. Direction to the DSS to provide a plan answering the questions raised in the agenda around the April 1 Fingerprint Imaging of Recipients reform by May 14, 2010.

3. Direction to the DSS to provide an update to the Legislature at May 14, 2010 on the July 1, 2010 provider enrollment deadline, delineating a detailed timeline for county instructions regarding the CMIPS workaround and a narrative listing describing the changes being made or that have already been made in CMIPS relevant to the July 1 date.

4. Direction to the DSS to coordinate and conduct a stakeholder working group, including representatives from consumer and provider groups, to meet on a regularly scheduled basis (e.g. monthly) where the administration will describe its implementation efforts across the reforms and provide written updates to this effect, answer questions from stakeholders, and take feedback on issues of concern. DSS is instructed to look to the Department of Developmental Services for a current model on this type of stakeholder convening and process.

5. Adoption of placeholder trailer bill language to require the administration, led by the Health and Human Services Agency, to collaborate with stakeholders, including academia and social science experts in the field, to construct a cost-benefit model for analysis of anti-fraud reforms going forward and present a report on the considerations, costs, thresholds for fraud deterrence assumptions, and risks that should be assessed for (1) implementation of reform proposals in IHSS and (2) for future reform proposals in IHSS or other social service programs. This model needs to include all costs and benefits and specifically detail the basis for all assumptions, including the analytical basis for deterrence assumptions. This report shall be due to the Legislature by March 1, 2011. Reforms to be implemented that should be subject to this cost-benefit analysis include the unannounced home visits, timecard fingerprinting, and targeted mailing policies that have yet to be developed, fully analyzed for costs, or implemented.

ISSUE 3: SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP) PROGRAM – PROPOSED FURTHER GRANT REDUCTION

Supplemental Security Income/State Supplementary Payment (SSI/SSP) grants are provided to aged, blind, and disabled recipients as a means of basic support for living expenses. In 2009, there were roughly 956,000 SSI/SSP households in California, representing about 1.25 million recipients. General Fund appropriated for SSI/SSP 2009-10 is $1.26 billion and total program funding is $5.5 billion.

2009-10 REDUCTIONS

Federal COLA Rescinded May 2009. In the February, 2009 special session, a 2009 federal cost-of-living adjustment was rescinded effective May 1, 2009, and grants were reduced 2.3 percent ($20 for individuals and $35 for couples) effective July 1, 2009.

October 1, 2010 Additional Reduction. This decrease meant that grants were further reduced, effective October 1, 2009, by $5 (0.6 percent) for individuals and $82 (5.5 percent) for couples. Couples' maximum grants of $1,407 per month are now at the MOE floor (around 116 percent of FPL). The SSI portion of grants will not receive a 2010 federal COLA. An estimated 2 percent of the federal COLA will, however, take effect January, 2011. The state must pass those funds through to recipients.

State SSP COLA Eliminated. As a result of the budget agreement last year, the state SSP COLA was eliminated permanently, and can only be enacted by a future change in statute.

Reductive Effect for CAPI. Grants for individuals in the Cash Assistance Program for Immigrants (CAPI) declined alongside the SSI/SSP reductions. CAPI payments are equivalent to SSI/SSP payments, less $10 per month for individuals and $20 per month for couples.

GOVERNOR'S PROPOSAL

The Governor's budget proposes to reduce, effective June 1, 2010, SSI/SSP grants to individual recipients. The proposed SSP grant would be set at the federally required MOE level of the 1983 payment standard. Savings include those resulting from grant reductions in the Cash Assistance Program for Immigrants and California Veterans Cash Benefit, as these grant levels tie to those for SSI/SSP.

Below Poverty Level Grants for Aged, Blind, and Disabled Individuals. Maximum grants for around one million aged, blind or disabled individual SSI/SSP recipients would be reduced from $845 to $830 monthly (92 percent of Federal Poverty Level (FPL).

Loss of Benefits for Thousands as a Result. 8,776 recipients would become ineligible, some of whom may seek services from DDS.

MOE Considerations. The federal MOE limits reductions states can make to SSP benefit levels without penalty. If a state reduced SSP benefits below the MOE, it would lose federal Medi-Cal funding.

Decline in Purchasing Power. Due to the suspension of numerous COLAs throughout the years, the purchasing power of SSI/SSP has declined compared to what it would have been had it been adjusted per inflation. This is displayed in the chart below.

SSI/SSP GRANT HISTORY – FOR INDIVIDUALS

		June 1990 Grant Adjusted for Inflation	Actual Grant
Jan-90	Jun-90	$630	$630
Jan-91	Jun-91	$659	$630
Jan-92	Jun-92	$695	$645
Jan-93	Jun-93	$708	$620
Jan-94	Jun-94	$725	$603
Jan-95	Jun-95	$737	$614
Jan-96	Jun-96	$748	$626
Jan-97	Jun-97	$752	$640
Jan-98	Jun-98	$771	$650
Jan-99	Jun-99	$793	$676
Jan-00	Jun-00	$812	$692
Jan-01	Jun-01	$836	$712
Jan-02	Jun-02	$880	$750
Jan-03	Jun-03	$913	$778
Jan-04	Jun-04	$945	$790
Jan-05	Jun-05	$971	$812
Jan-06	Jun-06	$1,010	$836
Jan-07	Jun-07	$1,048	$856
Jan-08	Jun-08	$1,087	$870
Jan-09	Jun-09	$1,144	$870
Jan-10	Jun-10*	$1,162	$830
Jan-11	Jun-11*	$1,195	$843

ELIMINATION OF CASH-OUT

In California, recipients of SSI/SSP are not eligible for federal food stamp benefits. This is because California has opted to increase the SSP portion of the grant (by $10 monthly) rather than administer food stamps to SSI/SSP recipients. This is known as the food stamp "cash–out" policy.

The Legislature has the option of reversing the cash–out policy to allow SSI/SSP recipients to apply for food stamps. Reversing the cash–out would benefit some SSI/SSP recipients by making them eligible for food stamps, while reducing food stamp benefits for others. Generally,

those who would benefit from the reversal of the cash–out would be those with lower income who live in households comprised only of SSI/SSP recipients. The households most likely to experience a reduction in food stamp benefits would be in cases where SSI/SSP recipients reside with other existing food stamp recipients whose total income tends to be higher.

Staff Comment. There are critical, differing analyses on who would benefit and who would lose as a result of this potential policy shift. The Legislature would benefit from an examination of the potential net benefits of reversing the food stamp cash–out policy.

PANELISTS

- Department of Social Services
- Legislative Analyst's Office
- Mike Herald, Western Center on Law and Poverty
- Department of Finance
- Public Comment

Possible Questions

- What are the expectations for how SSI/SSP individuals will grapple with a reduced grant?
- What is the general health status for SSI/SSP recipients?

Staff Recommendation:

Staff recommends the following:

1. Holding open the grant reduction proposal for SSI/SSP open pending May Revision.
2. Adopt placeholder trailer bill language to establish a working group of stakeholders, to include policy and budget staff of the Legislature, to evaluate the estimated effects of eliminating California's SSI cash-out policy.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) is responsible under the Lanterman Act for ensuring that more than 240,000 Californians with developmental disabilities receive the services and supports needed to live independent and productive lives. To be eligible for services, the disability must begin before the consumer's 18th birthday; be expected to continue indefinitely, present a significant disability; and be attributable to certain medical conditions, such as mental retardation, cerebral palsy, epilepsy or autism.

Services are delivered through four state-operated developmental centers (Fairview, Lanterman, Porterville, and Sonoma) and two community facilities, and under contract with a statewide network of 21 nonprofit regional centers (RC's). Approximately 99 percent of consumers live in the community and slightly more than one percent lives in a State-operated Developmental Centers.

ISSUE 1: ADDITIONAL RESOURCES TO INCREASE FEDERAL FUNDS PARTICIPATION

The Governor's Budget requests five two-year, limited-term position and the associated cost of $515,000 ($228,000 General Fund and $287,000 in reimbursement authority).

BACKGROUND

The Department of Developmental Services was required to make a $334 million reduction in 2009-10. As a part of the $334 million savings plan, the Department assumed a significant amount of additional Federal Financial Participation (FFP). This proposal would help the Department implement this proposal.

The additional positions will help the Department capture $78.8 million Federal Financial Participation (FFP) in 2009-10 and $132.5 million in 2010-11. Of these new federal dollars, $64.6 million FFP and $117.1 million in 2010-11 are associated with:

(1) Submission to the Centers for Medicare and Medicaid Services (CMS) of a 1915 (i) Medicaid State Plan Amendment (SPA). The SPA allows for federal funds for services to consumers who are Medi-Cal eligible, but are not on the existing Home and Community-Based Services (HCBS) Waiver.

(2) Submission to CMS of a state plan amendment seeking federal participation in cost of the day and non-medical transportation services received by regional center consumers residing in Skilled Nursing Facilities (SNF's), as well as day and transportation services of Intermediate Care Facilities –Developmental Disabilities (ICF-DD) residents.

(3) Working with DHCS and CMS to develop a payment process for providers receiving Medicaid dollars through the 1115 Medi-Cal waiver.

STAFF COMMENT

The new waiver submission will help the state address consumers who are on Medi-Cal, but are not eligible for the Home and Community Based Waiver because they do not meet the institutional level of care required for Waiver eligibility. Specifically, $64.6 million and $117.1 million in 2010-11 will maximize FFP for regional center consumer services.

Early establishment of these positions was necessary in order for the Department to generate the required $64.6 million this current year. As a result, the Department administratively established the positions January 1, 2010 and redirected resources to fund current year costs. However, the Department is currently under furlough days and has no elasticity to absorb long-term cost. Therefore, the establishment of five two-year, limited-term positions as of July 1, 2010 is still necessary to ensure the success of the three SPA's and ultimately, the 1915 (i).

The Departments current vacancy rate is 8 percent, but due to the magnitude of the work to be accomplished, approval of this proposal is critical to obtain future federal funds, achieve the General Fund (GF) savings, reduce reliance on state general fund dollars in the delivery of services to individuals with developmental disabilities and make California the second state with an approved CMS 1915 (i).

PANELISTS

- DDS –please comment on the need/benefits of these positions.
- DOF
- LAO –please share your position on this proposal.

Staff Recommendation: Approve as budgeted.

ISSUE 2: APRIL FINANCE LETTER: LANTERMAN DEVELOPMENTAL CENTER CLOSURE PLAN

Proposal. The Administration announced the closure of Lanterman Developmental Center (Lanterman) on January 29, 2010 and has since submitted an April Finance Letter for the closure. The closure has been proposed for three reasons: (1) its declining population, (2) the fixed expenses necessary to operate the facility (LDC has the highest per-resident cost among the developmental) and (3) the facility's aging infrastructure/repair needs to both water and sewer system cost.

The Closure plan was submitted pursuant to Section 4474.1 of Welfare and Institutions Code which requires the Department to provide a plan to the Legislature not later than April 1 and as a part of the Governor's proposed budget. The plan also included the required State statute categories –including a description of the residents, alternative placements, details of where services will be provided, summary of public testimony from meetings convened by DDS, methods for on-going communication, impact on RC services, potential job opportunities for employees, a description of the building and property, major implementations and timelines and the fiscal impact of closure.

BACKGROUND

Located in eastern Los Angeles County on the western end of the City of Pomona, Lanterman Developmental Center consists of three separate parcels with a total acreage of 286.6. Lanterman provides three levels-of-care; general acute care hospital needs, intermediate care facility (ICF), and a nursing facility (NF). As of March 3, 2010 it serves 393 consumers and employs 1,280 staff. Lanterman once housed 3,000 individuals, but has been experiencing a steady decline in resident population, ranging from 29 to 47 residents each year since 2006.

The Acute Care Hospital averages 7 residents per day, with an average length stay of 7 days per visit. The NF has 92 residents, or 23 percent of the residents, living on one of the five NF residences. The ICF has 301 residents, or 77 percent of the residents, living in one of the eleven ICF facilities.

Below are some details and highlights in comparison to Agnews Developmental Center.

	Agnews	Lanterman
Years of Residence	34% of residents lived there between 21-30 years (30% over 30 years).	59% of residents have lived there over 30 years.
Age	65% of residents were over the age of 40 years of age.	80% of residents are over the age of 40 years of age. *There are no children residing at Lanterman.
Gender	63% male and 37% female.	59% male and 41% female
Highest Level of retardation	41% "Profound Retardation."	77% "Profound Retardation."
Other	-	49% vision difficulties 18% hearing impairment 54% have epilepsy
Total Population (Prior to starting closure process)	376 (June 30, 2004)	393
Separation from Employment	1,294	1,280
Annual Budget Base	$78.5 million in 2006-07. $49.5 million in 2009-10.	$111.8 million in 2006-07. $116.5 million in 2009-10.
Duration of Closure Process	5+ years	At least 2 years

Closure Details. Overall the goal of the Department is to mirror closure as closely to the Agnews Closure as possible, but consider the differences between the two facilities. The core components for planning are: (1) the Individualized Program Plan (IPP), (2) the Placement Planning Process, (3) the Individualized Health Transition Plan (IHTP) and (4) Monitoring Resident Transition. The Department notes that this closure will be person-centered and the IPP will inform transitions. Additionally, a Quality Management System will inform remediation and improvement of the transition plan for consumers.

Community Resource Development. Over 99 percent of the individuals who reside in Lanterman are being served by a Southern California Regional Centers (RC's). Of the 12 RC's actively involved, the majority are served by San Gabriel/ Pomona RC (81 residents) and North Los Angeles County RC (71 residents). The key RC's have created the "Southern California Integrated Health and Living Project" to develop a variety of residential resources for targeted needs.

Each regional center will provide the DDS with detailed Community Placement Plans (CPP) for their service system area. The CPP aids in the move from a developmental center to community-based services. Based on these plans, the DDS provides supplemental funding to the RC's. These plans are updated biannually, or more if warranted as individuals transition.

Community Living Options. Various community options are to be available to consumers including: (1) supported living services; (2) Adult Residential Facilities for Persons with Special Health Care Needs (962 Homes); (3) Adult Family Homes; (4) Family Teaching Homes; and (5) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD).

Adult Residential Facilities for Persons with Special Health Care Needs (or 962 Homes) were established by SB 962 (Chesbro, 2005). These homes are established licensed residential projects designed for individuals with special health care needs and intensive support needs.

Services provided include: nutritional support, gastronomy feeding and hydration, renal dialysis, and special medication regimes including injections, intravenous medications, management of insulin, catheterization, and pain management. Nursing staff are on-duty 24-hours per day. These homes are required to follow existing law by: (1) Developing an Individual Health Care Plan that is updated at least every six months; (2) examinations by the consumers physician every six months; (3) a visit from a RC nurse at least every month; (4) DDS approval of the program plan and on-site visits to the home at least every six months; and (5) Licensure by the Department of Social Services of the home.

The DDS proposes trailer bill language to expand the 962 Homes model for Lanterman. The language provided, in **attachment 1**, creates a direct link between the 962 Homes and the RC Community Placement Plan, eliminates the 2005 language that established these homes as a pilot program for Agnews Developmental Center, gives DDS authority to establish reimbursement rates for these facilities and requires direct care personnel to have more in-service training as specified and for Administrators to have completed a certification program.

Access to Health and Medical Services. Health and Medical Services will be coordinated with the RC's and the Department of Health Care Services (DHCS), to ensure the availability of health, dental, and behavioral services. Memorandums of Understanding (MOU's) have been established with County Mental Health Plans and staff supporting the consumer in the community will be trained on implementing behavioral and mental health plans. Furthermore, as done in Agnews Developmental Center, through legislation guided by Senator Alquist, DDS proposes to operate an Outpatient Clinic at Lanterman through the closure process (**attachment 2)**.

Summary of Employee Workforce Information. As of March 1, 2010, there were 1,280 employees at Lanterman. Of these employees, 91 percent are full-time, 4 percent are part-time, and the status of the remaining 5 percent is intermittent, temporary, or limited-term. Forty-eighth of the employees have worked at Lanterman for 10 years or less, thirty percent of the staff has been employed at the facility between 11 and 20 years and the remaining 22 percent have worked at Lanterman for 20 years of more.

Lanterman classifications include: (1) direct care nursing (50 percent of the staff) such as registered nurses, psychiatric technicians, and psychiatric technician assistants; (2) level-of-care professionals (10 percent) such as physicians, rehabilitation therapist, social workers, teachers, respiratory therapist, physical and occupational therapist, and others; (3)Non-level-of-Care and administration support (40 percent), such as dietary employees, plan operations, health and safety, quality assurance reviewers, personnel and fiscal services and facility supervisors and managers.

The DDS is committed to the establishment and implementation of employee supports that promote workforce stability and provide opportunities for employees. A *Staff Support Advisory Group* is to be convened to ensure continuity of staffing, encourage camaraderie as the facility transitions and identify needs of employees. The DDS will communicate through monthly newsletters, regular employee meetings, give direct access to the DDS website for updated information on the closure and use of a hotline, so employees can submit questions to Lanterman managements for a response.

The Department has also included plans for an Employee Career Center, Voluntary Transfers to Other State Positions, Opportunities at other Developmental Centers and allow for staff to transition into positions within community services. AB 1378 (Lieber, 2005) provided State staff

to utilize their expertise in the community to meet the needs of residents transitioned into the community and to retain their State employee status. The DDS is proposing trailer bill language to expand this program to include Lanterman employees. **Attachment 3** would allow Lanterman employees to be contracted out by RC's or other DC's, if they choose, to work in the community and maintain their salaries and benefits, as was done with Agnews employees.

Budget. Lanterman has the highest per-resident cost among the Developmental Centers at $289,000 per resident based on existing expenditures. Currently, the DDS budget includes $116.5 million to serve 393 residents. The Department believes closure can take place without requesting additional resources if its existing level of funding is maintained. Funding through the RC Operations and Purchase of Services for consumers residing in the community is also provided, along with supplemental funds for Community Placement Program plans to increase capacity. The plan includes high-level fiscal assumptions of DC costs and Community Cost, but does not provide dollar amounts for each.

Future funding may be attained through the federal "Money Follows the Person" grant for staffing and consumer cost in the community during the first year of transition. Additionally, the DDS notes that almost all residents are Medi-Cal eligible and over 75 percent are also eligible for federal Medicare services.

Timeline. Closure will only occur when the necessary services and supports are in place for the closure and each resident has transitioned from the facility. No specific date has been set, but the Department notes that this closure will occur over at least two years.

STAFF COMMENT

This closure is a continuation of the national trend and State and Federal policies to deinstitutionalize people with developmental disabilities. The Departments considerations for the consumer's health and safety are shown in the careful proposals outlined in their Closure Plan and the trailer bill proposed. However, the plan is not ready for approval by the Legislature, for three key reasons; (1) the community should be included in the hearing process, (2) further oversight and monitoring to ensure transparency, accountability, adherence to State and Federal laws and protect the health and safety of consumers should be in place before approval, (3) the LAO will be releasing their analysis, where they encourage the Legislature to consider the lack of fiscal details.

It is recommended to leave this issue remain open for discussion at the Governor's May Revision, including the budget bill language and trailer bill language.

Bill language to be considered in the future includes:

1. Adoption of Budget Bill Language to require the DDS to provide a comprehensive status report of the Lanterman Plan by January 10 and May 14 of each fiscal year. (**Attachment 4**).

2. Adopt modified Trailer Bill Language to direct the DDS to provide outpatient clinic services at Lanterman Developmental Center, just as was done in the Agnews Developmental Center Closure. (**Attachment 2**).

3. Adopt modified Trailer Bill Language to have the Secretary of Health and Human Services Agency to verify protocols as noted for the health and safety of individuals transitioning from Lanterman. (**Attachment 5**).

4. Adopt modified Trailer Bill Language to provide for cost-based reimbursement for Health Plans serving consumers transitioned from Lanterman to ensure health care coverage, as was done in Agnews. (**Attachment 6**).

5. Adopt placeholder trailer bill language, provided by the DDS for Lanterman staff to be contracted out, if they choose, to work in the community, as was done in Agnews. (**Attachment 3**).

6. Adopt placeholder trailer bill language provided by the DDS to expand Adult Residential Facilities for Persons with Special Health Care Needs (962 Homes) so this residential model can be provided state-wide. (**Attachment 1**).

Questions:

Please provide a summary of the key aspects of the Lanterman Closure Plan.

How will consumers and interested parties stay informed and included in the progression of this closure?

What is the availability in other Developmental Centers, for residents who want to transition to another DC?

How much, on average, does it cost now to keep the former Agnews clients in either ICF's or 962 homes?

How are the areas Regional Centers coordinating efforts to meet the needs of the consumers?

How does DDS track those who have gone to live in "community" homes?

Considering the multiple reductions to regional centers, does the Department feel confident that the services are available to intake this population into the community? Will funding be seeked to address this need?

PANEL #1

It is requested that the Department present its Plan, including key components, and core next steps and address the questions above. Additionally, the Legislative Analyst Office (LAO) will present their position and key considerations the Legislature should consider.

- DDS
- DOF
- LAO

PANEL #2

- Terry DeBell, Representing the Families from Lanterman
- George Stevens, Executive Director of North Los Angeles Regional Center
- Michael Clark, Executive Director of Kern Regional Center
- Marty Omoto, California Disability Community Action Network
- William Leiner, Staff Attorney for Disability Rights California
- Robyn Herrera, SEIU Local 1000
- Tony Anderson, Executive Director for The Arc of California

Staff Recommendation: Hold item, budget bill language and trailer bill language in attachments 1 through 6, open for May Revision.

ISSUE 3: UPDATE ON AGNEWS DEVELOPMENTAL CENTER CLOSURE

BACKGROUND

The Agnews Developmental Center Closure (located in San Jose, Ca.) began July 1, 2004. Between 2004 and March 27, 2009, a total of 327 Agnews' residents transitioned to living arrangements in the community, including 5 who returned to their families and 20 who transferred to other developmental centers.

The Agnews closure was a process driven by the availability of housing and support services. In this closure, the Department established affordable community housing for Agnews residents. Through the Bay Area Housing Plan (BAHP), the department implemented the 962 Home Model (introduced by Senator Chesbro's Senate Bill 962), family teaching homes (FTHs) and specialized residential homes (SRHs) facilitated transitioning into the community.

The Department also helped Agnews employees by proposing Legislation that would authorize Agnews' employees to work in the community to support the transition of Agnews' residents into the community living options. Additional efforts to help employees included, career center services, job fairs and professional training. Overall, this closure has served as the successful model for the Department.

Agnews Community Clinic. With the last resident leaving Agnews March 27, 2009, DDS operates Agnews Community Clinic, to provide a safety net for health, dental and behavioral services to former Agnews' residents, as well as other people within the local community who have a developmental disability. Funding for the clinic is reimbursed from MediCaid.

Warm Shutdown. The facility is currently under Warm Shutdown, which requires 25 Personnel Years (PY's) for risk and liability maintenance. The 2010-11 Budget for Warm Shutdown is $4.8 million ($2.8 million GF). The daily cost incurred for Warm Shutdown is $12,328.

According to the Department, about one-third of the PY's are 24-7 employees for security and releasing steam. Another one-third is tasked with technical duties such as, electricity, maintenance and weekly walkthroughs. The remaining PY's are administrative positions who maintain records, including fiscal records. The Department is required by law to maintain the property "desirable."

Agnews land was included in Senate Bill 136 (2009) as part of the state's surplus property. The Department of General Services (DGS) placed the property on the market January 1, 2010 and to date, there has been one interest.

STAFF COMMENT

DDS states that they are actively working on "disposal." One of the limitations to cost and disposal of the property can very well be an agreement with a Plant, which requires DDS to release steam daily from the cogeneration plant. The sale of the land will require some mechanism for disposition of the cogeneration plant and/or the contract associated with the plant, which is set to expire 2020.

PANELISTS

- DDS –Please provide a brief overview of the Final Agnews Report.
- DOF
- DGS –Please respond to the questions below.
- LAO

Questions:

DGS- Who is the interest in the property? Is it a viable buyer?

What is the approximate value of the property?

What is the consequences/cost of terminating the contract with the cogeneration plant? Will termination be pursued?

Comparing it to other property sales similar to this one, what is the Departments best estimate to sell this property?

Staff Recommendation: The Committee may wish to request an update from DGS in written form by June 1, 2010 that outlines: (1) an update on "disposal" of the property and (2) whether a mechanism to end the contract associated with the cogeneration plant will be pursued and if so, give specifics including cost.

ISSUE 4: UPDATE ON 2009-10 IMPLEMENTED BUDGET REDUCTIONS

The Budget Act of 2009 proposed a $334 million (GF) reduction, with a corresponding federal fund reduction. The Legislature restored $234 million (GF) of this amount in its February 2009 budget, thereby reducing the DDS expenditures by only $100 million (GF). As part of this February Action, the Legislature directed the DDS to convene a diverse "workgroup" to assist in developing a cost reductions and efficiencies plan. Fifteen proposals were identified through this process. However, the State's fiscal status deteriorated and the Legislature was compelled by the Governor to reduce the DDS budget by another $234 million (GF).

Ultimately, the DDS was instructed to make a $334 million reduction. In conjunction with the workgroup resulted in 25 proposals that would generate the desired savings.

BACKGROUND

The 25 implemented proposals are as follows:

Proposal	Description	Anticipated Savings	Update
1. Expanded Federal Funding	(a) amending the 1915 (i) Medicaid plan, (b) adding services to existing waivers, (c) pursue the Department becoming an Organized Health Care Delivery System and (d) restricting regional centers from purchasing community care that does not qualify for federal Medicaid funds.	$78.8 million General Funds	Savings will be achieved.
2. Changes to Developmental Centers	(a) Closure of Sierra Vista, (b) Delayed capital outlay, (c) transfer of 30 Porterville residents, (d) furloughs and (e)staff reductions	$27.2 million General Funds	Savings will be achieved.
3. Changes to Regional Center (RC) General Standars	(a) Prohibit purchase of experimental treatments, therauputic services or devices, (b) require RC's to use generic services when available, (c) Medical and dental services will not be purchased without denial from insurance, (d)use of least costly provider and (e) RC's will provide consumers a summary of cost and services each year	$45.9 million General Funds	Savings will not be achieved, but it is difficult to tell which implementation is or is not on track.
4. Transportation Reform	(a) Requires RC to pursue lower cost transportation services that can meet the consumer's individual needs, including: public transportation and utilizing the familiy as the source of transportation.	$16.9 million General Funds	Savings will be achieved.

5. Uniform Holiday Schedule	(a) This proposal standardized the holidays schedule for most day programs, look-alike day programs and work activity programs and (b) extended the number of holidays from 10 to 14 days.	$16.3 million General Funds	Savings will be achieved.
6. New Service for Seniors at Reduced Rates	This proposal required most day programs, look-alike day programs and work activity programs to offer a senior component to their current program design. *This was an optional new service.	$1 million General Funds	Savings have not been achieved.
7. Custom Endeavors Option	This proposal expanded (through day programs, look-alike day programs and work activity programs) options for consumers to gain employment, work experience through volunteerism, and/or start their own business. *This option is provided to consumers through their Individual Program Plan (IPP).	$12.7 million General Funds	No savings have not been achieved. Only 11 participants have enrolled.
8. In-Home Supportive Services (IHSS)	Requires RC's to use generic services such as IHSS by: (a) requiring providers to help consumers get IHSS within 5 days of moving into supported living and (b) paying providers the IHSS rate for IHSS type services, while the consumer is waiting for IHSS services.	$1.3 million General Funds	Savings will be achieved.
9. Supported Living Services (SLS)	(a) RC's will work with SLS providers on rates of payment no higher than the rate on July 1, 2008, (b) unless needed to implement the consumers IPP RC's are not allowed to pay a consumer's rent, and (c) as long as needs are met, the RC will attempt to have consumers who share a home use the same SLS provider.	$6.9 million General Funds	Savings will be achieved.
10. Utilization of Neighboorhood Preschools	Supports a different service delivery model whereby families, can have their toddler's attend local preschools with the RC's also providing the necessary supports.	$8.9 million General Funds	Savings will be achieved.
11. Group Training for Parents on Behavioral Intervention Techniques	Required RC's to consider providing group training to parents in lieu of proving some or all of the in-home parent training component of the behavior intervention services.	$6.4 million General Funds	Savings will be achieved.

12. Behavioral Services	Established RC to: (a) purchase Applied Behavior Analysis (ABA) or Intensive Behavior Intervention (IBI) services if the service provider uses evidence-based practices and the service promotes positive social behaviors; (b) in order to purchase ABA or IBI parents of children must participate as described in the intervention plan; (c) ABA or IBI may not be used for purposes of providing respite, day care, or school services, or solely as emergency crisis services; (d) RC's will discontinue purchasing particular ABA or IBI when the consumer's treatment goals are achieved; (e) ABA or IBI hours will be evaluated at least every 6 months.	$19.3 million General Funds	Savings will be partially achieved.
13. Early Start – Eligibility Criteria	Elimination of eligibility for "at risk" infants and toddlers age 24 months or greater who are 'developmentally delayed' or have a risk of a developmental delay.	$15.5 million General Funds	Savings will be achieved, but it may be due to population decreases.
14. Early Start Program Proposals (Prevention Project)	Established a limited services program for those no longer eligible for Early Start. Services are restricted to case management, and information and referral to other agencies. RC's are also not required to provide: child care, diapers, dentistry, access to an interpreter and translator, genetic counseling, music therapy, and respite hours.	$19.5 million General Funds	Savings will be achieved.
15. Early Start – Use Private Insurance	Required parents of children under 3 to ask their private insurance or health providers to cover medical services.	$6.5 million General Funds	Savings will be achieved.
16. Expansion of In-Home Respite Agency Worker Duties	Allowed respite workers to assist consumers with colostomies/ileostomies, catheters and gastronomies.	$3.0 million General Funds	Savings will not be achieved. No applications were received.
17. Parental Fee Program	Established a monthly fee that varies by family size and income.	$900,000 General Funds	A $500,000 savings has been achieved. The Department notes that the state of the economy has impacted a family's ability to pay.

18. Individual Choice Budget	This proposal would implement the ICB, which would give consumers flexibility. It would save money in purchase of service expenditures.	No savings until implemented	This proposal has not been implemented.
19. Respite Program – Temporary Service Standards	The proposal limited out of home respite to a maximum of 21 days per year and in-home respite to a maximum of 90 hours per quarter (30 hours per month). It also prohibited the use of respite for Day Care services. *This proposal will be lifted upon certification of the Individual Choice Budget.	$4.8 million General Funds	Savings have been exceeded.
20. Temporary Suspended Services	Temporarily suspended: (a) social/recreational activities, (b) camping services, (c) educational services for minor, school-aged children, and (d) non-medical theraphies.	$27.4 million General Funds	Savings have not been fully realized. This may be due partially, because the proposal was implemented after the summer and the number of exemptions granted through the fair hearing process.
21. Quality Assurance Consolidation	Combined quality assurance studies.	$2.0 million General Funds	Savings will be achieved.
22. Suspended Wellness and Physician Training Program	Suspended training for consumers, families, providers and physicians.	$1.3 million General Funds	Savings will be achieved.
23. Eliminate Triennial Quality Assurance Review	Eliminated funding for triennial reviews, but maintained quarterly consumer visits and an annual facility monitoring visit.	$1.0 million General Funds	Savings will be achieved.
24. Reduction in One Time Regional Center Funding	Further reduced funding for RC's.	$3.5 million General Funds	Savings will be achieved.
25. Additional Regional Center Operations	This this was an additional reduction to the 3 percent reduction in Operations funding.	$7.0 million General Funds	Savings will be achieved.

Budget Savings			

STAFF COMMENT

At the DDS Work Group meeting on April 19, 2010, the DDS provided an update on current year implementations. The conclusion was that some of the proposals yielded the savings intended, others did not and some exceeded the intended savings. Up to date data is not available to the Department, therefore it has been difficult for the Department to determine the exact reason for outcomes. The Department notes that a decreasing birth rate and various other interrelated factors could be responsible, but notes that those options which were optional, did not achieved the estimated reduction.

Overall, the pressing issues for the committee to consider are the following:

1. Notification of Exemptions: Savings have been exceeded in Respite and in the area of Suspended Services, savings have not been achieved. Issues related to these areas include the process and consistency for notifying consumers of exemptions to these and other implemented reductions. In some cases, consumers have been verbally noticed by regional centers of termination of services and in other cases; consumers have not been informed of exemptions or the fair hearing process. Specifically, clarification on what constitutes "adequate notice" is necessary. Adequate notice should inform the applicant, recipient, and authorized representative in writing of the action the agency proposes to take, whether the individual is eligible for an exemption waiver, exceptional funding, or other exceptions. It is recommended that the committee adopt placeholder trailer bill language (**attachment 7**).

2. Intermediate Care Facilities-DD Billing Issue: In order for the Department to achieve the intended savings for the Expansion of Federal Funding, the approval of the Medicaid State Plan Amendment (SPA) requires Trailer Bill Language. Language provided by the DDS allows for payment of Intermediate Care Facilities for Transportation and Day Treatment Costs, modeled to the process of the Department of Health Care Services. The Department notes that the language has not been finalized. Please see **attachment 8** for the most recent version.

PANELISTS

Please provide a high-level overview of the implemented proposals and their outcome, but provide specific information on the highlighted proposals.

- DDS –Please respond to the questions below.
- DOF
- LAO

Questions:

Please explain the proposed trailer bill language for the technical billing issue on the ICF-DD. (Attachment 8).

Can the Department describe how exemptions are communicated to consumers and information about the fair hearing process is shared with consumers?

Will the Department be on budget?

What is the update on the Individual Choice Budget (ICB)?

Staff Recommendation: Adopt placeholder trailer bill language to clarify what constitutes notification of exemption and adopt in concept the necessary trailer bill language to resolve the ICF-DD billing issue.

ISSUE 5: DEFICIENCY FUNDING REQUEST

The Joint Legislative Budget Committee received notification of Receipt and Approval of Deficiency Funding Request from the Department of Developmental Services. As a result of the outcome of *Shaw v. Chiang* litigation, DDS has a net deficiency of $131,137,000 (GF).

BACKGROUND

As proposed by the Governor, the Budget Act of 2009 (July) appropriated $138,275,000 Public Transportation Account (PTA) funds, to backfill for General Fund support for regional center (RC) transportation services, which are an entitlement under the Lanterman Act. PTA funds derive primarily from sales taxes on gasoline and diesel fuels and its purpose of use is delineated in Section 14506 of the Government Code for expenditures. The Administration believed RC transportation needs were within the intended purpose. However, Shaw v. Chiang disallowed the use of PTA funds for this activity, as well as for other purposes.

As a result, GF is required to maintain the program funding level. The Department was able to offset a net decrease of $7,138,000 GF through a fund shift resulting from the receipt of increased federal funds in the Early Start Part C programs, but a net deficiency of $131,137,000 GF still remains.

STAFF COMMENT

The decision to use PTA funds was made by the Business and Transportation Commission, thus this is a technical issue. However, now the DDS request $131 GF due to re-estimated caseload and expenditures for the 2010-11 November estimate using updated actual data through May 2009. The General Fund backfill is necessary by June 30, 2010 or else the State would be in violation of the Lanterman Act and the "Olmstead" decision.

PANELISTS

- DDS –Please respond to the questions below.
- DOF
- LAO

Questions:

What is the importance of funding this deficiency?

If funds are not appropriated by June 30, what may happen and how will the state be vulnerable to further litigation?

ISSUE 6: $25 MILLION SAVINGS TARGET PLAN

The Governor's January 2010-11 Proposed budget, included a $48.2 million ($25 million GF) reduction to the DDS. To achieve this savings, the Governor is now proposing increasing the 3 percent reduction on both the Purchase of Services and Regional Center Operations by another 1.25 percent, for a total of 4.25 percent on each.

BACKGROUND

The 2010-11 Governor's Budget extended, by one-year, a three percent reduction to Regional Center funding, both for the Purchase of Services and for Operations. The proposal was adopted in the eight extraordinary session by both the Senate and the Assembly.

The adopted reduction accounted for the exemption of SSI and SSP consumers and consumers who regional centers demonstrate that a non-reduced payment is necessary to protect the health and safety of a consumer. The new sunset deadline adopted is June 30, 2011.

Additional Reduction. The additional 1.25% reduction would yield the desired savings of $48.2 million, of this total, $25.3 million is GF. About 82 percent or $39.3 million (total funds) would be from Purchase of Services and about $8.9 million would be from Operations.

In discussion with the department, this proposal would also include a "flex in service contracts" based after a 1992 model implemented by SB 485. This model would implement "provider relief." Trailer Bill Language is currently being developed by the Department.

STAFF COMMENT

Just as in the original consideration of this proposal in February, the primary concern is how this reduction will impact consumers. The impact of the continuation of this reduction includes a decrease in Purchase of Services which may result in the consolidation of programs and therefore limit consumer choices. Impact to regional center operations is difficult to identify, when you have 21 independent regional centers, but it is noted that higher caseloads per case worker will be a direct result and arguably impact quality of service. However, it is noted that a reduction across the board spreads impact throughout the developmental disabilities system.

At this point in time, without further information about the "flex in service contracts" or Trailer Bill Language, staff does not recommend action from the Subcommittee.

PANELISTS

- DDS –Please respond to the questions below.
- DOF
- LAO

Questions:

Did the Department consider any other options? Why was this one selected?

Please further explain the "flex in service contracts." What is envisioned for the Trailer Bill Language?

How will this proposal impact consumers?

Did the Department discuss this proposal with its Budget Advisory Workgroup?

Staff Recommendation: Hold Open until May Revise. Furthermore, the Subcommittee may wish to direct the Department to consult with its Budget Advisory Workgroup and other interested parties.

Attachment 1

Department of Developmental Services
Proposed Trailer Bill Legislation

Amendments to Article 3.5 Adult Residential Facilities for Persons with Special Health Care Needs

Amend WIC § 4684.50 as follows:

4684.50 (a)(1) "Adult Residential Facility for Persons with Special Health Care Needs (ARFPSHN)" means any adult residential facility that provides 24-hour health care and intensive support services in a homelike setting that is licensed to serve up to five adults with developmental disabilities as defined in Section 4512.

(2) For purposes of this article, an ARFPSHN may only be established in a facility ~~financed~~ approved pursuant to Section 4688.5 or through an approved regional center community placement plan pursuant to Section 4418.25.

(b) "Consultant" means a person professionally qualified by training and experience to give expert advice, information, training, or to provide health-related assessments and interventions specified in a consumer's individual health care plan.
(c) "Direct care personnel" means all personnel who directly provide program or nursing services to consumers. Administrative and licensed personnel shall be considered direct care personnel when directly providing program or nursing services to clients. Consultants shall not be considered direct care personnel.
(d) "Individual health care plan" means the plan that identifies and documents the health care and intensive support service needs of a consumer.
(e) "Individual health care plan team" means those individuals who develop, monitor, and revise the individual health care plan for consumers residing in an Adult Residential Facility for Persons with Special Health Care Needs. The team shall, at a minimum, be composed of all of the following individuals:
(1) Regional center service coordinator and other regional center representative, as necessary.
(2) Consumer, and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative.
(3) Consumer's primary care physician, or other physician as designated by the regional center.
(4) ARFPSHN administrator.
(5) ARFPSHN registered nurse.
(6) Others deemed necessary for developing a comprehensive and effective plan.
(f) "Intensive support needs" means the consumer requires physical assistance in performing four or more of the following activities of daily living:
(1) Eating.
(2) Dressing.
(3) Bathing.
(4) Transferring.
(5) Toileting.
(6) Continence.
(g) "Special health care needs" means the consumer has health conditions that are predictable and stable, as determined by the individual health care plan team, and for which the individual requires nursing supports for any of the following types of care:
(1) Nutrition support, including total parenteral feeding and gastrostomy feeding, and hydration.
(2) Cardiorespiratory monitoring.
(3) Oxygen support, including continuous positive airway pressure and bilevel positive airway pressure, and use of other inhalation-assistive devices.

(4) Nursing interventions for tracheostomy care and suctioning.
(5) Nursing interventions for colostomy, ileostomy, or other medical or surgical procedures.
(6) Special medication regimes including injection and intravenous medications.
(7) Management of insulin-dependent diabetes.
(8) Manual fecal impaction, removal, enemas, or suppositories.
(9) Indwelling urinary catheter/catheter procedure.
(10) Treatment for staphylococcus infection.
(11) Treatment for wounds or pressure ulcers (stages 1 and 2).
(12) Postoperative care and rehabilitation.
(13) Pain management and palliative care.
(14) Renal dialysis.

Amend WIC § 4684.53 as follows:

4684.53 (a) The State Department of Developmental Services and the State Department of Social Services shall jointly implement a ~~pilot project to test the effectiveness of providing~~ licensing program to provide special health care and intensive support services to adults in homelike community settings.
~~(b) The pilot project shall be implemented through the following regional centers only:~~
~~(1) The San Andreas Regional Center.~~
~~(2) The Regional Center of the East Bay.~~
~~(3) The Golden Gate Regional Center.~~
~~(c) The regional centers participating in this pilot project may contract for an aggregate total of services for no more than 120 persons in an ARFPSHN.~~
(b)Each ARFPSHN shall possess a community care facility license issued pursuant to Article 9 (commencing with Section 1567.50) of Chapter 3 of Division 2 of the Health and Safety Code, and shall be subject to the requirements of Chapter 1 (commencing with Section 80000) of Division 6 of Title 22 of the California Code of Regulations, except for Article 8 (commencing with Section 80090).
(c) For purposes of this article, a health facility licensed pursuant to subdivision (e) or (h) of Section 1250 may place its licensed bed capacity in voluntary suspension for the purpose of ~~using~~ licensing the facility to operate an ARFPSHN if the facility is selected to participate ~~in the pilot project~~ pursuant to Section 4684.58. Consistent with subdivision (a) of Section 4684.50, any facility ~~selected to participate in the program shall be~~ licensed ~~to~~ under this section shall serve up to five adults. A facility's bed capacity shall not be placed in voluntary suspension until all consumers residing in the facility under the license to be suspended have been relocated. No consumer may be relocated unless it is reflected in the consumer's individual program plan developed pursuant to Sections 4646 and 4646.5.
(d) Each ARFPSHN shall be subject to the requirements of Subchapters 5 through 9 of Chapter 1 of, and Subchapters 2 and 4 of Chapter 3 of, Division 2 of Title 17 of the California Code of Regulations.
(e) Each ARFPSHN shall ensure that an operable automatic fire sprinkler system is installed and maintained.
(f) Each ARFPSHN shall have an operable automatic fire sprinkler system that is approved by the State Fire Marshal and that meets the National Fire Protection Association (NFPA) 13D standard for the installation of sprinkler systems in single- and two-family dwellings and manufactured homes. A local jurisdiction shall not require a sprinkler system exceeding this standard by amending the standard or by applying standards other than NFPA 13D. A public water agency shall not interpret this section as changing the status of a facility from a residence entitled to residential water rates, nor shall a new meter or larger connection pipe be required of the facility.
(g) Each ARFPSHN shall provide an alternative power source to operate all functions of the facility for a minimum of six hours in the event the primary power source is interrupted. The alternative power source shall comply with ~~Section 517-50 of the California Electric Code~~ the manufacturer's recommendations for installation and operation. The alternative power source shall be maintained in safe operating condition, and shall be tested every 14 days under the full load condition for a minimum of 10 minutes. Written records of inspection, performance, exercising period, and repair of the alternative power source shall be regularly maintained on the premises and available for inspection by the State Department of Developmental Services.

Amend WIC § 4684.55 as follows:

4684.55 (a) No regional center may pay a rate to any ARFPSHN for any consumer that exceeds the ~~average annual cost of serving a consumer at Agnews Developmental Center, as determined by the State Department of Developmental Services~~ rate in the State Department of Developmental Services approved community placement plan for that facility unless the regional center demonstrates that a higher rate is necessary to protect a consumer's health and safety, and the department has granted prior written authorization.
(b) The payment rate for ARFPSHN services shall be negotiated between the regional center and the ARFPSHN, and shall be paid by the regional center under the service code "Specialized Residential Facility (Habilitation)."
(c) The established rate for a full month of service shall be made by the regional center when a consumer is temporarily absent from the ARFPSHN 14 days or less per month. When the consumer's temporary absence is due to the need for inpatient care in a health facility, as defined in subdivision (a), (b), or (c) of Section 1250 of the Health and Safety Code, the regional center shall continue to pay the established rate as long as no other consumer occupies the vacancy created by the consumer's temporary absence, or until the individual health care plan team has determined that the consumer will not return to the facility. In all other cases, the established rate shall be prorated for a partial month of service by dividing the established rate by 30.44 then by multiplying the quotient by the number of days the consumer resided in the facility.

Amend WIC § 4684.58 as follows:

4684.58 (a) The regional center may recommend for participation, to the State Department of Developmental Services, an applicant ~~for this pilot project~~ to provide services as part of an approved community placement plan when the applicant meets all of the following requirements: ~~and has been selected through a request for proposals process issued by one or more of the three participating regional centers:~~
(1) The applicant employs or contracts with a program administrator who has a successful record of administering residential services for at least two years, as evidenced by substantial compliance with the applicable state licensing requirements.
(2) The applicant prepares and submits, to the regional center, a complete facility program plan that includes, but is not limited to, all of the following:
(A) The total number of the consumers to be served.
(B) A profile of the consumer population to be served, including their health care and intensive support needs.
(C) A description of the program components, including a description of the health care and intensive support services to be provided.
(D) A week's program schedule, including proposed consumer day and community integration activities.
(E) A week's proposed program staffing pattern, including licensed, unlicensed, and support personnel and the number and distribution of hours for such personnel.
(F) An organizational chart, including identification of lead and supervisory personnel.
(G) The consultants to be utilized, including their professional disciplines and hours to be worked per week or month, as appropriate.
(H) The plan for accessing and retaining consultant and health care services, including assessments, in the areas of physical therapy, occupational therapy, respiratory therapy, speech pathology, audiology, pharmacy, dietary/nutrition, dental, and other areas required for meeting the needs identified in consumers' individual health care plans.
(I) A description, including the size, layout, location, and condition of the proposed home.
(J) A description of the equipment and supplies available, or to be obtained, for programming and care.
(K) The type, location, and response time of emergency medical service personnel.
(L) The in-service training program plan for at least the next 12 months which shall include the plan for ensuring that the direct care personnel understand their roles and responsibilities related to implementing individual health care plans, prior to, or within the first seven days of providing direct care in the home and for ensuring the administrator understands the unique roles, responsibilities, and expectations for administrators of community-based facilities.

(M) The plan for ensuring that outside services are coordinated, integrated, and consistent with those provided by the ARFPSHN.
(N) Written certification that an alternative power system required by subdivision ~~(i)~~ (g) of Section 4684.53 meets the manufacturer's recommendations for installation and operation.
(3) Submits a proposed budget itemizing direct and indirect costs, total costs, and the rate for services.
(4) The applicant submits written certification ~~Certifies, in writing,~~ that the applicant has the ability to comply with all of the requirements of Section 1520 of the Health and Safety Code.
(b) The regional center shall provide all documentation specified in subdivision~~s (b) to (d),~~ (a)(2)-(4), inclusive, of Section 4684.58 and a letter recommending program certification to the State Department of Developmental Services.
(c) The State Department of Developmental Services shall either approve or deny the recommendation and transmit its written decision to the regional center and to the State Department of Social Services within 30 days of its decision. The decision of the State Department of Developmental Services not to approve an application for program certification shall be the final administrative decision.
(d) Any change in the ARFPSHN operation that alters the contents of the approved program plan shall be reported to the State Department of Developmental Services and the contracting regional center, and approved by both agencies, prior to implementation.

Amend WIC § 4684.60 as follows:

4684.60 The vendoring regional center shall, before placing any consumer into an ARFPSHN, ensure that the ARFPSHN has a license issued by the State Department of Social Services for not more than five adults and a contract with the regional center that includes, at a minimum, all of the following:
(a) The names of the regional center and the licensee.
~~(b) The purpose of the pilot project.~~
(b) ~~(c)~~ A requirement that the contractor shall comply with all applicable statutes and regulations, including Section 4681.1.
(c) ~~(d)~~ The effective date and termination date of the contract.
(d) ~~(f)~~ The definition of terms.
~~(e) A requirement that, under no circumstances, shall the contract extend beyond the stated termination date, which shall not be longer than the pilot legislation end date of January 1, 2010~~.
(e) ~~(g)~~ A requirement that the execution of any amendment or modification to the contract be in accordance with all applicable federal and state statutes and regulations and be by mutual agreement of both parties.
(f) ~~(h)~~ A requirement that the licensee and the agents and employees of the licensee, in the performance of the contract, shall act in an independent capacity, and not as officers or employees or agents of the regional center.
(g) ~~(i)~~ A requirement that the assignment of the contract for consumer services shall not be allowed.
(h) ~~(j)~~ The rate of payment per consumer.
(i) ~~(k)~~ Incorporation, by reference, of the ARFPSHN's approved program plan.
(j) ~~(l)~~ A requirement that the contractor verify, and maintain for the duration of the project, possession of commercial general liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence.
(k) ~~(m)~~ Contractor performance criteria.
~~(n) An agreement to provide, to the evaluation contractor engaged pursuant to subdivision (a) of Section 4684.74, all information necessary for evaluating the projects.~~

Amend WIC§ 4684.63 as follows:

4684.63 (a) Each ARFPSHN shall do all of the following:
(1) Meet the minimum requirements for a Residential Facility Service Level 4-i pursuant to Sections 56004 and 56013 of Title 17 of the California Code of Regulations, and ensure that all of the following conditions are met:
(A) That a licensed registered nurse, licensed vocational nurse, or licensed psychiatric technician, is awake and on duty 24-hours per day, seven days per week.
(B) That a licensed registered nurse is awake and on duty at least eight hours per person, per week.

(C) That at least two staff on the premises are awake and on duty when providing care to four or more consumers.
(2) Ensure the consumer remains under the care of a physician at all times and is examined by the primary care physician at least once every 60 days, or more often if required by the consumer's individual health care plan.
(3) Ensure that an administrator is on duty at least 20 hours per week to ensure the effective operation of the ARFPSHN.
(4) Ensure that the administrator ~~shall have~~ completes the 35 hour administrator certification program pursuant to Health and Safety Code 1562.3, subdivision (c)(1) without exception; has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities; and ~~shall meet~~ is one or more of the following ~~qualifications~~:
(A) ~~Be~~ A licensed registered nurse.
(B) ~~Be~~ A licensed nursing home administrator.
(C) ~~Be~~ A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
(D) ~~Be~~ An individual with a bachelor's degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.
(b) The regional center shall ~~may~~ require an ARFPSHN to provide additional professional, administrative, or supportive personnel whenever the regional center determines, in consultation with the individual health care plan team, that additional personnel are needed to provide for the health and safety of consumers.
~~(c)ARFPSHNs may utilize appropriate staff from Agnews Developmental Center.~~
(c) An ARFPSHN shall ensure that all direct care personnel ~~shall be subject to~~ complete the training requirements specified in Section 4695.2.

Amend WIC § 4684.65 as follows:

4684.65 (a) A regional center shall not place, or fund the placement for, any consumer in an ARFPSHN until the individual health care plan team has prepared a written individual health care plan that can be fully and immediately implemented upon the consumer's placement.
(b)(1) An ARFPSHN shall only accept, for initial admission, consumers who meet the following requirements:
(A) Reside ~~at Agnews~~ in a Developmental Center at the time of the proposed placement.
(B) Have an individual program plan that specifies placement in an ARFPSHN.
(C) Have special health care and intensive support needs.
(2) Except as provided in paragraph (3), when a vacancy in an ARFPSHN occurs due to the permanent relocation or death of a resident, the vacancy may only be filled by a consumer who meets the requirements of paragraph (1).
(3) If there is no resident residing ~~at Agnews~~ in a Developmental Center who meets the requirements of subparagraphs (B) and (C) of paragraph (1), a vacancy may be filled by a consumer who is ~~residing at another~~ at risk of placement into a developmental center, as determined by the regional center, and who meets the requirements of subparagraphs (B) and (C) of paragraph (1).
(c) The ARFPSHN shall not admit a consumer if the individual health care plan team determines that the consumer is likely to exhibit behaviors posing a threat of substantial harm to others, or has a serious health condition that is unpredictable or unstable. A determination that the individual is a threat to others may only be based on objective evidence or recent behavior and a determination that the threat cannot be mitigated by reasonable interventions.

§ 4684.68. Individual health care plan requirements; additional requirements relating to medications

(a) The individual health care plan shall include, at a minimum, all of the following:
(1) An evaluation of the consumer's current health.
(2) A description of the consumer's ability to perform the activities of daily living.
(3) A list of all current prescription and nonprescription medications the consumer is using.

(4) A list of all health care and intensive support services the consumer is currently receiving or may need upon placement in the ARFPSHN.
(5) A written statement from the consumer's primary care physician familiar with the health care needs of the consumer, or other physician as designated by the regional center, that the consumer's medical condition is predictable and stable, and that the consumer's level of care is appropriate for the ARFPSHN.
(6) Provision for the consumer to be examined by his or her primary care physician at least once every 60 days, or more frequently if indicated.
(7) A list of the appropriate professionals assigned to provide the health care as described in the plan.
(8) A description of, and plan for providing, any training required for all direct care personnel to meet individuals' needs.
(9) The name of the individual health care plan team member, and an alternate designee, who is responsible for day-to-day monitoring of the consumer's health care plan and ensuring its implementation as written.
(10) Identification of the legally authorized representative to make health care decisions on the consumer's behalf, if the consumer lacks the capacity to give informed consent.
(11) The name and telephone number of the person or persons to notify in case of an emergency.
(12) The next meeting date of the individual health care plan team, which shall be at least every six months, to evaluate and update the individual health care plan.
(b) In addition to Section 80075 of Title 22 of the California Code of Regulations, the ARFPSHN shall comply with all of the following requirements:
(1) Medications shall be given only on the order of a person lawfully authorized to prescribe.
(2) Medications shall be administered as prescribed and shall be recorded in the consumer record. The name and title of the person administering the medication or treatment, and the date, time, and dosage of the medication administered shall be recorded. Initials may be used provided the signature of the person administering the medication or treatment is recorded on the medication or treatment record.
(3) Preparation of dosages for more than one scheduled administration time shall not be permitted.
(4) Persons administering medications shall confirm each consumer's identity prior to the administration.
(5) Medications shall be administered within two hours after dosages are prepared and shall be administered by the same person who prepared the dosages. Dosages shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.
(6) All medications shall be administered only by those persons specifically authorized to do so by their respective scope of practice.
(7) No medication shall be administered to or used by any consumer other than the consumer for whom the medication was prescribed.
(8) Medication errors and adverse drug reactions shall be recorded and reported immediately to the practitioner who ordered the drug or another practitioner responsible for the medical care of the consumer. Minor adverse reactions which are identified in the literature accompanying the product as a usual or common side effect, need not be reported to the practitioner immediately, but in all cases shall be recorded in the consumer's record. Medication errors include, but are not limited to, the failure to administer a drug ordered by a prescriber within one hour of the time prescribed, administration of any drugs other than prescribed or the administration of a dose not prescribed.

Amend WIC § 4684.70 as follows:

4684.70 (a) The State Department of Social Services, in administering the licensing program, shall not have any responsibility for evaluating consumers' level of care or health care provided by ARFPSHN. Any suspected deficiencies in a consumer's level of care or health care identified by the State Department of Social Services' personnel shall be reported immediately to the appropriate regional center and the State Department of Developmental Services for investigation.

(b) The regional center shall have responsibility for monitoring and evaluating the implementation of the consumer's individual plan objectives, including, but not limited to, the health care and intensive support service needs identified in the consumer's individual health care plan and the consumer's integration and participation in community life.

(c) For each consumer placed in an ARFPSHN, the regional center shall assign a service coordinator pursuant to subdivision (b) of Section 4647.

(d) A regional center licensed registered nurse shall visit, with or without prior notice, the consumer, in person, at least monthly in the ARFPSHN, or more frequently if specified in the consumer's individual health care plan. At least four of these visits, annually, shall be unannounced.

(e) The State Department of Developmental Services shall monitor and ensure the regional centers' compliance with the requirements of this article. The monitoring shall include onsite visits to all the ARFPSHNs at least every six months ~~for the duration of the pilot project~~.

§ 4684.73. Contract termination; rescission of program certification; transfer of property and services

(a) In addition to any other contract termination provisions, a regional center may terminate its contract with an ARFPSHN when the regional center determines that the ARFPSHN is unable to maintain substantial compliance with state laws, regulations, or its contract with the regional center, or the ARFPSHN demonstrates an inability to ensure the health and safety of the consumers.

(b) The ARFPSHN may appeal a regional center's decision to terminate its contract by sending, to the executive director of the contracting regional center, a detailed statement containing the reasons and facts demonstrating why the termination is inappropriate. The appeal must be received by the regional center within 10 working days from the date of the letter terminating the contract. The executive director shall respond with his or her decision within 10 working days of the date of receipt of the appeal from the ARFPSHN. The executive director shall submit his or her decision to the State Department of Developmental Services on the same date that it is signed. The decision of the executive director shall be the final administrative decision.

(c) The Director of Developmental Services may rescind an ARFPSHN's program certification when, in his or her sole discretion, an ARFPSHN does not maintain substantial compliance with an applicable statute, regulation, or ordinance, or cannot ensure the health and safety of the consumers. The decision of the Director of Developmental Services shall be the final administrative decision. The Director of Developmental Services shall transmit his or her decision rescinding an ARFPSHN's program certification to the State Department of Social Services and the regional center with his or her recommendation as to whether to revoke the ARFPSHN's license.

(d) In addition to complying with Section 1524.1 of the Health and Safety Code, any ARFPSHN licensee that is unable to continue to provide services to consumers in the facility shall, upon the date on which a new ARFPSHN license is issued pursuant to Sections 1520 and 1525 of the Health and Safety Code, arrange with the regional center or department the transfer of all information, property, and documents related to the operation of the facility and the provision of services to the consumers. The department or the regional center shall take all steps permitted by this article to ensure that at all times the consumers who are residing in the facility receive services set forth in their individual health care plans.

Delete WIC 4684.74

~~**4684.74**. (a) By July 1, 2006, the State Department of Developmental Services shall contract with an independent agency or organization to evaluate the pilot project and prepare a written report of its findings. The scope of services for the contractor shall be jointly prepared by the State Department of Developmental Services, the State Department of Social Services, the State Department of Public Health, and the State Department of Health Care Services and, at a minimum, shall address all of the following:~~

~~(1) The number, business status, and location of all the ARFPSHNs.~~
~~(2) The number and characteristics of the consumers served.~~
~~(3) The effectiveness of the pilot project in addressing consumers' health care and intensive support needs.~~
~~(4) The extent of consumers' community integration and satisfaction.~~
~~(5) The consumers' access to, and quality of, community-based health care and dental services.~~
~~(6) The types, amounts, qualifications, and sufficiency of staffing.~~
~~(7) The overall impressions, problems encountered, and satisfaction with the ARFPSHN service model by ARFPSHN employees, regional center participants, state licensing and monitoring personnel, and consumers and families.~~
~~(8) The costs of all direct, indirect, and ancillary services.~~
~~(9) An analysis and summary findings of all ARFPSHN consumer special incident reports and unusual occurrences reported during the evaluation period.~~
~~(10) The recommendations for improving the ARFPSHN service model.~~
~~(11) The cost-effectiveness of the ARFPSHN model of care compared with other existing public and private models of care serving similar consumers.~~
~~(b) The contractor's written report shall be submitted to the State Department of Developmental Services, the State Department of Social Services, the State Department of Public Health, and the State Department of Health Care Services. The State Department of Developmental Services shall submit the report to the appropriate fiscal and policy committees of the Legislature by January 1, 2010.~~

Amend WIC § 4684.75 as follows:

4684.75 (a) The State Department of Developmental Services may adopt emergency regulations to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the State Department of Developmental Services is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. A certificate of compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this section.
~~(b) This article shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute extends or deletes that date.~~
(b) This article shall only be implemented to the extent that funds are made available through an appropriation in the annual Budget Act.
~~(c)~~

Amend Health & Safety Code § 1567.50 as follows:

1567.50 (a) Notwithstanding that a community care facility means a place that provides nonmedical care under subdivision (a) of Section 1502, pursuant to Article 3.5 (commencing with Section 4684.50) of Chapter 6 of Division 4.5 of the Welfare and Institutions Code, the department shall jointly implement with

the State Department of Developmental Services a ~~pilot project to test the effectiveness of providing~~ licensing program to provide special health care and intensive support services to adults in homelike community settings.
(b) The State Department of Social Services may license, subject to the following conditions, an Adult Residential Facility for Persons with Special Health Care Needs to provide 24-hour services to up to five adults with developmental disabilities who have special health care and intensive support needs, as defined in subdivisions (f) and (g) of Section 4684.50 of the Welfare and Institutions Code.
(1) The State Department of Developmental Services shall be responsible for granting the certificate of program approval for an Adult Residential Facility for Persons with Special Health Care Needs (ARFPSHN). The State Department of Social Services shall not issue a license unless the applicant has obtained a certification of program approval from the State Department of Developmental Services.
(2) The State Department of Social Services shall ensure that the ARFPSHN meets the administration requirements under Article 2 (commencing with Section 1520) including, but not limited to, requirements relating to fingerprinting and criminal records under Section 1522.
(3) The State Department of Social Services shall administer employee actions under Article 5.5 (commencing with Section 1558).
(4) The regional center shall monitor and enforce compliance of the program and health and safety requirements, including monitoring and evaluating the quality of care and intensive support services. The State Department of Developmental Services shall ensure that the regional center performs these functions.
(5) The State Department of Developmental Services may decertify any ARFPSHN that does not comply with program requirements. When the State Department of Developmental Services determines that urgent action is necessary to protect clients of the ARFPSHN from physical or mental abuse, abandonment, or any other substantial threat to their health and safety, the State Department of Developmental Services may request the regional center or centers to remove the clients from the ARFPSHN or direct the regional center or centers to obtain alternative services for the consumers within 24 hours.
(6) The State Department of Social Services may initiate proceedings for temporary suspension of the license pursuant to Section 1550.5.
(7) The State Department of Developmental Services, upon its decertification, shall inform the State Department of Social Services of the licensee's decertification, with its recommendation concerning revocation of the license, for which the State Department of Social Services may initiate proceedings pursuant to Section 1550.
(8) The State Department of Developmental Services and the regional centers shall provide the State Department of Social Services all available documentation and evidentiary support necessary for any enforcement proceedings to suspend the license pursuant to Section 1550.5, to revoke or deny a license pursuant to Section 1551, or to exclude an individual pursuant to Section 1558.
(9) The State Department of Social Services Community Care Licensing Division shall enter into a memorandum of understanding with the State Department of Developmental Services to outline a formal protocol to address shared responsibilities, including monitoring responsibilities, complaint investigations, administrative actions, and closures.
(10) The licensee shall provide documentation that, in addition to the administrator requirements set forth under paragraph (4) of subdivision (a) of Section 4684.63 of the Welfare and Institutions Code, the administrator, prior to employment, has completed a minimum of 35 hours of initial training in the general laws, regulations and policies and procedural standards applicable to facilities licensed by the State Department of Social Services under Article 2 (commencing with Section 1520). Thereafter, the licensee shall provide documentation every two years that the administrator has completed 40 hours of continuing education in the general laws, regulations and policies and procedural standards applicable to adult residential facilities. The training specified in this section shall be provided by a vendor approved by the State Department of Social Services and the cost of the training shall be borne by the administrator or licensee.
~~(c) The article shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute extends or deletes that date.~~
(c) This article shall only be implemented to the extent that funds are made available through an appropriation in the annual Budget Act.
~~(d)~~

Attachment 2

Lanterman Outpatient Clinic
Modify Section 4474. 8 to the Welfare and Institutions Code as follows:
(Underlined section is the proposed modification).

4474.8 Notwithstanding any provision of law to the contrary, the department shall continue the operation of the Agnews Outpatient Clinic, and the Lanterman Outpatient Clinic until such time as the Department of Developmental Services is no longer responsible for the property. At the respective developmental center as applicable.

Attachment 3

REVISED April 26, 2010 5:45 p.m.

SECTION 1. Section 854.1 of the Government Code is amended to read:

854.1. (a) It is the intent of the Legislature to ensure continuity of care for clients of Agnews Developmental Center and Lanterman Developmental Center.

(b) In the effort to achieve these goals, it is the intent of the Legislature to seek and implement recommendations that include all of the following services to retain Agnews and Lanterman staff as employees:

(1) Crisis management teams that provide behavioral, medical, and dental treatment, training, and technical assistance.

(2) Specialized services, including adaptive equipment design and fabrication, and medical, dental, psychological, and assessment services.

(3) Staff support in community homes to assist individuals with behavioral or psychiatric needs.

(c) As used in this chapter, the terms "mental institution" or "medical facility" also include a developmental services facility. For the purposes of this chapter "developmental services facility" means any facility or place where a public employee provides developmental services relating to the closure of Agnews Developmental Center or Lanterman Developmental Center.

SECTION 2. Section 4474.2 of the Welfare and Institutions Code is amended to read:

4474.2. (a) Notwithstanding any provision of law to the contrary, the department may operate any facility, provide its employees to assist in the operation of any facility, or provide other necessary services and supports if in the discretion of the department it determines that the activity will assist in meeting the goal of ~~an~~the orderly closures of Agnews Developmental Center and Lanterman Developmental Center. The department may contract with any entity for the use of the department's employees to provide services in furtherance of ~~an~~the orderly closures of Agnews Developmental Center and Lanterman Developmental Center.

(b) The department shall prepare a report on the use of the department's employees in providing services in the community to assist in the orderly closure of Agnews Developmental Center and Lanterman Developmental Center. The report shall include data on the number and classification of state employees working in the community program. The report shall be submitted with the Governor's proposed budget for fiscal year 2012-2013 and annually thereafter to the fiscal committees of both houses of the Legislature.

SECTION 3. Section 4474.3 of the Welfare and Institutions Code is amended to read:

4474.3. The provisions of Section 10411 of the Public Contract Code shall not apply to any person who, in connection with the closures of Agnews Developmental Center or Lanterman Developmental Center, provides developmental services.

Attachment 4

Budget Bill Language for Lanterman Plan Updates
Item 4300-001-0001

Provision x.

"The state Department of Developmental Services shall provide the fiscal and policy committees of the Legislature with a comprehensive status update on the Lanterman Plan, by no later than January 10, and May 14, of *each* fiscal year which will include *at a minimum* all of the following:

(a) A description and progress report on all pertinent aspects of the community-based resources development, including the status of the Lanterman transition placement plan.

(b) An aggregate update on the consumers living at Lanterman and consumers who have been transitioned to other living arrangement, including a description of the living arrangements (Developmental Center or community-based and model being used) and the range of services the consumers receive.

(c) An update to the Major Implementation Steps and Timelines.

(d) A comprehensive update to the fiscal analyses.

(e) An update to the plan regarding Lanterman's employees, including employees who are providing medical services to consumers on an outpatient basis, as well as employees who are providing services to consumers in residential settings.

(f) Specific measures the State, including the Department of Developmental Services, the Department of Health Care Services, and Department of Mental Health, is taking in meeting the health, mental health, medical, dental, and over all well-being of consumers living in the community and those residing at Lanterman until appropriately transitioned in accordance with the Lanterman Act.

(g) Any other pertinent information that facilities the understanding of issues, concerns, or potential policy changes that are applicable to the transition of Lanterman Developmental Center.

Attachment 5

Assurance from Secretary of Health and Human Services

Proposed Trailer Bill Language Modify Section 4474.4 to the Welfare and Institutions Code as follows:

(Underlined section is the proposed modification):

Notwithstanding any other provision of law to the contrary, the Secretary of the Health and Human Services Agency shall verify that the Department of Developmental Services and the Department of Health Services have established protocols in place between the departments, as well as with the Regional Centers and health care plans participating in the Medi-Cal Program who will be providing services, including health, dental and vision care, to people with developmental disabilities transitioning from Agnews Developmental Center, and Lanterman Developmental Center.

The Secretary of the Health and Human Services Agency shall provide written verification of the establishment of these protocols to the Joint Legislative Budget Committee, as well as to the fiscal and policy committees of the Legislature which oversee health and human services programs.

The purpose of the protocols is to ensure that a mutual goal of providing appropriate, high quality care and services to children and adults who have developmental disabilities in order to optimize the health and welfare of each individual. Further, it is to ensure that all involved parties, including consumers and families, the state, Regional Centers and providers are clear as to their roles and responsibilities, and are appropriately accountable for optimizing the health and welfare of each individual.

The protocols, at a minimum, shall address enrollment for services, all referral practices including those to specialty care, authorization practices for services of all involved parties, coordination of case management services, education and training services to be provided, the management of medical records and provider reimbursement methods. These protocols shall be provided to the consumers and their families, and available to the public upon request.

Attachment 6

Reimbursement of Health Plans for Lanterman Consumers

Modify Welfare and Institutions Code within the Lanterman Act as follows.

(a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara counties pursuant to the Plan for the Closure of Agnews Developmental Center, and consumers transitioning from Lanterman Developmental Center into various health plans whose Individual Program Plan documents the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal Fee-For-Service system, services provided under the contract shall be provided by Medi-Cal managed care health plans who are currently operational in these counties as a county organized health system or a local initiative if consumers, where applicable, choose to enroll. Reimbursement shall be by the Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare program.

(b) Medi-Cal managed care health plans enrolling members referred to in subdivision (a) shall be further reimbursed for the reasonable cost of administrative services. Administrative services pursuant to this subdivision include, but are not limited to, coordination of care and case management not provided by a regional center; provider credentialing and contracting; quality oversight; assuring member access to covered services; consultation with Agnews Developmental Center staff, Lanterman Developmental Center staff, regional center staff, Department of Developmental Services staff, contractors and family members; and financial management of the program, including claims processing. Reasonable cost is defined as the actual cost incurred by the Medi-Cal managed care health plan, including both direct and indirect costs incurred by the Medi-Cal managed care health plan, in the performance of administrative services, but shall not include any incurred costs found by the Department of Health Care Services to be unnecessary for the efficient delivery of necessary health services. Payment for administrative services shall continue on a reasonable cost basis until sufficient cost experience exists to allow such costs to be part of an all-inclusive capitation rate covering both administrative services and direct patient care services.

(c) Until the Department of Health Care Services is able to determine by actuarial methods, prospective per capita rates of payment for services for those members who enroll in the Medi-Cal managed care health plans specified in subdivision (a), the Department of Health Care Services shall reimburse the Medi-Cal managed care health plans for the net reasonable cost of direct patient care services and supplies set forth in the scope of services in the contract between the Medi-Cal managed care health plans and the Department of Health Care Services and that are not reimbursed by the Medicare program. Net reasonable cost is defined as the actual cost incurred by the

Medi-Cal managed care health plans, as measured by the Medi-Cal managed care health plan's payments to providers of services and supplies, less payments made to the plans by third parties other than Medicare, and shall not include any incurred cost found to be unnecessary by the Department of Health Care Services in the efficient delivery of necessary health services. Reimbursement shall be accomplished by the Department of Health Care Services making 21 estimated payments at reasonable intervals, with these estimates being reconciled to actual net reasonable cost at least semi-annually.

(d) The Department of Health Care Services shall seek any approval necessary for implementation of this section from the federal government, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other provision of law, this section shall be implemented only to the extent that federal financial participation is available pursuant to necessary federal approvals.

(The DDS Hand Outs are available at the Subcommittee Hearing from the Department.)

Attachment 7

Notification of Exceptions

Section 4701 of the Welfare and Institutions Code is amended to read:

4701. "Adequate notice" means a written notice informing the applicant, recipient, and authorized representative of at least all of the following:

(a) The action that the service agency proposes to take, including a statement of the basic facts upon which the service agency is relying, and whether or not the individual is eligible for an exemption, waiver, exceptional funding, or other exception to the action;

(b) The reason or reasons for that action.

(c) The effective date of that action.

(d) The specific law, regulation, or policy supporting the action including any relevant exemption, waiver, exceptional funding, or other exception.

Attachment 8

Intermediate Care Facilities
Payment for Transportation and Day Treatment Costs
Proposed Amendments

Section 1. Section 4646.55 is added to the Welfare and Institutions Code to read:

4646.55 (a) Notwithstanding any other provision of law or regulation to the contrary and to the extent federal financial participation is available, effective July 1, 2007, the California Department of Developmental Services is hereby authorized to make supplemental payment to enrolled Medi-Cal providers that are licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled for day treatment and transportation services provided pursuant to Sections 4646, 4646.5 and applicable regulations and 14132.95, to Medi-Cal beneficiaries residing in a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled. These payments shall be considered supplemental Medi-Cal payments to the enrolled Medi-Cal provider and paid accordingly (without a separate DDS contract).

(b) Notwithstanding any other provision of law and to the extent federal financial participation is available, and in furtherance of this section and 14132.95, the Department shall amend the regional center contracts for the fiscal year 2007-08 to extend the contract liquidation period until June 30, 2011. The contract amendments and budget adjustments shall be exempt from the provisions of Article 1, (commencing with Section 4620) of Chapter 5 of Division 4.5 of the Welfare and Institutions Code.

Section 2. Section 14132.925 is added to the Welfare and Institutions Code to read:

(a) Notwithstanding any other provision of law or regulation to the contrary and to the extent federal financial participation is available, and in furtherance of Section 14105.06 and subdivisions (a) and (c) of Section 14132.92 effective July 1, 2007, a licensed intermediate care facility/developmentally disabled-habilitative, a licensed intermediate care facility/developmentally disabled-nursing or a licensed intermediate care facility/developmentally disabled shall be responsible for providing day treatment and transportation services consistent with 14105.06 and subdivision (a) of Section 14132.92 that are selected and authorized through the individual program plan process pursuant to Sections 4646, 4646.5 and applicable regulations for each beneficiary receiving such services who resides in that licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled. These services shall be arranged by the regional center pursuant to Sections 4646, 4646.5 and applicable regulations, and the licensed

intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled, shall reimburse the regional center for the costs incurred in arranging for such services. Nothing herein shall authorize the licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled to substitute day treatment or transportation services not selected and authorized through the individual program plan process pursuant to Sections 4646, 4646.5 and applicable regulations.

(b) The State Department of Developmental Services shall be responsible for reimbursing a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled for the costs incurred pursuant to subdivision (a), (a reasonable coordination fee shall be provided – method of payment TBD). This payment shall be a supplement to the Medi-Cal payment from the Department of Health Care Services described in 14105.06 and 14132.92. A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled may authorize the regional center to invoice the State Department of Developmental Services on its behalf for the services described in subdivision (a). The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled shall dispense payment to the regional center within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instruction from the State Department of Developmental Services. Failure to pay the regional center within 30 days shall result in (TBD).

(c) A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled shall report the costs incurred pursuant to subdivision (a) according to instruction from the Department of Health Care Services. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this subdivision by means of a provider bulletin or similar instruction from the Department of Health Care Services.

(d) If services meeting the conditions of subdivision (a) have been provided to a Medi-Cal beneficiary on or after July 1, 2007, and, notwithstanding Section 14115, an invoice for the day treatment and transportation services is submitted, the services shall be reimbursed. The department shall seek federal financial participation, including American Recovery and Reinvestment Act money, pursuant to a federally approved state plan amendment authorizing reimbursement for these services provided during that period. Upon approval of the amendment the payments made pursuant to this section shall be subject to the Quality Assurance fee provided for in Health and Safety Code Sections 1324 through 1324.14. If federal financial participation is not made

available for that period, the services nonetheless shall be reimbursed from the General Fund by the Department of Developmental Services. (Note: This subsection is placeholder language that may need DHCS edits)

Section 3**.** Due to a change in the availability of federal funding that addresses the ability of California to capture additional federal financial participation for day treatment and transportation services provided to a Medi-Cal beneficiary residing in a licensed intermediate care facility/developmentally disabled-habilitative, a licensed intermediate care facility/developmentally disabled-nursing or a licensed intermediate care facility/developmental disability, as specified in Section 4646.55 and 14132.925, funds appropriated in Item 4300-101-0001, Budget Act of 2007 (Chapters 171 and 172, Statutes of 2007), shall be available for liquidation until June 30, 2011.