EXECUTIVE DIRECTOR REPORT

November 1, 2013

I. LEGISLATION

- **Attachment #1**: SB 468 (Emmerson): Self Determination Program
- **Attachment #2**: SB 555 (Correa): Native Language Requirements for IPPs and IFSPs
- **Attachment #3:** AB 1041 (Chesbro): Employment First Policy for Californians with Developmental Disabilities
- **Attachment #4:** SB 126 (Steinberg): Extension of Autism Health Insurance Mandate
- **Attachment #5:** CDCAN Report #095-2013: Governor Takes Action on Several Bills Impacting People with Developmental Disabilities

SB 468 (Emmerson), the Self Determination Program bill, passed unanimously by both houses of the Legislature was also signed into law by Governor Brown. SB 468 will open up the Self Determination Program to all persons with developmental disabilities eligible for Regional Center funded services throughout the State, but will be phased in over three years and initially serve up to 2500 persons. After the initial phase in period, the program will be available on a voluntary basis. The bill will require DDS, among other things, apply for federal funding for the program by December 31, 2014. The bill also requires each Regional Center to establish a local voluntary advisory committee to provide oversight of the project. ARCA's position was support with amendments. ARCA was able to work with the bill's sponsors to address several important issues, as the Regional Center system remains in support of the self determination concept. ARCA continues to question DDS about how Regional Center operations costs to implement the new program will be funded **(Attachment #1)**.

SB 555 (Correa) was signed into law by Governor Brown that would require Regional Centers to communicate and provide written materials in the person and family's native language during the assessment, evaluation, and planning process.

The person's native language is to be documented in the IFSP/IPP and is defined as the language normally used or the preferred language identified by the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative. This bill provides no additional funding to Regional Centers for implementation costs which could be substantial. ARCA and the Regional Centers are working with DDS to determine the most cost and time effective ways of implementing the requirements of this bill **(Attachment #2)**.

AB 1041 (Chesbro), the Employment First Policy for people with developmental disabilities, was signed into law by Governor Brown that will establish a statewide "Employment First" policy for persons with developmental disabilities eligible for Regional Center funded services. Existing law requires the State Council on Developmental Disabilities to, among other responsibilities, form a standing Employment First Committee to identify strategies and recommend legislative, regulatory, and policy changes to increase integrated employment, self-employment, and microenterprises for persons with developmental disabilities. This bill would define competitive employment, microenterprises, and self-employment for these purposes. The bill would additionally require the Employment First Committee to identify existing sources of data on persons receiving Regional Center services to be matched with employment data and to recommend goals for measuring employment participation and outcomes for persons with developmental disabilities. The bill would require the State Council on Developmental Disabilities to develop an informational brochure into various languages, and to post the brochure on the Council's internet website. The bill would require each Regional Center planning team, when developing an individual program plan, to consider a specified Employment First policy **(Attachment #3)**.

SB 126 (Steinberg), the extension of the California Autism Health Insurance Mandate (SB 946), was signed into law by Governor Brown. This bill extends, until January 1, 2017, the provisions of SB 946 requiring private health care insurance plans to provide coverage for "behavioral health treatment" of children with Autism and Pervasive Developmental Disorders. SB 126 also provides for the evaluation of recommendations by the Department of Managed Health Care Autism Taskforce, a process of licensure for providers and paraprofessionals of behavioral health treatments, coordination with "Obamacare" – officially known as the "Affordable Care Act of 2010", and assessment of future guidelines of that federal law. SB 946 reportedly has already helped more than 12,500 Californians receive insurance coverage for early Autism treatment **(Attachment #4-#5)**.

II. FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

- **Attachment #6:** ARCA report: Funding the Work of California's Regional Centers

The Lanterman Developmental Disabilities Service Act sets forth the State's commitment to people with developmental disabilities, as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. . . " The State has elected to discharge this responsibility through a network of 21 Regional Centers. This statewide network of Regional Centers manages over $4.1 billion in annual federal and state funds and serves as the primary safety net for 259,000 of California's most vulnerable citizens. Regional Centers provide Californians who have a developmental disability with community based services and supports to allow children to remain in their family homes and adults to reach the highest level of independence possible. However, chronic underfunding of the Regional Centers' OPS budget is undermining the Regional Centers' ability to meet their mandate under the Lanterman Ac and to comply with statutory and contractual responsibilities, hence threatening the viability of this network. Absent intervention, the State is exposed to potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of persons receiving services from Regional Centers and their families for whom the State has "accepted a responsibility" is directly threatened. Therefore, ARCA believes it is essential that those who influence and make public policy understand the seriousness of this issue, particularly as the State's improving economic situation begins to allow fiscal restoration of vital public programs.

This paper is designed to: (1) provide information on the existing budgeting methodology used by the State to fund Regional Center operations, (2) identify the reasons and extent to which the Regional Center operations budget is underfunded, and (3) alert the public and policy makers that this situation cannot continue without directly threatening the health and well-being of persons receiving regional center services, and the continued receipt of over $1 billion per year in federal funds to the State.

This paper's focus on the operations side of the budget should not be construed as diminishing the serious underfunding that also exists in the Purchase of Services budget. ARCA addresses the Purchase of Service underfunding issue in its position statement titled, "The Budget Crisis Affecting California's Regional Centers" **(Attachment #6)**.

III. Q&A

Senate Bill No. 468

CHAPTER 683

An act to add Section 4685.8 to the Welfare and Institutions Code, relating to developmental services.

[Approved by Governor October 9, 2013. Filed with
Secretary of State October 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 468, Emmerson. Developmental services: statewide Self-Determination Program.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services contracts with regional centers to provide services and supports to individuals with developmental disabilities. Under existing law, the regional centers purchase needed services and supports for individuals with developmental disabilities through approved service providers, or arrange for their provision through other publicly funded agencies. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP), developed in accordance with prescribed requirements. Existing law establishes, contingent upon approval of a federal waiver, the Self-Directed Services Program, and requires the program to be available in every regional center catchment area to provide participants, within an individual budget, greater control over needed services and supports.

This bill would require the department, contingent upon approval of federal funding, to establish and implement a state Self-Determination Program, as defined, that would be available in every regional center catchment area to provide participants and their families, within an individual budget, increased flexibility and choice, and greater control over decisions, resources, and needed and desired services and supports to implement their IPP, in accordance with prescribed requirements. The statewide program would be phased in over 3 years, serving up to 2,500 regional center consumers during the phase-in period, and thereafter, available on a voluntary basis to all eligible regional center consumers. The bill would require the department to, among other things, apply for federal funding for the program by December 31, 2014.

This bill would provide that program participants receive an individual budget, as prescribed, to be used for the purchase of services and supports necessary to implement the participant's IPP. The bill would require program participants to agree to, among other things, manage self-determination services and supports within the individual budget. The bill would require the department to require nonvendored providers of services and supports who meet specified criteria to submit to a criminal background check, as specified. The bill would require the department, with respect to this background check, to submit fingerprint images and related information to the Department of Justice, and would require the Department of Justice to provide specified responses to the department. The bill would require the Department of Justice to charge a fee sufficient to cover the cost of processing this request. The bill would, among other things, require each regional center to be responsible for implementing the program as a term of its contract, and to establish a local voluntary advisory committee to provide oversight of the project. The bill would require the State Council on Developmental Disabilities to form a volunteer statewide committee to, among other things, identify self-determination best practices. The bill would require the State Council on Developmental Disabilities, in collaboration with specified entities, to issue to the Legislature a report regarding the status of the program and recommendations to the program, as specified, and would require the department, beginning January 10, 2017, to provide to the appropriate policy and fiscal committees of the Legislature prescribed information relating to the program.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) In 1998, the Legislature expanded the Lanterman Developmental Disabilities Services Act to include self-determination pilot projects. Those pilot projects were continued by the Legislature in 2002 and 2003. However, the pilot projects were only available at three regional centers pursuant to Section 13 of Chapter 1043 of the Statutes of 1998, as amended, and two additional regional centers pursuant to Article 4 (commencing with Section 4669.2) of Chapter 5 of Division 4.5 of the Welfare and Institutions Code, and the number of individuals served by the local self-determination pilot projects remains small at about 140 regional center consumers.

(b) As reflected in the State Department of Developmental Services 2002 Report to the Legislature, the pilot projects remain an innovative, cost-effective, and successful way of providing services to regional center consumers and their families. The findings in the report show that self-determination pilot project participants were happy and experienced more freedom and responsibility in controlling the direction of their services and life choices, and the project was cost neutral in the aggregate. The report also found that good self-determination requires intensive person-centered planning, collaboration, and follow-along services and supports.

(c) Most other states have self-directed or self-determination services as a model for providing services. Many California consumers and families have asked for a statewide expansion of the pilot project believing it will do the following: increase innovative and effective services, eliminate bureaucracy, and increase choices for consumers and parents, thereby allowing them to increase their control of services and supports by easily navigating increasingly complex service systems.

(d) Consumers in traditionally underserved linguistic, cultural, socioeconomic, and ethnic communities have unique challenges in accessing needed regional center services that have been impacted by service limitations imposed as a response to California's recent budget shortfalls. This is particularly true for consumers living at home with a parent or guardian. The Self-Determination Program offers increased service flexibility, which will help promote access to needed services for these consumers and their families.

(e) This act allows for voluntary participation in the Self-Determination Program in all 21 regional centers and ensures cost-neutrality and a consistent statewide method of administration. The intent of this act is to ensure that the program is available to all consumers regardless of geographic location, economic or educational background, or race or ethnicity.

(f) To ensure these outcomes are achieved, it is the intent of the Legislature that the State Department of Developmental Services and regional centers be responsible for oversight and monitoring of funds used for the Self-Determination Program and the achievement of consumer outcomes.

(g) In addition, the intent of this act is that the Self-Determination Program be phased in over a three-year period and that the program will continue to be available to all consumers as an option after the initial phase-in period ends.

SEC. 2. Section 4685.8 is added to the Welfare and Institutions Code, to read:

4685.8. (a) The department shall implement a statewide Self-Determination Program. The Self-Determination Program shall be available in every regional center catchment area to provide participants and their families, within an individual budget, increased flexibility and choice, and greater control over decisions, resources, and needed and desired services and supports to implement their IPP. The statewide Self-Determination Program shall be phased in over three years, and during this phase-in period, shall serve up to 2,500 regional center consumers, inclusive of the remaining participants in the self-determination pilot projects authorized pursuant to Section 13 of Chapter 1043 of the Statutes of 1998, as amended, and Article 4 (commencing with Section 4669.2) of Chapter 5. Following the phase-in period, the program shall be available on a voluntary basis to all regional center consumers who are eligible for the Self-Determination Program. The program shall be available to individuals who reflect the disability, ethnic, and geographic diversity of the state.

(b) The department in establishing the statewide program shall do both of the following:

(1) For the first three years of the Self-Determination Program, determine, as part of the contracting process described in Sections 4620 and 4629, the number of participants each regional center shall serve in its Self-Determination Program. To ensure that the program is available on an equitable basis to participants in all regional center catchment areas, the number of Self-Determination Program participants in each regional center

shall be based on the relative percentage of total consumers served by the regional centers minus any remaining participants in the self-determination pilot projects authorized pursuant to Section 13 of Chapter 1043 of the Statutes of 1998, as amended, and Article 4 (commencing with Section 4669.2) of Chapter 5 or another equitable basis.

(2) Ensure all of the following:

(A) Oversight of expenditure of self-determined funds and the achievement of participant outcomes over time.

(B) Increased participant control over which services and supports best meet their needs and the IPP objectives. A participant's unique support system may include the purchase of existing service offerings from service providers or local businesses, hiring his or her own support workers, or negotiating unique service arrangements with local community resources.

(C) Comprehensive person-centered planning, including an individual budget and services that are outcome based.

(D) Consumer and family training to ensure understanding of the principles of self-determination, the planning process, and the management of budgets, services, and staff.

(E) Choice of independent facilitators who can assist with the person-centered planning process and choice of financial management services providers vendored by regional centers who can assist with payments and provide employee-related services.

(F) Innovation that will more effectively allow participants to achieve their goals.

(c) For purposes of this section, the following definitions shall apply:

(1) "Financial management services" means services or functions that assist the participant to manage and direct the distribution of funds contained in the individual budget, and ensure that the participant has the financial resources to implement his or her IPP throughout the year. These may include bill paying services and activities that facilitate the employment of service and support workers by the participant, including, but not limited to, fiscal accounting, tax withholding, compliance with relevant state and federal employment laws, assisting the participant in verifying provider qualifications, including criminal background checks, and expenditure reports. The financial management services provider shall meet the requirements of Sections 58884, 58886, and 58887 of Title 17 of the California Code of Regulations and other specific qualifications established by the department. The costs of financial management services shall be paid by the participant out of his or her individual budget, except for the cost of obtaining the criminal background check specified in subdivision (w).

(2) "Independent facilitator" means a person, selected and directed by the participant, who is not otherwise providing services to the participant pursuant to his or her IPP and is not employed by a person providing services to the participant. The independent facilitator may assist the participant in making informed decisions about the individual budget, and in locating, accessing, and coordinating services and supports consistent with the participant's IPP. He or she is available to assist in identifying immediate

and long-term needs, developing options to meet those needs, leading, participating, or advocating on behalf of the participant in the person-centered planning process and development of the IPP, and obtaining identified services and supports. The cost of the independent facilitator, if any, shall be paid by the participant out of his or her individual budget. An independent facilitator shall receive training in the principles of self-determination, the person-centered planning process, and the other responsibilities described in this paragraph at his or her own cost.

(3) "Individual budget" means the amount of regional center purchase of service funding available to the participant for the purchase of services and supports necessary to implement the IPP. The individual budget shall be determined using a fair, equitable, and transparent methodology.

(4) "IPP" means individual program plan, as described in Section 4646.

(5) "Participant" means an individual, and when appropriate, his or her parents, legal guardian or conservator, or authorized representative, who has been deemed eligible for, and has voluntarily agreed to participate in, the Self-Determination Program.

(6) "Self-determination" means a voluntary delivery system consisting of a defined and comprehensive mix of services and supports, selected and directed by a participant through person-centered planning, in order to meet the objectives in his or her IPP. Self-determination services and supports are designed to assist the participant to achieve personally defined outcomes in community settings that promote inclusion. The Self-Determination Program shall only fund services and supports provided pursuant to this division that the federal Centers for Medicare and Medicaid Services determines are eligible for federal financial participation.

(d) Participation in the Self-Determination Program is fully voluntary. A participant may choose to participate in, and may choose to leave, the Self-Determination Program at any time. A regional center shall not require or prohibit participation in the Self-Determination Program as a condition of eligibility for, or the delivery of, services and supports otherwise available under this division. Participation in the Self-Determination Program shall be available to any regional center consumer who meets the following eligibility requirements:

(1) The participant has a developmental disability, as defined in Section 4512 and is receiving services pursuant to this division.

(2) The consumer does not live in a licensed long-term health care facility, as defined in paragraph (44) of subdivision (a) of Section 54302 of Title 17 of the California Code of Regulations. An individual, and when appropriate his or her parent, legal guardian or conservator, or authorized representative, who is not eligible to participate in the Self-Determination Program pursuant to this paragraph may request that the regional center provide person-centered planning services in order to make arrangements for transition to the Self-Determination Program, provided that he or she is reasonably expected to transition to the community within 90 days. In that case, the regional center shall initiate person-centered planning services within 60 days of that request.

(3) The participant agrees to all of the following terms and conditions:

(A) The participant shall receive an orientation to the Self-Determination Program prior to enrollment, which includes the principles of self-determination, the role of the independent facilitator and the financial management services provider, person-centered planning, and development of a budget.

(B) The participant shall utilize the services and supports available within the Self-Determination Program only when generic services and supports are not available.

(C) The participant shall only purchase services and supports necessary to implement his or her IPP and shall comply with any and all other terms and conditions for participation in the Self-Determination Program described in this section.

(D) The participant shall manage Self-Determination Program services and supports within his or her individual budget.

(E) The participant shall utilize the services of a financial management services provider of his or her own choosing and who is vendored by a regional center.

(F) The participant may utilize the services of an independent facilitator of his or her own choosing for the purpose of providing services and functions as described in paragraph (2) of subdivision (c). If the participant elects not to use an independent facilitator, he or she may use his or her regional center service coordinator to provide the services and functions described in paragraph (2) of subdivision (c).

(e) A participant who is not Medi-Cal eligible may participate in the Self-Determination Program and receive self-determination services and supports if all other program eligibility requirements are met and the services and supports are otherwise eligible for federal financial participation.

(f) An individual receiving services and supports under a self-determination pilot project authorized pursuant to Section 13 of Chapter 1043 of the Statutes of 1998, as amended, or pursuant to Article 4 (commencing with Section 4669.2) of Chapter 5, may elect to continue to receive self-determination services and supports pursuant to this section or the regional center shall provide for the participant's transition from the self-determination pilot program to other services and supports. This transition shall include the development of a new IPP that reflects the services and supports necessary to meet the individual's needs. The regional center shall ensure that there is no gap in services and supports during the transition period.

(g) The additional federal financial participation funds generated by the former participants of the self-determination pilot projects authorized pursuant to Section 13 of Chapter 1043 of the Statutes of 1998, as amended, or pursuant to Article 4 (commencing with Section 4669.2) of Chapter 5, shall be used as follows:

(1) First, to offset the cost to the department for the criminal background check conducted pursuant to subdivision (w), and other administrative costs incurred by the department in implementing the Self-Determination Program.

(2) With the remaining funds, to offset the costs to the regional centers in implementing the Self-Determination Program, including, but not limited to, operations costs for caseload ratio enhancement, training for regional center staff, costs associated with the participant's initial person-centered planning meeting, the development of the participant's initial individual budget, and the costs associated with training consumers and family members.

(h) If at any time during participation in the Self-Determination Program a regional center determines that a participant is no longer eligible to continue in, or a participant voluntarily chooses to exit, the Self-Determination Program, the regional center shall provide for the participant's transition from the Self-Determination Program to other services and supports. This transition shall include the development of a new IPP that reflects the services and supports necessary to meet the individual's needs. The regional center shall ensure that there is no gap in services and supports during the transition period.

(i) An individual determined to be ineligible for or who voluntarily exits the Self-Determination Program shall be permitted to return to the Self-Determination Program upon meeting all applicable eligibility criteria and upon approval of the participant's planning team, as described in subdivision (j) of Section 4512. An individual who has voluntarily exited the Self-Determination Program shall not return to the program for at least 12 months. During the first three years of the program, the individual's right to return to the program is conditioned on his or her regional center not having reached the participant cap imposed by paragraph (1) of subdivision (b).

(j) An individual who participates in the Self-Determination Program may elect to continue to receive self-determination services and supports if he or she transfers to another regional center catchment area, provided that he or she remains eligible for the Self-Determination Program pursuant to subdivision (d). The balance of the participant's individual budget shall be reallocated to the regional center to which he or she transfers.

(k) The IPP team shall utilize the person-centered planning process to develop the IPP for a participant. The IPP shall detail the goals and objectives of the participant that are to be met through the purchase of participant-selected services and supports. The IPP team shall determine the individual budget to ensure the budget assists the participant to achieve the outcomes set forth in his or her IPP and ensures his or her health and safety. The completed individual budget shall be attached to the IPP.

(*l*) The participant shall implement his or her IPP, including choosing and purchasing the services and supports allowable under this section necessary to implement the plan. A participant is exempt from the cost control restrictions regarding the purchases of services and supports pursuant to Sections 4648.5 and 4686.5. A regional center shall not prohibit the purchase of any service or support that is otherwise allowable under this section.

(m) A participant shall have all the rights established in Sections 4646 to 4646.6, inclusive, and Chapter 7 (commencing with Section 4700).

(n) (1) Except as provided in paragraph (4), the IPP team shall determine the initial and any revised individual budget for the participant using the following methodology:

(A) (i) Except as specified in clause (ii), for a participant who is a current consumer of the regional center, his or her individual budget shall be the total amount of the most recently available 12 months of purchase of service expenditures for the participant.

(ii) An adjustment may be made to the amount specified in clause (i) if both of the following occur:

(I) The IPP team determines that an adjustment to this amount is necessary due to a change in the participant's circumstances, needs, or resources that would result in an increase or decrease in purchase of service expenditures, or the IPP team identifies prior needs or resources that were unaddressed in the IPP, which would have resulted in an increase or decrease in purchase of service expenditures.

(II) The regional center certifies on the individual budget document that regional center expenditures for the individual budget, including any adjustment, would have occurred regardless of the individual's participation in the Self-Determination Program.

(iii) For purposes of clauses (i) and (ii), the amount of the individual budget shall not be increased to cover the cost of the independent facilitator or the financial management services.

(B) For a participant who is either newly eligible for regional center services or who does not have 12 months of purchase service expenditures, his or her individual budget shall be calculated as follows:

(i) The IPP team shall identify the services and supports needed by the participant and available resources, as required by Section 4646.

(ii) The regional center shall calculate the cost of providing the services and supports to be purchased by the regional center by using the average cost paid by the regional center for each service or support unless the regional center determines that the consumer has a unique need that requires a higher or lower cost. The regional center shall certify on the individual budget document that this amount would have been expended using regional center purchase of service funds regardless of the individual's participation in the Self-Determination Program.

(iii) For purposes of clauses (i) and (ii), the amount of the individual budget shall not be increased to cover the cost of the independent facilitator or the financial management services.

(2) The amount of the individual budget shall be available to the participant each year for the purchase of program services and supports. An individual budget shall be calculated no more than once in a 12-month period, unless revised to reflect a change in circumstances, needs, or resources of the participant using the process specified in clause (ii) of subparagraph (A) of paragraph (1).

(3) The individual budget shall be assigned to uniform budget categories developed by the department in consultation with stakeholders and distributed according to the timing of the anticipated expenditures in the IPP and in a manner that ensures that the participant has the financial resources to implement his or her IPP throughout the year.

(4) The department, in consultation with stakeholders, may develop alternative methodologies for individual budgets that are computed in a fair, transparent, and equitable manner and are based on consumer characteristics and needs, and that include a method for adjusting individual budgets to address a participant's change in circumstances or needs.

(o) Annually, participants may transfer up to 10 percent of the funds originally distributed to any budget category set forth in paragraph (3) of subdivision (n) to another budget category or categories. Transfers in excess of 10 percent of the original amount allocated to any budget category may be made upon the approval of the regional center or the participant's IPP team.

(p) Consistent with the implementation date of the IPP, the IPP team shall annually ascertain from the participant whether there are any circumstances or needs that require a change to the annual individual budget. Based on that review, the IPP team shall calculate a new individual budget consistent with the methodology identified in subdivision (n).

(q) (1) On or before December 31, 2014, the department shall apply for federal Medicaid funding for the Self-Determination Program by doing one or more of the following:

(A) Applying for a state plan amendment.

(B) Applying for an amendment to a current home- and community-based waiver for individuals with developmental disabilities.

(C) Applying for a new waiver.

(D) Seeking to maximize federal financial participation through other means.

(2) To the extent feasible, the state plan amendment, waiver, or other federal request described in paragraph (1) shall incorporate the eligibility requirements, benefits, and operational requirements set forth in this section. Except for the provisions of subdivisions (k), (m), (p), and this subdivision, the department may modify eligibility requirements, benefits, and operational requirements as needed to secure approval of federal funding.

(3) Contingent upon approval of federal funding, the Self-Determination Program shall be established.

(r) (1) The department, as it determines necessary, may adopt regulations to implement the procedures set forth in this section. Any regulations shall be adopted in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding paragraph (1) and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and only to the extent that all necessary federal approvals are obtained, the department, without taking any further regulatory action, shall implement,

interpret, or make specific this section by means of program directives or similar instructions until the time regulations are adopted. It is the intent of the Legislature that the department be allowed this temporary authority as necessary to implement program changes only until completion of the regulatory process.

(s) The department, in consultation with stakeholders, shall develop informational materials about the Self-Determination Program. The department shall ensure that regional centers are trained in the principles of self-determination, the mechanics of the Self-Determination Program, and the rights of consumers and families as candidates for, and participants in, the Self-Determination Program.

(t) Each regional center shall be responsible for implementing the Self-Determination Program as a term of its contract under Section 4629. As part of implementing the program, the regional center shall do both of the following:

(1) Contract with local consumer or family-run organizations to conduct outreach through local meetings or forums to consumers and their families to provide information about the Self-Determination Program and to help ensure that the program is available to a diverse group of participants, with special outreach to underserved communities.

(2) Collaborate with the local consumer or family-run organizations identified in paragraph (1) to jointly conduct training about the Self-Determination Program.

(u) The financial management services provider shall provide the participant and the regional center service coordinator with a monthly individual budget statement that describes the amount of funds allocated by budget category, the amount spent in the previous 30-day period, and the amount of funding that remains available under the participant's individual budget.

(v) Only the financial management services provider is required to apply for vendorization in accordance with Subchapter 2 (commencing with Section 54300) of Chapter 3 of Title 17 of the California Code of Regulations, for the Self-Determination Program. All other service and support providers shall not be on the federal debarment list and shall have applicable state licenses, certifications, or other state required documentation, including documentation of any other qualifications required by the department, but are exempt from the vendorization requirements set forth in Title 17 of the California Code of Regulations when serving participants in the Self-Determination Program.

(w) To protect the health and safety of participants in the Self-Determination Program, the department shall require a criminal background check in accordance with all of the following:

(1) The department shall issue a program directive that identifies nonvendored providers of services and supports who shall obtain a criminal background check pursuant to this subdivision. At a minimum these staff shall include both of the following:

(A) Individuals who provide direct personal care services to a participant.

(B) Other nonvendored providers of services and supports for whom a criminal background check is requested by a participant or the participant's financial management service.

(2) Subject to the procedures and requirements of this subdivision, the department shall administer criminal background checks consistent with the department's authority and the process described in Sections 4689.2 to 4689.6, inclusive.

(3) The department shall electronically submit to the Department of Justice fingerprint images and related information required by the Department of Justice of nonvendored providers of services and supports, as specified in paragraph (1), for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(4) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this section. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the department.

(5) The Department of Justice shall provide a state or federal response to the department pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(6) The department shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1).

(7) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this subdivision.

(8) The fingerprints of any provider of services and supports who is required to obtain a criminal background check shall be submitted to the Department of Justice prior to employment. The costs of the fingerprints and the financial management service's administrative cost authorized by the department shall be paid by the services and supports provider or his or her employing agency. Any administrative costs incurred by the department pursuant to this subdivision shall be offset by the funds specified in subdivision (g).

(9) If the criminal record information report shows a criminal history, the department shall take the steps specified in Section 4689.2. The department may prohibit a provider of services and supports from becoming employed, or continuing to be employed, based on the criminal background check, as authorized in Section 4689.6. The provider of services and supports who has been denied employment shall have the rights set forth in Section 4689.6.

(10) The department may utilize a current department-issued criminal record clearance to enable a provider to serve more than one participant, as long as the criminal record clearance has been processed through the

department and no subsequent arrest notifications have been received relative to the cleared applicant.

(11) Consistent with subdivision (h) of Section 4689.2, the participant or financial management service that denies or terminates employment based on written notification from the department shall not incur civil liability or unemployment insurance liability.

(x) To ensure the effective implementation of the Self-Determination Program and facilitate the sharing of best practices and training materials commencing with the implementation of the Self-Determination Program, local and statewide advisory committees shall be established as follows:

(1) Each regional center shall establish a local volunteer advisory committee to provide oversight of the Self-Determination Program. The regional center and the area board shall each appoint one-half of the membership of the committee. The committee shall consist of the regional center clients' rights advocate, consumers, family members, and other advocates, and community leaders. A majority of the committee shall be consumers and their family members. The committee shall reflect the multicultural diversity and geographic profile of the catchment area. The committee shall review the development and ongoing progress of the Self-Determination Program, including whether the program advances the principles of self-determination and is operating consistent with the requirements of this section, and may make ongoing recommendations for improvement to the regional center and the department.

(2) The State Council on Developmental Disabilities shall form a volunteer committee, to be known as the Statewide Self-Determination Advisory Committee, comprised of the chairs of the 21 local advisory committees or their designees. The council shall convene the Statewide Self-Determination Advisory Committee twice annually, or more frequently in the sole discretion of the council. The Statewide Self-Determination Advisory Committee shall meet by teleconference or other means established by the council, to identify self-determination best practices, effective consumer and family training materials, implementation concerns, systemic issues, ways to enhance the program, and recommendations regarding the most effective method for participants to learn of individuals who are available to provide services and supports. The council shall synthesize information received from the Statewide Self-Determination Advisory Committee, local advisory committees, and other sources, shall share the information with consumers, families, regional centers, and the department, and shall make recommendations, as appropriate, to increase the program's effectiveness in furthering the principles of self-determination.

(y) Commencing January 10, 2017, the department shall annually provide the following information to the appropriate policy and fiscal committees of the Legislature:

(1) Number and characteristics of participants, by regional center.

(2) Types and amount of services and supports purchased under the Self-Determination Program, by regional center.

(3) Range and average of individual budgets, by regional center, including adjustments to the budget to address the adjustments permitted in clause (ii) of subparagraph (A) of paragraph (1) of subdivision (n).

(4) The number and outcome of appeals concerning individual budgets, by regional center.

(5) The number and outcome of fair hearing appeals, by regional center.

(6) The number of participants who voluntarily withdraw from the Self-Determination Program and a summary of the reasons why, by regional center.

(7) The number of participants who are subsequently determined to no longer be eligible for the Self-Determination Program and a summary of the reasons why, by regional center.

(z) (1) The State Council on Developmental Disabilities, in collaboration with the protection and advocacy agency identified in Section 4900 and the federally funded University Centers for Excellence in Developmental Disabilities Education, Research, and Service, may work with regional centers to survey participants regarding participant satisfaction under the Self-Determination Program, and, when data is available, the traditional service delivery system, including the proportion of participants who report that their choices and decisions are respected and supported and who report that they are able to recruit and hire qualified service providers, and to identify barriers to participation and recommendations for improvement.

(2) The council, in collaboration with the protection and advocacy agency identified in Section 4900 and the federally funded University Centers for Excellence in Developmental Disabilities Education, Research, and Service, shall issue a report to the Legislature, in compliance with Section 9795 of the Government Code, no later than three years following the approval of the federal funding on the status of the Self-Determination Program authorized by this section, and provide recommendations to enhance the effectiveness of the program. This review shall include the program's effectiveness in furthering the principles of self-determination, including all of the following:

(A) Freedom, which includes the ability of adults with developmental disabilities to exercise the same rights as all citizens; to establish, with freely chosen supporters, family and friends, where they want to live, with whom they want to live, how their time will be occupied, and who supports them; and, for families, to have the freedom to receive unbiased assistance of their own choosing when developing a plan and to select all personnel and supports to further the life goals of a minor child.

(B) Authority, which includes the ability of a person with a disability, or family, to control a certain sum of dollars in order to purchase services and supports of their choosing.

(C) Support, which includes the ability to arrange resources and personnel, both formal and informal, that will assist a person with a disability to live a life in his or her community that is rich in community participation and contributions.

(D) Responsibility, which includes the ability of participants to take responsibility for decisions in their own lives and to be accountable for the use of public dollars, and to accept a valued role in their community through, for example, competitive employment, organizational affiliations, spiritual development, and general caring of others in their community.

(E) Confirmation, which includes confirmation of the critical role of participants and their families in making decisions in their own lives and designing and operating the system that they rely on.

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Attachment #2

Senate Bill No. 555

CHAPTER 685

An act to amend Section 95020 of the Government Code, and to amend Sections 4512, 4642, 4643, and 4646 of the Welfare and Institutions Code, relating to developmental services.

[Approved by Governor October 9, 2013. Filed with
Secretary of State October 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 555, Correa. Developmental services: regional centers: individual program plans and individualized family service plans.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services contracts with regional centers to provide services and supports to individuals with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP) or individualized family service plan (IFSP), developed in accordance with prescribed requirements. Existing law states that it is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, as specified.

This bill would require a regional center to communicate and provide written materials in the family's native language during the IFSP process. The bill would require the family's native language to be documented in the IFSP. The bill would similarly require a regional center to communicate in the consumer's native language, or, when appropriate, the native language of his or her family, legal guardian, conservator, or authorized representative, during the IPP planning process and to provide alternative communication services, including a copy of the IPP in the native language of the consumer or his or her family, legal guardian, conservator, or authorized representative, or both. The bill would require the native language of the consumer or his or her family, legal guardian, or authorized representative, or both, to be documented in the IPP.

Under existing law, a person believed to have a developmental disability or to have a high risk of parenting a developmentally disabled infant is eligible for initial intake and assessment in the regional centers, as specified.

This bill would require a regional center to communicate with the consumer and his or her family pursuant to those provisions in their native language.

This bill would make other conforming changes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares the following:

(a) California's diverse language and ethnic communities account for about 60 percent of its population. The number of people in the United States who do not speak English as their native language has grown 140 percent over the past three decades. In California, about 40 percent of Californians speak a language other than English at home, and the number of individuals whose first language is not English is rapidly growing.

(b) Health disparities can result in significant health, social, and economic consequences. Culturally and linguistically competent health care services can assist in achieving health equity. Health literacy plays a central role in promoting quality of life, health development, and health behaviors across all groups and life stages.

(c) To address any disparities in the regional center system, it is the intent of the Legislature that the State Department of Developmental Services and regional centers ensure both of the following:

(1) That all consumers and their families receive culturally and linguistically competent information, including written documents, about the individual program plan and individualized family service plan processes and procedures.

(2) That regional centers comply with Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and implementing regulations, and with Sections 11135 to 11139.7, inclusive, of the Government Code and implementing regulations.

SEC. 2. Section 95020 of the Government Code is amended to read:

95020. (a) An eligible infant or toddler shall have an individualized family service plan. The individualized family service plan shall be used in place of an individualized education program required pursuant to Sections 4646 and 4646.5 of the Welfare and Institutions Code, the individualized program plan required pursuant to Section 56340 of the Education Code, or any other applicable service plan.

(b) For an infant or toddler who has been evaluated for the first time, a meeting to share the results of the evaluation, to determine eligibility and, for children who are eligible, to develop the initial individualized family service plan shall be conducted within 45 calendar days of receipt of the written referral. Evaluation results and determination of eligibility may be shared in a meeting with the family prior to the individualized family service plan. Written parent consent to evaluate and assess shall be obtained within the 45-day timeline. A regional center, local educational agency, or the designee of one of those entities shall initiate and conduct this meeting. Families shall be afforded the opportunity to participate in all decisions regarding eligibility and services. During intake and assessment, but no later than the individualized family service plan meeting, the parents, legal guardian, or conservator shall provide copies of any health benefit cards under which the consumer is eligible to receive health benefits, including, but not limited to, private health insurance, a health care service plan, Medi-Cal, Medicare, and TRICARE. If the individual, or, where appropriate, the parents, legal guardians, or conservators, have no such benefits, the regional center shall not use that fact to negatively impact the services that the individual may or may not receive from the regional center.

(c) Parents shall be fully informed of their rights, including the right to invite another person, including a family member or an advocate or peer parent, or any or all of them, to accompany them to any or all individualized family service plan meetings. With parental consent, a referral shall be made to the local family resource center or network.

(d) The individualized family service plan shall be in writing and shall address all of the following:

(1) A statement of the infant's or toddler's present levels of physical development including vision, hearing, and health status, cognitive development, communication development, social and emotional development, and adaptive developments.

(2) With the concurrence of the family, a statement of the family's concerns, priorities, and resources related to meeting the special developmental needs of the eligible infant or toddler.

(3) A statement of the major outcomes expected to be achieved for the infant or toddler and family where services for the family are related to meeting the special developmental needs of the eligible infant or toddler.

(4) The criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions are necessary.

(5) (A) A statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler as identified in paragraph (3), including, but not limited to, the frequency, intensity, location, duration, and method of delivering the services, and ways of providing services in natural generic environments, including group training for parents on behavioral intervention techniques in lieu of some or all of the in-home parent training component of the behavior intervention services, and purchase of neighborhood preschool services and needed qualified personnel in lieu of infant development programs.

(B) Effective July 1, 2009, at the time of development, review, or modification of an infant's or toddler's individualized family service plan, the regional center shall consider both of the following:

(i) The use of group training for parents on behavior intervention techniques, in lieu of some or all of the in-home parent training component of the behavior intervention services.

(ii) The purchase of neighborhood preschool services and needed qualified personnel, in lieu of infant development programs.

(6) A statement of the agency responsible for providing the identified services.

(7) The name of the service coordinator who shall be responsible for facilitating implementation of the plan and coordinating with other agencies and persons.

(8) The steps to be taken to ensure transition of the infant or toddler upon reaching three years of age to other appropriate services. These may include, as appropriate, special education or other services offered in natural environments.

(9) The projected dates for the initiation of services in paragraph (5) and the anticipated duration of those services.

(e) Each service identified on the individualized family service plan shall be designated as one of three types:

(1) An early intervention service, as defined in subsection (4) of Section 1432 of Title 20 of the United States Code, and applicable regulations, that is provided or purchased through the regional center, local educational agency, or other participating agency. The State Department of Health Care Services and the State Department of Social Services shall provide services in accordance with state and federal law and applicable regulations, and up to the level of funding as appropriated by the Legislature. Early intervention services identified on an individualized family service plan that exceed the funding, statutory, and regulatory requirements of these departments shall be provided or purchased by regional centers or local educational agencies under subdivisions (b) and (c) of Section 95014. The State Department of Health Care Services and the State Department of Social Services shall not be required to provide early intervention services over their existing funding, statutory, and regulatory requirements.

(2) Another service, other than those specified in paragraph (1), which the eligible infant or toddler or his or her family may receive from other state programs, subject to the eligibility standards of those programs.

(3) A referral to a nonrequired service that may be provided to an eligible infant or toddler or his or her family. Nonrequired services are those services that are not defined as early intervention services or do not relate to meeting the special developmental needs of an eligible infant or toddler related to the disability, but that may be helpful to the family. The granting or denial of nonrequired services by a public or private agency is not subject to appeal under this title. Notwithstanding any other provision of law or regulation to the contrary, effective July 1, 2009, with the exception of durable medical equipment, regional centers shall not purchase nonrequired services, but may refer a family to a nonrequired service that may be available to an eligible infant or toddler or his or her family.

(f) An annual review, and other periodic reviews, of the individualized family service plan for an infant or toddler and the infant's or toddler's family shall be conducted to determine the degree of progress that is being made in achieving the outcomes specified in the plan and whether modification or revision of the outcomes or services is necessary. The frequency, participants, purpose, and required processes for annual and periodic reviews shall be consistent with the statutes and regulations under Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and this title, and shall be specified in regulations adopted pursuant to Section 95028. At the time of the review, the parents, legal guardian, or conservator shall provide copies of any health benefit cards under which the consumer is eligible to receive health benefits, including, but not limited to, private health insurance, a health care service plan, Medi-Cal, Medicare, and TRICARE. If the parents, legal guardian, or conservator have no such benefit cards, the regional center shall not use that fact to negatively impact the services that the individual may or may not receive from the regional center.

(g) (1) A regional center shall communicate and provide written materials in the family's native language during the assessment, evaluation, and planning process for the individualized family service plan, as required by Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and implementing regulations, and as required by Sections 11135 to 11139.7, inclusive, and implementing regulations, including providing alternative communication services pursuant to Sections 98210 to 98211, inclusive, of Title 22 of the California Code of Regulations.

(2) The family's native language shall be documented in the individualized family service plan.

SEC. 3. Section 4512 of the Welfare and Institutions Code is amended to read:

4512. As used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

(b) "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, and normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills training, specialized medical and dental care, supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan.

(c) Notwithstanding subdivisions (a) and (b), for any organization or agency receiving federal financial participation under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, as amended, "developmental disability" and "services for persons with developmental disabilities" mean the terms as defined in the federal act to the extent required by federal law.

(d) "Consumer" means a person who has a disability that meets the definition of developmental disability set forth in subdivision (a).

(e) "Natural supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships, friendships reflecting the diversity of the neighborhood and the community, associations with fellow students or employees in regular classrooms and workplaces, and associations developed through participation in clubs, organizations, and other civic activities.

(f) "Circle of support" means a committed group of community members, who may include family members, meeting regularly with an individual with developmental disabilities in order to share experiences, promote autonomy and community involvement, and assist the individual in establishing and maintaining natural supports. A circle of support generally includes a plurality of members who neither provide nor receive services or supports for persons with developmental disabilities and who do not receive payment for participation in the circle of support.

(g) "Facilitation" means the use of modified or adapted materials, special instructions, equipment, or personal assistance by an individual, such as assistance with communications, that will enable a consumer to understand and participate to the maximum extent possible in the decisions and choices that effect his or her life.

(h) "Family support services" means services and supports that are provided to a child with developmental disabilities or his or her family and that contribute to the ability of the family to reside together.

(i) "Voucher" means any authorized alternative form of service delivery in which the consumer or family member is provided with a payment, coupon, chit, or other form of authorization that enables the consumer or family member to choose his or her own service provider.

(j) "Planning team" means the individual with developmental disabilities, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, one or more regional center representatives, including the designated regional center service coordinator pursuant to subdivision (b) of Section 4640.7, any individual, including a service provider, invited by the consumer, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, and including a minor's, dependent's, or ward's court-appointed developmental services decisionmaker appointed pursuant to Section 319, 361, or 726.

(k) "Stakeholder organizations" means statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations.

(*l*) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

(m) "Native language" means the language normally used or the preferred language identified by the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative.

SEC. 4. Section 4642 of the Welfare and Institutions Code is amended to read:

4642. (a) (1) Any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant shall be eligible for initial intake and assessment services in the regional centers. In addition, any infant having a high risk of becoming developmentally disabled may be eligible for initial intake and assessment services in the regional centers. For purposes of this section, "high-risk infant" means a child less than 36 months of age whose genetic, medical, or environmental history is predictive of a substantially greater risk for developmental disability than that for the general population. The department, in consultation with the State Department of Public Health, shall develop specific risk and service criteria for the high-risk infant program on or before July 1, 1983. These criteria may be modified in subsequent years based on analysis of actual clinical experience.

(2) Initial intake shall be performed within 15 working days following request for assistance. Initial intake shall include, but need not be limited to, information and advice about the nature and availability of services provided by the regional center and by other agencies in the community, including guardianship, conservatorship, income maintenance, mental health, housing, education, work activity and vocational training, medical, dental, recreational, and other services or programs that may be useful to persons with developmental disabilities or their families. Intake shall also include a decision to provide assessment.

(b) A regional center shall communicate with the consumer and his or her family pursuant to this section in their native language, including providing alternative communication services, as required by Sections 11135 to 11139.7, inclusive, of the Government Code and implementing regulations.

SEC. 5. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b).

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

(c) At the time of assessment, the individual, or, where appropriate, the parents, legal guardian, or conservator, shall provide copies of any health benefit cards under which the consumer is eligible to receive health benefits, including, but not limited to, private health insurance, a health care service plan, Medi-Cal, Medicare, and TRICARE. If the individual, or where appropriate, the parents, legal guardians, or conservators, have no such benefits, the regional center shall not use that fact to negatively impact the services that the individual may or may not receive from the regional center.

(d) A regional center shall communicate with the consumer and his or her family pursuant to this section in their native language, including providing alternative communication services, as required by Sections 11135 to 11139.7, inclusive, of the Government Code and implementing regulations.

SEC. 6. Section 4646 of the Welfare and Institutions Code is amended to read:

4646. (a) It is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments. It is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.

(b) The individual program plan is developed through a process of individualized needs determination. The individual with developmental disabilities and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, shall have the opportunity to actively participate in the development of the plan.

(c) An individual program plan shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment. At the time of intake, the regional center shall inform the consumer and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, of the services available through the local area board and the protection and advocacy agency designated by the Governor pursuant to federal law, and shall provide the address and telephone numbers of those agencies.

(d) Individual program plans shall be prepared jointly by the planning team. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the consumer's individual program plan and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative at the program plan meeting.

(e) Regional centers shall comply with the request of a consumer, or when appropriate, the request of his or her parents, legal guardian, conservator, or authorized representative, that a designated representative receive written notice of all meetings to develop or revise his or her individual program plan and of all notices sent to the consumer pursuant to

Section 4710. The designated representative may be a parent or family member.

(f) If a final agreement regarding the services and supports to be provided to the consumer cannot be reached at a program plan meeting, then a subsequent program plan meeting shall be convened within 15 days, or later at the request of the consumer or, when appropriate, the parents, legal guardian, conservator, or authorized representative or when agreed to by the planning team. Additional program plan meetings may be held with the agreement of the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative.

(g) An authorized representative of the regional center and the consumer or, when appropriate, his or her parent, legal guardian, conservator, or authorized representative shall sign the individual program plan prior to its implementation. If the consumer or, when appropriate, his or her parent, legal guardian, conservator, or authorized representative, does not agree with all components of the plan, he or she may indicate that disagreement on the plan. Disagreement with specific plan components shall not prohibit the implementation of services and supports agreed to by the consumer or, when appropriate, his or her parent, legal guardian, conservator, or authorized representative. If the consumer or, when appropriate, his or her parent, legal guardian, conservator, or authorized representative, does not agree with the plan in whole or in part, he or she shall be sent written notice of the fair hearing rights, as required by Section 4701.

(h) (1) A regional center shall communicate in the consumer's native language, or, when appropriate, the native language of his or her family, legal guardian, conservator, or authorized representative, during the planning process for the individual program plan, including during the program plan meeting, and including providing alternative communication services, as required by Sections 11135 to 11139.7, inclusive, of the Government Code and implementing regulations.

(2) A regional center shall provide alternative communication services, including providing a copy of the individual program plan in the native language of the consumer or his or her family, legal guardian, conservator, or authorized representative, or both, as required by Sections 11135 to 11139.7, inclusive, of the Government Code and implementing regulations.

(3) The native language of the consumer or his or her family, legal guardian, conservator, or authorized representative, or both, shall be documented in the individual program plan.

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Attachment #3

Assembly Bill No. 1041

CHAPTER 677

An act to amend Sections 4646.5 and 4868 of, and to add Section 4869 to, the Welfare and Institutions Code, relating to developmental services.

[Approved by Governor October 9, 2013. Filed with
Secretary of State October 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1041, Chesbro. Developmental services: Employment First Policy.

The Lanterman Developmental Disabilities Services Act authorizes the State Department of Developmental Services to contract with regional centers to provide support and services to individuals with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP), developed in accordance with prescribed requirements.

Existing law requires the State Council on Developmental Disabilities to, among other responsibilities, form a standing Employment First Committee to identify strategies and recommend legislative, regulatory, and policy changes to increase integrated employment, as defined, self-employment, and microenterprises for persons with developmental disabilities, as specified.

This bill would define competitive employment, microenterprises, and self-employment for these purposes. The bill would additionally require the Employment First Committee to identify existing sources of consumer data that can be matched with employment data, as specified, and to recommend goals for measuring employment participation and outcomes for various consumers within the developmental services system. The bill would require the State Council on Developmental Disabilities to develop an informational brochure about the Employment First Policy, translate the brochure into various languages, and post the brochure on the council's Internet Web site. This bill would require each regional center planning team, when developing an individual program plan for a transition age youth or working age adult, to consider a specified Employment First Policy. The bill would also require regional centers to provide consumers 16 years of age or older, and, when appropriate, other specified persons, with information about the Employment First Policy, options for integrated competitive employment, and services and supports, including postsecondary education, that are available to enable the consumer to transition from school to work, and to achieve the outcomes of obtaining and maintaining integrated competitive employment. The bill would authorize the department to request information from regional centers on current and planned activities related to the Employment First Policy.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares that under existing state and federal law, special education local planning agencies (SELPAs) have concurrent responsibilities to eligible students beginning at 16 years of age for the provision of assessment, planning, and necessary services to aid in the transition from school to postschool activities.

(b) This act shall not be construed to expand the responsibilities and duties of SELPAs under state and federal law.

SEC. 2. Section 4646.5 of the Welfare and Institutions Code is amended to read:

4646.5. (a) The planning process for the individual program plan described in Section 4646 shall include all of the following:

(1) Gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the person with developmental disabilities. For children with developmental disabilities, this process should include a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments shall be conducted by qualified individuals and performed in natural environments whenever possible. Information shall be taken from the consumer, his or her parents and other family members, his or her friends, advocates, authorized representative, if applicable, providers of services and supports, and other agencies. The assessment process shall reflect awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

(2) A statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities, and a statement of specific, time-limited objectives for implementing the person's goals and addressing his or her needs. These objectives shall be stated in terms that allow measurement of progress or monitoring of service delivery. These goals and objectives should maximize opportunities for the consumer to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over his or her life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals.

(3) When developing individual program plans for children, regional centers shall be guided by the principles, process, and services and support parameters set forth in Section 4685.

(4) When developing an individual program plan for a transition age youth or working age adult, the planning team shall consider the Employment First Policy described in Chapter 14 (commencing with Section 4868).

(5) A schedule of the type and amount of services and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the individual program plan goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports.

The individual program plan shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services.

(6) When agreed to by the consumer, the parents, legally appointed guardian, or authorized representative of a minor consumer, or the legally appointed conservator of an adult consumer or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548, subdivision (b) of Section 4701.6, and subdivision (e) of Section 4705, a review of the general health status of the adult or child, including medical, dental, and mental health needs, shall be conducted. This review shall include a discussion of current medications, any observed side effects, and the date of the last review of the medication. Service providers shall cooperate with the planning team to provide any information necessary to complete the health status review. If any concerns are noted during the review, referrals shall be made to regional center clinicians or to the consumer's physician, as appropriate. Documentation of health status and referrals shall be made in the consumer's record by the service coordinator.

(7) (A) The development of a transportation access plan for a consumer when all of the following conditions are met:

(i) The regional center is purchasing private, specialized transportation services or services from a residential, day, or other provider, excluding vouchered service providers, to transport the consumer to and from day or work services.

(ii) The planning team has determined that a consumer's community integration and participation could be safe and enhanced through the use of public transportation services.

(iii) The planning team has determined that generic transportation services are available and accessible.

(B) To maximize independence and community integration and participation, the transportation access plan shall identify the services and supports necessary to assist the consumer in accessing public transportation and shall comply with Section 4648.35. These services and supports may include, but are not limited to, mobility training services and the use of transportation aides. Regional centers are encouraged to coordinate with local public transportation agencies.

(8) A schedule of regular periodic review and reevaluation to ascertain that planned services have been provided, that objectives have been fulfilled within the times specified, and that consumers and families are satisfied with the individual program plan and its implementation.

(b) For all active cases, individual program plans shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years. If the consumer or, where appropriate, the consumer's parents, legal guardian, authorized representative, or conservator requests an individual program plan review, the individual program shall be reviewed within 30 days after the request is submitted.

(c) (1) The department, with the participation of representatives of a statewide consumer organization, the Association of Regional Center Agencies, an organized labor organization representing service coordination staff, and the Organization of Area Boards shall prepare training material and a standard format and instructions for the preparation of individual program plans, which embody an approach centered on the person and family.

(2) Each regional center shall use the training materials and format prepared by the department pursuant to paragraph (1).

(3) The department shall biennially review a random sample of individual program plans at each regional center to ensure that these plans are being developed and modified in compliance with Section 4646 and this section.

SEC. 3. Section 4868 of the Welfare and Institutions Code is amended to read:

4868. (a) The State Council on Developmental Disabilities shall form a standing Employment First Committee consisting of the following members:

(1) One designee of each of the members of the state council specified in subparagraphs (B), (C), (D), (F), and (H) of paragraph (2) of subdivision (b) of Section 4521.

(2) A member of the consumer advisory committee of the state council.

(b) In carrying out the requirements of this section, the committee shall meet and consult, as appropriate, with other state and local agencies and organizations, including, but not limited to, the Employment Development Department, the Association of Regional Center Agencies, one or more supported employment provider organizations, an organized labor organization representing service coordination staff, and one or more consumer family member organizations.

(c) The responsibilities of the committee shall include, but need not be limited to, all of the following:

(1) Identifying the respective roles and responsibilities of state and local agencies in enhancing integrated and gainful employment opportunities for people with developmental disabilities.

(2) Identifying strategies, best practices, and incentives for increasing integrated employment and gainful employment opportunities for people with developmental disabilities, including, but not limited to, ways to improve the transition planning process for students 14 years of age or older, and to develop partnerships with, and increase participation by, public and private employers and job developers.

(3) Identifying existing sources of employment data and recommending goals for, and approaches to measuring progress in, increasing integrated employment and gainful employment of people with developmental disabilities.

(4) Identifying existing sources of consumer data that can be used to provide demographic information for individuals, including, but not limited to, age, gender, ethnicity, types of disability, and geographic location of

consumers, and that can be matched with employment data to identify outcomes and trends of the Employment First Policy.

(5) Recommending goals for measuring employment participation and outcomes for various consumers within the developmental services system.

(6) Recommending legislative, regulatory, and policy changes for increasing the number of individuals with developmental disabilities in integrated employment, self-employment, and microenterprises, and who earn wages at or above minimum wage, including, but not limited to, recommendations for improving transition planning and services for students with developmental disabilities who are 14 years of age or older. This shall include, but shall not be limited to, the development of a policy with the intended outcome of significantly increasing the number of individuals with developmental disabilities who engage in integrated employment, self-employment, and microenterprises, and in the number of individuals who earn wages at or above minimum wage. This proposed policy shall be in furtherance of the intent of this division that services and supports be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age and that support their integration into the mainstream life of the community, and that those services and supports result in more independent, productive, and normal lives for the persons served. The proposed policy shall not limit service and support options otherwise available to consumers, or the rights of consumers, or, where appropriate, parents, legal guardians, or conservators to make choices in their own lives.

(d) For purposes of this chapter, the following definitions shall apply:

(1) "Competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

(2) "Integrated employment" means "integrated work" as defined in subdivision (o) of Section 4851.

(3) "Microenterprises" means small businesses owned by individuals with developmental disabilities who have control and responsibility for decisionmaking and overseeing the business, with accompanying business licenses, taxpayer identification numbers other than social security numbers, and separate business bank accounts. Microenterprises may be considered integrated competitive employment.

(4) "Self-employment" means an employment setting in which an individual works in a chosen occupation, for profit or fee, in his or her own small business, with control and responsibility for decisions affecting the conduct of the business.

(e) The committee, by July 1, 2011, and annually thereafter, shall provide a report to the appropriate policy committees of the Legislature and to the Governor describing its work and recommendations. The report due by July

1, 2011, shall include the proposed policy described in paragraph (4) of subdivision (c).

SEC. 4. Section 4869 is added to the Welfare and Institutions Code, to read:

4869. (a) (1) In furtherance of the purposes of this division to make services and supports available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age, to support the integration of persons with developmental disabilities into the mainstream life of the community, and to bring about more independent, productive, and normal lives for the persons served, it is the policy of the state that opportunities for integrated, competitive employment shall be given the highest priority for working age individuals with developmental disabilities, regardless of the severity of their disabilities. This policy shall be known as the Employment First Policy.

(2) Implementation of the policy shall be consistent with, and shall not infringe upon, the rights established pursuant to this division, including the right of people with developmental disabilities to make informed choices with respect to services and supports through the individual program planning process.

(3) Integrated competitive employment is intended to be the first option considered by planning teams for working age individuals, but individuals may choose goals other than integrated competitive employment.

(4) Postsecondary education, technical or vocational training, and internship programs may be considered as a means to achieve integrated competitive employment or career advancement.

(5) This chapter shall not be construed to expand the existing entitlement to services for persons with developmental disabilities described in this division.

(6) This chapter shall not alleviate schools of their responsibility to provide transition services to individuals with developmental disabilities.

(b) The State Council on Developmental Disabilities shall develop an informational brochure about the Employment First Policy, translate the brochure into various languages, and post the brochure on its Internet Web site.

(c) Regional centers shall provide consumers 16 years of age or older, and, when appropriate, their parents, legal guardians, conservators, or authorized representative with information, in an understandable form, about the Employment First Policy, options for integrated competitive employment, and services and supports, including postsecondary education, that are available to enable the consumer to transition from school to work, and to achieve the outcomes of obtaining and maintaining integrated competitive employment.

(d) The department may request information from regional centers on current and planned activities related to the Employment First Policy.

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Attachment #4

Senate Bill No. 126

CHAPTER 680

An act to amend Section 1374.73 of the Health and Safety Code, and to amend Sections 10144.51 and 10144.52 of the Insurance Code, relating to health care coverage.

[Approved by Governor October 9, 2013. Filed with
Secretary of State October 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 126, Steinberg. Health care coverage: pervasive developmental disorder or autism.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism, except as specified. A willful violation of these provisions with respect to health care service plans is a crime. These provisions are inoperative on July 1, 2014, and are repealed on January 1, 2015.

This bill would extend the operation of these provisions until January 1, 2017. By extending the operation of provisions establishing crimes, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.73 of the Health and Safety Code is amended to read:

1374.73. (a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not

require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health care service plan from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised and employed by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment.

(B) Is employed and supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is employed and supervised by a qualified autism service provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(d) This section shall not apply to the following:

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) A health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(4) A health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 1374.72.

(f) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 2. Section 10144.51 of the Insurance Code is amended to read:

10144.51. (a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare

and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240) of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health insurer from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised and employed by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment.

(B) Is employed and supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is employed and supervised by a qualified autism service provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(d) This section shall not apply to the following:

(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.

(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) A health insurance policy in the Healthy Families Program (Part 6.2 (commencing with Section 12693)).

(4) A health care benefit plan or policy entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 10144.5.

(f) As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 3. Section 10144.52 of the Insurance Code is amended to read:

10144.52. (a) For purposes of this part, the terms "provider," "professional provider," "network provider," "mental health provider," and "mental health professional" shall include the term "qualified autism service provider," as defined in subdivision (c) of Section 10144.51.

(b) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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Attachment #5

Omar Noorzad - Re: CDCAN REPORT #095-2013 (OCT 09 2013): GOVERNOR TAKES ACTION ON SEVERAL BILLS IMPACTING PEOPLE WITH DEVELOPMENTAL DISABILITIES - SIGNS SELF DETERMINATION BILL, BILL TO REQUIRE NATIVE LANGUAGE COMMUNICATION IN REGIONAL CENTER IPP/IFSP; EMPLOYMENT FIRST

From: "Marty Omoto - CDCAN (California Disability Community Action Network)" <martyomoto@rcip.com>
To: <CDCANreportlist01@rcip.com>
Date: 10/10/2013 12:45 AM
Subject: Re: CDCAN REPORT #095-2013 (OCT 09 2013): GOVERNOR TAKES ACTION ON SEVERAL BILLS IMPACTING PEOPLE WITH DEVELOPMENTAL DISABILITIES - SIGNS SELF DETERMINATION BILL, BILL TO REQUIRE NATIVE LANGUAGE COMMUNICATION IN REGIONAL CENTER IPP/IFSP; EMPLOYMENT FIRST

CDCAN DISABILITY RIGHTS REPORT

CALIFORNIA DISABILITY COMMUNITY ACTION NETWORK

#095-2013 – October 09, 2013 – Wednesday

Advocacy Without Borders: One Community – Accountability With Action
CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com Twitter: martyomoto
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549

SPECIAL NOTE ON CHANGES FOR CDCAN REPORTS – HELP NEEDED:

- *NEW EMAIL LIST SERVICE PROVIDER – **This WILL happen for sure by November 1st!!!!** CDCAN has been in the process of transitioning over the past couple of months to a different email list service to send out future CDCAN reports very soon that should provide a lot of ways to improve and expand reporting. The reports will look basically the same, though there will be differences in format and we won't be able to send out attachments. Please let me know if you are receiving the reports using the new service, and if the format and reporting looks okay or have other comments.*
- *HELP NEEDED: It will cost more every month, so any support would be greatly (and urgently) needed and appreciated. Please help! (see below)*
- *I want to pay special tribute to River City Internet Providers (RCIP) and the staff there for their tremendous support they have given over the past 15 years to CDCAN and the work of advocacy for people with disabilities, mental health needs, the blind and seniors. Without them I could not have been able to provide the reports I was able to do over the years.*

State Capitol Update

GOVERNOR BROWN SIGNS SEVERAL BILLS IMPACTING PEOPLE WITH DEVELOPMENTAL DISABILITIES

- ***Signs SB 468 Self Determination Program***
- ***Approves SB 555 Regional Center Requirement to Provide***

Communications in Native Language for Individual Program Plans and Individualized Family Service Plans

- ***Signs AB 1041 Employment First Policy and SB 126 that Extends Autism Health Insurance Mandate to 2017***

SACRAMENTO, CA (CDCAN) [Last updated – 10/09/2013 – 06:00 PM] – Governor Brown took action on 32 bills today, signing 25 and vetoing 7.

Several bills the Governor did sign had major potential impact on people with developmental disabilities dealing with implementation of a statewide self determination program; a requirement for all regional centers to provide communications in the native language of a person with developmental disabilities (and their families) Individual Program Plan and Individualized Family Service Plan (ISFP), a bill to extend to 2017 what is known as the "autism health insurance mandate" originally established by SB 946 in 2011, and legislation that will establish a statewide "employment first" policy for persons with developmental disabilities. Information about the bills impacting people with developmental disabilities are included below in this CDCAN Report. A report on other bills the Governor signed today – and earlier this week and last week impacting Medi-Cal, health, transportation, foster care – will be included in the next CDCAN Report.

The Governor vetoed 2 bills dealing with people with developmental disabilities: AB 1231 dealing with telehealth and SB 158 that would have established a autism demonstration project.

The Governor has until midnight October 13, 2013 to sign or veto bills sent to him by the Legislature before they adjourned on September 12th.

SELF DETERMINATION BILL SIGNED BY GOVERNOR BROWN

Governor Brown's approval of SB 468 by Sen. Bill Emmerson (Republican – Redlands) [pictured in photo left] was hailed by many disability rights advocates, including families in developmental centers and in community-based services as a "landmark" and "historic" step in advancing the rights of people with developmental disabilities across the State.

- Emmerson said that the statewide Self Determination Program will build upon the successful Self-Determination Pilot Project the Legislature passed in 1998 that only applied to five of the 21 regional centers and was capped at 200 participants.
- SB 468 will open up the Self-Determination Program to all persons with developmental disabilities eligible for regional center funded services throughout the State, but will be phased in over three years and serve up to 2,500 consumers.
- After the initial phase in period, the program will be available on a voluntary basis.
- Sen. Emmerson, in a statement released after the Governor signed his bill, said self determination "...is a giant leap forward for consumers in the regional center system. Individuals with developmental disabilities will be able to take charge of their future by choosing services that are most effective rather than relying on services chosen by the regional centers."
- Emmerson said the bill will also eliminate "...needless bureaucracy as the participants and their parents will have control over the services, supports and resources that are available, which is the original intent of the Lanterman Act."
- The bill was co-sponsored by Disability Rights California and Autism Society of Los Angeles.

- Connie Lapin of the Autism Society of Los Angeles and a family member and long time advocate who pushed hard for the bill said that the enactment of SB 486 will mean that California is "...the only state in the country that has achieved this in legislation - not just in regulations and administratively [as done in some other states]".
- Lapin said that self determination under SB 486 means "freedom, choice and flexibility for consumers and families," and offered her thanks to Governor Brown and his Administration, Senators Emmerson, Jim Beall Jr (Democrat – San Jose), Holly Mitchell (Democrat – Los Angeles), Assemblymember Wes Chesbro (Democrat – Arcata) and former Assemblymember Bob Blumefield (Democrat – Van Nuys) for realizing the dream for thousands of people and families across the State who can look forward to "an amazing journey."
- "SB 468 is the most important law to have passed in decades for individuals with developmental disabilities like my son, who is now 45 years old. These individuals want choice and control over their lives. This law makes that possible" said Dr. Harvey A. Lapin, member of Autism Society of Los Angeles and a longtime disability rights advocate.
- Some advocates for some of the regional centers, while supportive of the self determination concept expressed concerns about the State's commitment in providing sufficient resources and funding for the program as it expands and opens up to more people across the State.

BILL IMPOSING NATIVE LANGUAGE REQUIREMENT FOR REGIONAL CENTER INDIVIDUAL PROGRAM PLANS AND FAMILY PLANS

- Governor Brown also signed SB 555 by Sen. Lou Correa (Democrat – Santa Ana) that would require the 21 regional centers to provide communications related to a person with developmental disabilities (and their families) Individual Program Plan (IPP) or Individualized Family Service Plan (IFSP).
- Correa previously said his bill was needed because for people with developmental disabilities, "...health disparities can result in significant health, social, and economic consequences," and that "...California's diverse language and ethnic communities account for about 60% of its population and that ethnic disparities exist within the regional center system."
- Correa contended that people with developmental disabilities receiving services from regional centers – and their family members who are limited English proficient "...have the right to get culturally and linguistically competent information about the Individual Program Plan (IPP) and the Individual Family Services Plan (IFSP) processes and procedures," adding that "...health literacy is essential to promoting quality of life, health development, and healthy behaviors across all groups and life stages."
- SB 555 is one of three bills that focused on the issue of cultural competency and linguistics related to regional center funded services (AB 1232, SB 367, and SB 555).

AUTISM HEALTH INSURANCE MANDATE EXTENDED

- In another major bill impacting people with developmental disabilities, Governor Brown also today signed SB 126 by Senate President Pro Tem Darrell Steinberg (Democrat – Sacramento) that will extend by another two and half years what is known as the "California Autism Health Insurance Mandate".
- SB 126 passed the Assembly on August 30, 2013 by a vote of 78 to 0, and passed the State Senate in its final vote on September 6, 2013, by a vote of 37 to 0
- The state law reportedly has already helped more than 12,500 Californians receive insurance coverage for early autism treatment under SB 946 – also authored by Steinberg - that was signed into law by Governor Brown on October 9, 2011 but was set to expire July 1, 2014.

- SB 126 extends, until January 1, 2017, the provisions of SB 946 requiring private health care insurance plans to provide coverage for "behavioral health treatment" of children with autism and pervasive developmental disorders.
- Steinberg, widely respected by advocates for families with children with autism spectrum and related disorders, said in a statement issued following the signing of SB 126 that "earlier this year, I stood on the Capitol steps and called for an extension to help tens of thousands more receive autism behavioral health treatments. Today, that hope for more effective therapy is a reality for those who desperately need it. I'm proud that California is leading the nation on ensuring treatments for those with autism."
- SB 126 also provides for the evaluation of recommendations by the Department of Managed Health Care Autism Taskforce, a process for licensure for providers and paraprofessionals of behavioral health treatments, coordination with "Obamacare" – officially known as the "Affordable Care Act of 2010", and assessment of future guidelines of that federal law.
- Autism is the nation's most rapidly growing serious developmental disability, as the number of those living with autism in the United States is 300% higher than it was in 2005. Nearly one in every 50 children in U.S. children exhibits signs of autism spectrum disorders.
- Research demonstrated that early behavioral intervention therapies improve brain functions, promote higher cognitive functions and reduce self-injurious behaviors for a significant number of individuals with autism spectrum and related disorders
- Since the autism insurance mandate initially went into effect on July 1, 2012, the California Department of Insurance estimates annual taxpayer savings of up to $200 million in intervention costs from regional centers and special education programs.
- The bill was sponsored by Autism Speaks.

GOVERNOR SIGNS "EMPLOYMENT FIRST POLICY" FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

- Governor Brown also signed this afternoon AB 1041 by Assemblymember Wes Chesbro (Democrat – Arcata) that will establish a statewide "Employment First" policy for persons with developmental disabilities eligible for regional center funded services.
- Assemblymember Chesbro, considered by many advocates and policymakers as a leader in the Legislature for disability rights, said his bill was needed because the State "…has failed to adequately support people with developmental disabilities to achieve one of the central elements of leading a normal, productive life-employment," adding that his bill "…seeks to re-orient the provision of developmental services by making employment opportunities the priority of the state."
- The action by the Governor was applauded by many advocates and families across the State, though some advocates have argued that the State needs to do more in funding employment related services for people with developmental disabilities after years of budget reductions.

CDCAN SUMMARY OF BILLS ACTED ON BY GOVERNOR IMPACTING PEOPLE WITH DISABILTIIES

The following are the bills acted on today (October 9th) by Governor Brown that impact directly people with developmental disabilities. The bills are listed by bill number, Assembly bills first, followed by Senate bills – with links to the latest versions of the bill (as sent to the Governor).

AB 602 – STATE HOSPITALS AND DEVELOPMENTAL CENTERS: REPORTING ABUSE
AUTHOR: Assemblymember Mariko Yamada (Democrat – Davis)
CDCAN SUMMARY:

- *Require the commission to establish, by July 1, 2015, and keep updated a training course* *relating to law enforcement interaction with mentally disabled or developmentally disabled persons living within a state mental hospital or state developmental center, as specified in the bill.*

- *Provides that the training course would be required for law enforcement personnel in law enforcement agencies with jurisdiction over state mental health hospitals and state developmental centers, as part of the agency's officer training program.*
- *Requires a report to be made to designated investigators of the Department of State Hospitals or the Department of Developmental Services, and also to the local enforcement agency, if the suspected or alleged abuse or neglect occurred in a state mental hospital or state developmental center and resulted in any specified incidents, including a death or a sexual assault.*
- *Would also remove the requirement that mandated reporters in the Department of Developmental Services immediately report suspected abuse to the Office of Protective Services or to the local law enforcement agency.*
- *Requires a local law enforcement agency to coordinate efforts with the designated investigators of the Department of State Hospitals or the Department of Developmental Services to provide a response to investigate reports received pursuant to specified provisions.*
- *Provides that a developmental center is required to report that information immediately, but no later than within 2 hours of the mandated reporter observing, obtaining knowledge of, or suspecting abuse.*

LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION –32 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0601-0650/ab_602_bill_20130916_enrolled.pdf
LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 673, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.
CDCAN COMMENT:

- This bill would incorporate additional changes in Section 4427.5 of the Welfare and Institutions Code made by SB 651, to become operative if SB 651 and this bill are both enacted and become effective on or before January 1, 2014, and AB 602 is enacted last (meaning signing AFTER signing SB 651).
- However, as 11:56 PM, no action by the Governor has been reported on SB 651.

AB 620 – HEALTH AND CARE FACILITIES: MISSING PATIENTS AND PARTICIPANTS

AUTHOR: Assemblymember Joan Buchanan (Democrat - Alamo)
CDCAN SUMMARY:
Requires intermediate care facilities, nursing facilities, congregate living facilities, and adult day centers to develop and comply with a patient or resident absentee notification plan for the purpose of addressing issues that arise when a resident is missing from the facility.
LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 8 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0601-0650/ab_620_bill_20130916_enrolled.pdf
LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 674, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.
CDCAN COMMENT:

- According to Assemblymember Buchanan, current state regulations require these long-term care facilities to report to regulators when the facility has filed a missing persons report with a law enforcement agency.

- However, those long term facilities are not required to file a missing persons report with law enforcement or to notify relevant family members or caregivers when a person is missing. Assemblymember Buchanan contends that the safety of individuals living in care facilities, or participating in a day program, is at risk, as is evidenced by recent cases (the Contra Costa Times reported on October 10, 2012 about an incident involving a 86 year old female resident of a facility who went missing from Julia's Home, an adult care home in Concord, CA.

AB 1041 – DEVELOPMENTAL SERVICES: EMPLOYMENT FIRST POLICY

AUTHOR: Assemblymember Wesley Chesbro (Democrat - Arcata)
CDCAN SUMMARY:

- *Creates a statewide "Employment First Policy" and sets requirements related to the inclusion of employment opportunities and services in the individual program plan (IPP) of a person with developmental disabilities eligible for regional center funded services under the Lanterman Developmental Disabilities Services Act.*
- *Requires a regional center planning team to consider the Employment First Policy, as specified, when developing an IPP for a transition age youth or a working age adult.*
- *Defines "competitive employment" as work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting and for which an individual is compensated at or above the minimum wage, as specified in the bill.*
- *Creates a statewide Employment First Policy, which establishes that opportunities for integrated, competitive employment shall be given the highest priority for working age individuals with development disabilities, regardless of the severity of their disabilities.*
- *Requires implementation of the Employment First Policy to not infringe upon the rights of people with developmental disabilities to make informed choices with respect to the services and supports they need through the IPP process.*
- *Provides that integrated competitive employment shall be the first option considered by planning teams for working individuals, but individuals may choose goals other than integrated competitive employment.*
- *Requires that the Employment First Policy not be construed to expand the existing entitlement to services for persons with developmental disabilities or alleviate schools of their responsibility to provide transition services to individuals with developmental disabilities.*
- *Requires regional centers to ensure that consumers, beginning at 16 years of age, as well as their parents, legal guardians, or conservators, as appropriate, are provided information in a language the consumer or appropriate representative understands, pertaining to the following: (a) The Employment First Policy; (b) Options for integrated competitive employment; and (c) Services and supports, including postsecondary education, available to enable the consumer to transition from school to work and to achieve the outcomes of obtaining and maintaining integrated competitive employment.*
- *Provides the Department of Developmental Services authority to request information from regional centers related to a regional center's current and planned activities related to the Employment First Policy.*

  LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 16 PAGES]:
  http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1001-1050/ab_1041_bill_20130916_enrolled.pdf

LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 677, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.

AB 1231 – REGIONAL CENTERS: TELEHEALTH

AUTHOR: Assemblymember V. Manuel Pérez (Democrat - Coachella)
CDCAN SUMMARY:
Requires the Department of Developmental Services to inform the 21 regional centers that appropriate health care services and dentistry services may be provided to regional center consumers through the use of telehealth.
LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 8 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1201-1250/ab_1231_bill_20130916_enrolled.pdf
LATEST ACTION 10/09/2013: **VETOED** by Governor.
VETO MESSAGE BY GOVERNOR:
Oct 09 2013
To the Members of the California State Assembly:
I am returning Assembly Bill 1231 without my signature.
This bill would require the Department of Developmental Services to inform regional centers that any appropriate health care services, including dentistry, may be provided through telehealth. The bill would additionally require the department to ask regional centers to consider using telehealth in their parent training programs and provide technical assistance on telehealth.
Everything required by this bill either can be done, or is already being done, under existing law.
Sincerely,
[signed]
Edmund G. Brown, Jr.
NEXT STEPS: In theory the author could try to have the Legislature over-ride the Governor's veto in January when they reconvene. That requires 2/3rds vote in both houses – 54 votes in the Assembly and 27 in the State Senate and the approval of the Democratic legislative leadership. Vetoes by governors are very rarely overridden – though it did happen several times during Brown's first two terms. It is highly unlikely it will happen to this or any other bill however.

AB 1232 – DEVELOPMENTAL SERVICES: QUALITY ASSESSMENT SYSTEM
AUTHOR: Assemblymember V. Manuel Pérez (Democrat – Coachella
CDCAN SUMMARY:

- *Includes linguistic and cultural competency among the outcomes measured with the Department of Developmental Services quality assurance instrument*
- *Declares the legislative finding that the current quality assessment system does not require evaluation or oversight by the Department of Developmental Services to ensure that regional center funded services are provided in a linguistically and culturally competent manner.*
- *Changes the scope of the existing quality assurance instrument identified by the Department of Developmental Services, which includes an assessment of the provision of services, to include an assessment of whether services are provided in a linguistically and culturally competent manner.*
- *Requires that the quality assurance instrument include outcome-based measures to evaluate the linguistic and cultural competency of regional center funded services provided to people with developmental disabilities who receive those services across their lifetime.*
- *Requires the independent agency or organization that the Department of Developmental Services contracts with for implementation of the quality assurance assessment to have experience with issues related to linguistic and cultural competency.*
  LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 8 PAGES]:
  http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1201-1250/ab_1232_bill_20130912_enrolled.pdf

LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter

679, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.

- AB 1232 was part of a package of bills introduced earlier this year as a result of a 2012 hearing of the Senate Select Committee on Autism and Related Disorders, chaired by Senate President Pro Tem Darrell Steinberg (Democrat – Sacramento) that focused on disparities in services provided to underserved communities.
- It is one of three bills that focused on the issue of cultural competency and linguistics related to regional center funded services (AB 1232, SB 367, and SB 555).

SB 126 – HEALTH CARE COVERAGE: PERVASIVE DEVELOPMENTAL DISORDERS OR AUTISM

AUTHOR: Senate President Pro Tem Darrell Steinberg (Democrat - Sacramento) CDCAN SUMMARY:
Extends the sunset from July 1, 2014 to January 1, 2017, on State laws implementing requirements on health plans and insurers to provide coverage for behavioral health treatment (BHT) for pervasive developmental disorder or autism (PDD/A).
LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 16 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0101-0150/sb_126_bill_20130909_enrolled.pdf
LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 680, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.
CDCAN COMMENT:
The enacted version of the original bill - SB 946, also by Steinberg (PDF version – 13 pages) can be found at this link: http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0901-0950/sb_946_bill_20111009_chaptered.pdf

SB 158 – AUTISM DEMONSTRATION PROGRAM

AUTHOR: Sen. Lou Correa (Democrat - Santa Ana)
CDCAN SUMMARY:

- *Would authorize, until January 1, 2019, the establishment of a demonstration program that would be known as the Regional Center Excellence in Community Autism Partnerships (RE CAP) program to provide improved services, supports, interventions, and other resources to assist individuals with autism spectrum disorders, and their families, who are persons with developmental disabilities receiving regional center funded services and who reside in underserved communities.*
- *Would authorize the Department of Developmental Services to contract with a University of California or California State University campus to serve as a coordinating center to develop the program.*

LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 4 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0151-0200/sb_158_bill_20130906_enrolled.pdf
LATEST ACTION 10/09/2013: **VETOED** by Governor.
VETO MESSAGE BY GOVERNOR:
Oct 09 2013
To Members of the California State Senate:
I am returning Senate Bill 158 without my signature.
The bill seeks to give the Department of Developmental Services permission to establish a voluntary program with no identified funding to focus attention on autism spectrum disorders and underserved communities.
Understanding the needs of disparate communities is a responsibility and goal the department, regional centers, and the three University Centers on Excellence in Developmental Disabilities all share. The bill imparts no new authority, alters no mission, and provides no new money to

these efforts. As such, the work that the bill seeks to promote is already underway, to the best extent of available resources.

If new federal or private resources should become available, the infrastructure and the will to do more are already there.

Sincerely,

[signed]

Edmund G. Brown, Jr.

NEXT STEPS: In theory the author could try to have the Legislature over-ride the Governor's veto in January when they reconvene. That requires 2/3rds vote in both houses – 54 votes in the Assembly and 27 in the State Senate and the approval of the Democratic legislative leadership. Vetoes by governors are very rarely overridden – though it did happen several times during Brown's first two terms. It is highly unlikely it will happen to this or any other bill however.

SB 367 – REGIONAL CENTERS: CULTURAL AND LINGUISTIC COMPETENCY

AUTHOR: Sen. Marty Block (Democrat - San Diego)

CDCAN SUMMARY:

- *Requires each of the 21 regional centers to provide necessary training and support to regional center board members to facilitate their understanding and participation, including issues relating to linguistic and cultural competency.*
- *Requires each regional center to post on its internet website information regarding the training and support provided to regional center board members.*
- *Requires each of the 21 regional center boards to annually review the performance of the regional center in providing services that are linguistically and culturally appropriate and may provide recommendations to the director of the regional center based on the results of that review.*

LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 8 PAGES]: http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0351-0400/sb_367_bill_20130903_enrolled.pdf

LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 682, Statutes of 2013.

NEXT STEPS: Takes effect January 1, 2014.

CDCAN COMMENT:

- SB 367 was part of a package of bills introduced earlier this year as a result of a 2012 hearing of the Senate Select Committee on Autism and Related Disorders, chaired by Senate President Pro Tem Darrell Steinberg (Democrat – Sacramento) that focused on disparities in services provided to underserved communities.
- Supporters of this bill testified at that hearing and in subsequent policy committee hearings that it was needed to address inconsistencies in access to services and supports for people with developmental disabilities and their families, and also regional center spending on those persons, by ensuring regional centers and their governing boards are sensitive to the linguistic and cultural needs of the people they serve in their respective service areas
- It is one of three bills that focused on the issue of cultural competency and linguistics related to regional center funded services (AB 1232, SB 367, and SB 555).

SB 468 – STATEWIDE SELF DETERMINATION PROGRAM

AUTHOR: Sen. Bill Emmerson (Republican - Redlands)

CDCAN SUMMARY

- *Requires the Department of Developmental Services, contingent upon approval of federal funding, to establish and implement a state Self-Determination Program, that would be available in every regional center service (catchment) area to provide participants and their* *families, within an individual budget, increased flexibility and choice, and greater control over decisions, resources, and needed and desired services and supports to implement their Individual Program Plan (IPP), under the requirements of this bill.*

- *The statewide program would be phased in over 3 years, serving up to 2,500 regional center consumers during the phase-in period, and thereafter, available on a voluntary basis to all eligible regional center consumers.*
- *Requires the Department of Developmental Services to, among other things, apply for federal funding for the program by December 31, 2014.*
- *Provides that Self Determination Program participants receive an individual budget, under the requirements of this bill, to be used for the purchase of services and supports necessary to implement the participant's Individual Program Plan (IPP).*
- *Requires Self Determination Program participants to agree to, among other things, manage self-determination services and supports within the individual budget.*
- *Requires the Department of Developmental Services to require non-vendored providers of services and supports who meet specified criteria to submit to a criminal background check, as specified in the bill.*
- *Requires the Department of Developmental Services, with respect to this background check, to submit fingerprint images and related information to the (California) Department of Justice, and would require the Department of Justice to provide specified responses to the department.*
- *Requires the Department of Justice to charge a fee sufficient to cover the cost of processing this request.*
- *Would, among other things, require each of the 21 regional centers to be responsible for implementing the program as a term of its contract, and to establish a local voluntary advisory committee to provide oversight of the project.*
- *Requires the State Council on Developmental Disabilities to form a volunteer statewide committee to, among other things, identify self-determination best practices.*
- *Requires the State Council on Developmental Disabilities, in collaboration with specified entities, to issue to the Legislature a report regarding the status of the program and recommendations to the program, as specified, and would require the department, beginning January 10, 2017, to provide to the appropriate policy and fiscal committees of the Legislature information as required by this bill relating to the Self Determination Program.*

LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 32 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0451-0500/sb_468_bill_20130917_enrolled.pdf
LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 683, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.
CDCAN COMMENT:
Implementation contingent on the Department of Developmental Services securing federal funding.

SB 555 – REGIONAL CENTERS: INDIVIDUAL PROGRAM PLANS AND INDIVIDUALIZED FAMILY SERVICES PLANS – NATIVE LANGUAGE

AUTHOR: Sen. Lou Correa (Democrat - Santa Ana)
CDCAN SUMMARY:

- *Requires a regional center to communicate and provide written materials in the family's native language during the assessment, evaluation, and planning process for the Individualized Family Service Plan (IFSP),including during the IFSP meeting.*
- *Requires the family's native language to be documented in the IFSP.*
- *Adds to the list of definitions related to the Department of Developmental Services system*

"Native language."

- *Adds to the list of required elements of a regional center assessment the requirement that a regional center communicate with the person with developmental disabilities receiving services and his/her family in their native language.*
- *Requires a regional center to communicate in the native language of the person with developmental disabilities receiving services and his/her family, including providing alternative communication services, as specified in the bill.*
- *Requires a regional center to provide a copy of the Individual Program Plan (IPP) in the native language of the person with developmental disabilities receiving services or his or her family, legal guardian, conservator, or authorized representative, or both.*
- *Requires the native language of the person with developmental disabilities or his or her family, legal guardian, conservator, or authorized representative, or both, to be documented in the IPP.*

LATEST COPY OF BILL (AS SENT TO GOVERNOR) [PDF VERSION – 16 PAGES]:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0551-0600/sb_555_bill_20130906_enrolled.pdf
LATEST ACTION 10/09/2013: **SIGNED** by Governor. Filed with Secretary of State, Chapter 685, Statutes of 2013.
NEXT STEPS: Takes effect January 1, 2014.
CDCAN COMMENTS:

- This bill was sponsored by Disability Rights California and is part of a package that resulted from an informational hearing in 2012 by the State Senate Select Committee on Autism and Related Disorders, chaired by Senate President Pro Tem Darrell Steinberg (Democrat – Sacramento), that focused on disparities in services in underserved communities.
- The bills intent language states that California's diverse language and ethnic communities account for about 60% of its population, and that the number of people in the United States who do not speak English as their native language has grown 140% over the past three decades.
- The intent language in the bill further states that in California, about 40% of Californians speak a language other than English at home, and the number of individuals whose first language is not English is rapidly growing.
- The bill's intent language also states that to address any disparities in the regional center system, that "it is the intent of the Legislature that the Department of Developmental Services and regional centers ensure that all consumers and their families receive culturally and linguistically competent information, including written documents, about the IPP [Individual Program Plan] and IFSP [Individualized Family Service Plan] processes and procedures and that regional centers comply with Part C of the federal Individuals with Disabilities Education Act".

PLEASE HELP!!!!!!

October 09, 2013

PLEASE HELP CDCAN CONTINUE ITS WORK

CDCAN Townhall Telemeetings, CDCAN Reports and Alerts and other activities cannot continue without YOUR help. To continue the CDCAN website and the CDCAN Reports and Alerts sent out and read by over 65,000 people and organizations, policy makers and media across the State, and to continue and resume CDCAN Townhall Telemeetings, trainings and other events, please send your contribution/donation (please make check payable to "CDCAN" or "California Disability Community Action Network" and mail to:

CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833

[replaces 1225 8th Street Suite 480, Sacramento, CA 95814]
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549 (replaced 916-212-0237)

Many, many thanks to all the organizations and individuals for their continued support that make these reports and other CDCAN efforts possible!

Attachment #6

FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

Prepared by the
Association of Regional Center Agencies

September 2013

CONTENTS

FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

EXECUTIVE SUMMARY

The Lanterman Act (Division 4.5 of the Welfare and Institutions Code) mandates the Department of Developmental Services (DDS) to "contract with an appropriate private nonprofit corporation or corporations to operate regional centers…"[i] The regional center system has grown and evolved from two regional centers in 1966 serving fewer than a thousand clients to 21 regional centers serving more than 259,000 consumers and their families. Regional center staff perform outreach and community education, intake and assessment, eligibility determination, resource development, and on-going case management services. They also vendor and pay the thousands of organizations and individuals who provide services to regional center consumers.

The regional center budgets are divided into two parts, Purchase of Service (POS), which provides funding to pay the many service providers in the community, and Operations (OPS), which provides funding to pay the regional center staff and all the expenses associated with operating a multi-million dollar business.

Over the past years the types of services purchased for consumers have expanded greatly. The recordkeeping requirements have also expanded as more reliance has been placed on capturing federal funds to operate the regional centers. As this expansion occurred, there have also been several fiscal crises in California which has resulted in cut-backs to the regional center budgets. Both the Purchase of Service and Operations budgets have been affected. This paper focuses on problems caused by the concurrent expansion of workload requirements and Operations budget reductions.

These problems can be categorized into four groups: (1) actions leading to a direct reduction in the OPS budget without a corresponding decrease in operations workload,

(2) actions imposing additional workload for which no additional, or inadequate, funding was added to the OPS budget, (3) inaction with respect to updating the OPS budgeting formula, and (4) design flaws inherent in the OPS budgeting formula.

1. Actions Leading to a Direct Reduction in the OPS Budget Without a Corresponding Decrease in Operations Workload

This is exemplified by unallocated reductions to the OPS budget. The Administration will arbitrarily reduce the budget to meet the state's overall budget requirements and leave the regional centers to determine how they will absorb those reductions and still meet the many mandated requirements for which regional centers are responsible.

2. Actions Imposing Additional Workload for Which no Additional, or Inadequate, Funding was Added to the OPS Budget

Over the past thirty years there have been numerous legislative and regulatory changes which have increased the workload to regional center staff, both in case management and in administration, without any increase (or an inadequate increase) in the OPS budget. These have ranged from increased data gathering from consumers and their families to increased monitoring of facilities and programs, to increased reporting to DDS.

3. Inaction with Respect to Updating the OPS Formula to Keep Pace with the Increasing Costs of Doing Business.

The core staffing formula is the basis for the OPS budget allocations to the regional centers. It was originally designed with the salaries in the core staffing formula comparable to State salaries for similar positions. As State salaries increased, the salaries in the core staffing formula had increased. Then in FY 1991-92, as part of the state's response to a budget crisis, the salaries in the core staffing formula ceased to be adjusted as state salaries increased. Therefore, the salaries in the core staffing formula today, with some minor adjustments, remain at the 1991 levels.

The Lanterman Act specifies that regional centers must adhere to certain caseload ratios (ratios of Consumer Program Coordinators [CPCs] to consumers served). However, since salaries have been frozen at 1991 levels, regional centers are unable to hire sufficient CPCs to meet the required caseload ratios and, consequently, puts over $1 billion in federal funds at risk.

4. Design Flaws in the OPS Formula

There are many design flaws in the core staffing formula that further complicates the problem. When the core staffing formula was designed, regional centers served on the average about 2,000 consumers each. Now the average number of consumers served by regional centers is about 7,000. As with any organization, as it grows in size there is an increased need for middle managers. The core staffing formula does not adequately allow for middle management and support staff to properly operate the larger organizations regional centers have become.

Another design flaw in the core staffing formula is the Fringe Benefit rate of 23.7%. This is wholly inadequate since the Department uses a rate of 41.6% for the Developmental Center staff. The average fringe benefit rate for regional centers is 34%.

Over the years there have been a number of studies conducted to update the core staffing formula, most notably the Citygate study of 1999. The Department used the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal was supported within the Administration, but is not included in the Governor's budget because of a severe economic downturn.

CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[ii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has "accepted a responsibility" is directly threatened.

I. INTRODUCTION

Regional centers are a critical publicly-funded safety net for 259,000 of California's most vulnerable citizens. Regional centers provide Californians who have a developmental disability with community-based services and supports to allow children to remain in their family homes and adults to reach the highest level of independence possible. However, chronic underfunding is undermining the regional centers' ability to meet their mandate under the Lanterman Act and the needs of these individuals and to comply with their statutory and contractual responsibilities. Therefore, the Association of Regional Center Agencies (ARCA) believes it is essential that those who influence and make public policy understand the seriousness of this issue, particularly as the state's improving economic situation begins to allow for fiscal restoration of vital public programs.

This paper is designed to: (1) provide information on the existing budgeting methodology used by the state to fund regional center operations, (2) identify the reasons and extent to which the regional center operations budget is underfunded, and (3) alert the public and policy makers that this situation cannot continue without directly threatening the health and well-being of consumers, and the continued receipt of over $1 billion in federal funds to the state.

This paper's focus on the operations side of the budget should not be construed as diminishing the serious underfunding that also exists in the purchase of services budget. ARCA addresses the purchase of service funding issue in its position statement titled "The Budget Crisis Affecting California's Regional Centers."

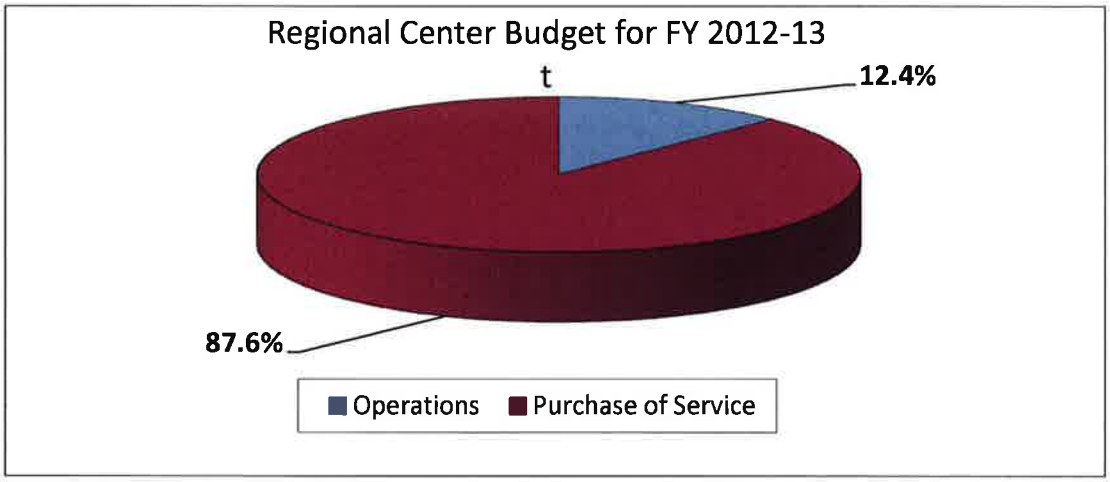
II. BACKGROUND

A. Budget Overview - The state will provide regional centers approximately $4.2 billion in the FY 2013-14. This funding is budgeted and allocated in two distinct categories: purchase of services (POS) and operations (OPS).

Funds allocated for POS are used to purchase services and supports from community-based service providers. These services and supports are needed by consumers and their families to implement consumers' individual program plans (IPPs), or for consumers under the age of three, their individualized family service plans (IFSPs). These IPPs and IFSPs are plans developed by a planning team that include the consumer, the consumer's parents (for a minor), regional center representatives, service providers, and others as appropriate or as invited by the consumer. These plans describe the services required by the consumer to improve or ameliorate their condition, identify who will provide those services, and who will pay for the services.

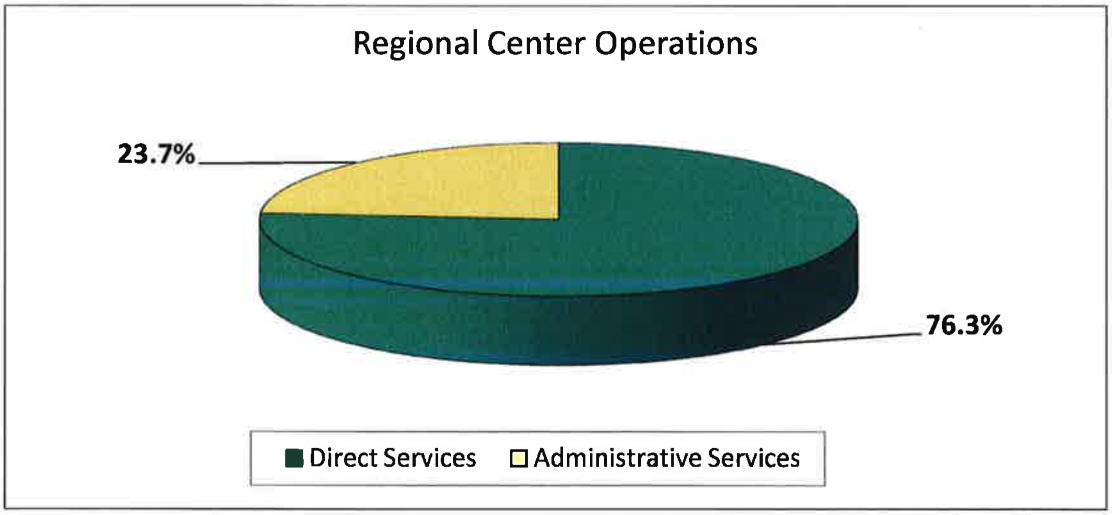
The OPS budget funds a regional center's costs related to personnel and benefits, insurance, leases, equipment, information technology, accounting/payment functions, personnel management, consultant services, independent financial audits, consulting/legal services, board support, travel, office facilities, and other administrative/managerial expenses. Chart 1 shows the relative percentages of the total budget allocated for OPS and POS.

Chart 1



The following chart (Chart 2) shows how the descriptor "OPS budget" is misleading, in that it connotes administrative costs, whereas more than three-fourths of the regional center OPS budget actually funds direct services to consumers and their families.

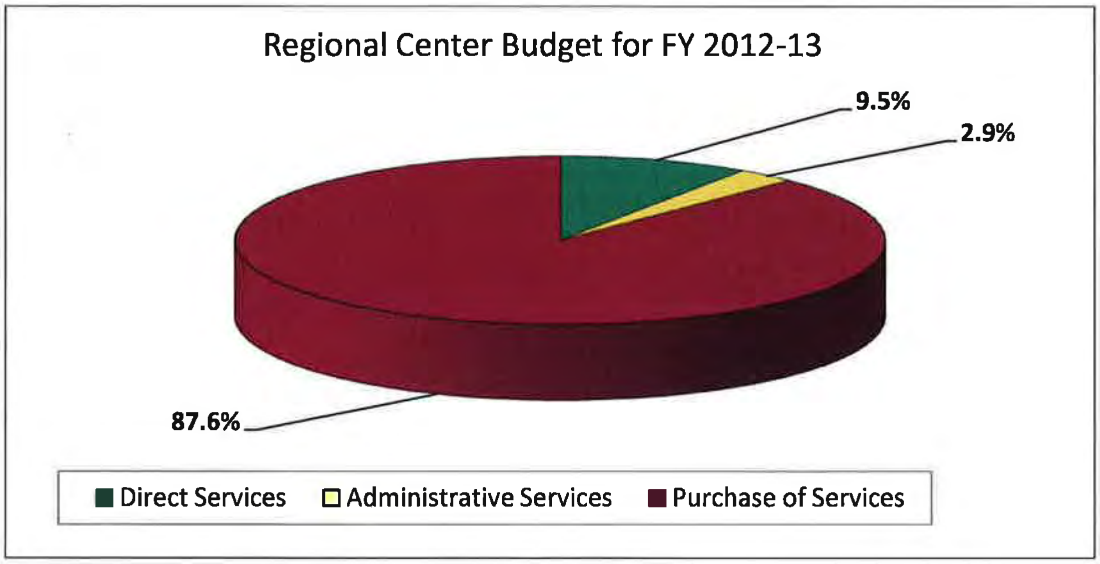
Chart 2



Direct services funded through the OPS budget include service coordination, assessment/diagnosis, individual program planning, consumer money/benefits management, clinical services, 24-hour emergency response, quality assurance, advocacy, intake/assessment/referral, family support, training, special incident reporting/investigation, etc. Therefore, reductions in the regional-center OPS budget impact the provision of direct services to consumers. An attached publication prepared by Frank D. Lanterman Regional Center describes, in greater detail, the range of important direct services provided by regional centers.[iii]

The balance of the OPS budget (23.7%), funds all the regional centers' administrative costs and operating expenses, and represents just 2.9% of the total (OPS and POS) regional center budget.[iv] Chart 3 shows the OPS budget for the current fiscal year and how the funds are apportioned.

Chart 3



B. Budgeting and Allocation Methodology - Prior to 1979-80, each regional center developed its own staffing pattern and budget through negotiations with the Department of Developmental Services (DDS). Each staffing pattern was based on a program-budget methodology, and the budget-allocation methodology for compensation was based on projected actual salaries and benefits. While this approach addressed local variation and provided for flexibility and innovation, there was also argument for a less subjective and more equitable method for allocating staffing resources to regional centers taking into account the size of the regional center (based on caseload) and the resources necessary to accomplish the regional centers' statutory and contractual mandates. This led to the development of the current methodology for funding the regional centers' personnel and related operational costs, which is commonly referred to as the "core staffing formula." This formula, developed in 1978, was crafted by DDS personnel based on their knowledge of existing regional center staffing patterns that had previously been approved by DDS, and other standards that were available at the time. For example, the case management ratio of one service coordinator to 62 consumers was based on what county welfare offices used for the Absent Parent Program to receive federal funding. This 1978 formula was arguably an improvement over the initial approach to budgeting and allocating OPS funding, but the formula was still an *ad hoc* creation developed without the benefit of the specialized study that such an important and complex statewide publicly-funded service system needed. There is no written analysis, justification, or documentation supporting the 1978 base formula, which is the same formula used today, except for some "add-ons" and minor changes.

The 1978 formula established specific positions, salaries, benefits, and operating expense assumptions/standards associated with the regional centers' mandates at the time. Salaries for various regional center staff positions were based on equivalent state classifications, with the assumption that as state salaries increased the formula salaries would increase at a similar rate. It also was assumed that benefit and operating expense assumptions would be periodically updated. See Attachment A for a copy of the current core staffing formula.

DDS and ARCA jointly develop the methodology for apportioning budgeted funds to the regional centers, with DDS retaining authority for the final allocation. The percentage of the total regional center funds budgeted to support regional center operations is 12.8 % in the current fiscal year, as shown in Chart 4. Charts 5 and 6 show the steady decline since FY 1988-89 in the proportion of operations funding compared to the total regional center budget.

CHART 4

CATEGORY	FY 2013-14 MAY REVISION FY 2012-13 BUDGET *(Dollars in thousands)*	% OF TOTAL BUDGET
Operations	$537,415	12.8
Purchase of Services	3,647,976	86.7
Early Intervention and Prevention Programs	22,384	0.5
TOTAL	**$4,207,775**	**100.0**

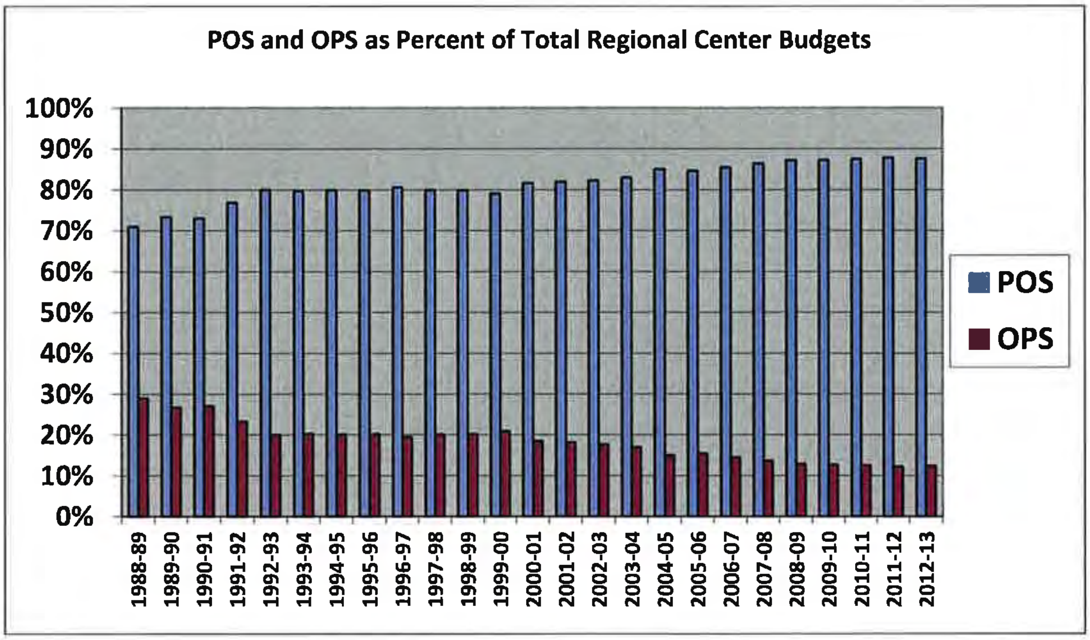
CHART 5

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	**TOTAL BUDGET** *(Dollars in thousands)*	**% POS**	**% OPS**
1988-89	458,620	71.0	29.0
1989-90	558,237	73.3	26.7
1990-91	581,532	73.0	27.0
1991-92	647,799	76.8	23.2
1992-93	668,223	80.0	20.0
1993-94	740,511	79.7	20.3
1994-95	804,571	79.9	20.1
1995-96	905,416	79.8	20.2
1996-97	1,009,755	80.6	19.4
1997-98	1,145,438	79.9	20.1
1998-99	1,376,132	79.8	20.2
1999-00	1,584,201	79.1	20.9
2000-01	1,830,955	81.6	18.4
2001-02	2,027,554	81.9	18.1
2002-03	2,218,303	82.3	17.7
2003-04	2,397,486	83.0	17.0
2004-05	2,620,686	85.0	15.0
2005-06	2,784,773	84.6	15.4

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]

FISCAL YEAR	TOTAL BUDGET *(Dollars in thousands)*	% POS	% OPS
2006-07	3,167,170	85.5	14.5
2007-08	3,512,929	86.4	13.6
2008-09	3,861,302	87.2	12.8
2009-10	3,886,591	87.3	12.7
2010-11	3,909,604	87.5	12.5
2011-12	3,958,227	87.8	12.2
2012-13	4,162,793	87.6	12.4

CHART 6



C. Factors Leading to OPS Underfunding – The factors that have led to the diminution of regional centers' operating capacity and to the current regional center OPS funding crisis fall within four primary categories: (1) actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in operational workload, (2) actions imposing additional workload for which the regional centers received no additional - or inadequate - funding, (3) inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business, and (4) design flaws in the OPS formula. While not an exhaustive list, these factors, broken out by category, are as follows:

CATEGORY I: ***Actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in operational workload.***

- Eliminating Hospital Liaison Positions: The FY 1983-84 budget transferred case management services for consumers residing in state developmental centers from regional center employees to developmental center employees, and the regional center OPS budget was reduced accordingly. Prior to this time, regional centers were funded to regularly attend individual program plan meetings and to visit consumers residing in state developmental centers. At one time, regional centers were allocated one position for every 60 consumers residing in the developmental centers. This allocation was later changed to one position for every 120 consumers. In FY 1983-84, regional center staffing for state developmental center consumers was eliminated. A small number of similar positions (one position for every 400 developmental center consumers) were subsequently reestablished in the core staffing formula and continue to the present. This minimal allocation, however, did not compensate regional centers for the workload they continue to incur for state developmental center consumers, including the significant probate and criminal court demands developmental center residents generate. In FY 2009-10, as a result of the settlement in the Capitol People First, et. al. v. Department of Developmental Disabilities (DDS), funding was restored to provide a caseload ratio of one position for every 66 consumers residing in the developmental centers.

- Extending Regional Center Assessment Timelines: Regional centers have mandated timelines for completing their assessment of prospective consumers and for developing an individual program plan or individualized family service plan for those found eligible for services.[vi] The timeline for completing the assessment phase of the process for consumers over age three has intermittently been extended from 60 to 120 calendar days to justify reducing the regional center OPS budget. This change was first enacted in FY 1992-93 through an urgency statute (Senate Bill 485, Chapter 722, Statutes of 1992) which sunset July 1, 1996. This action was implemented again in FY 2002-03 and, through subsequent legislative actions, has continued into the current fiscal year, and became permanent in FY 2008-09. The savings associated with this action derive from the reduced number of regional center clinical personnel needed for performing the required assessments. The justification for the estimated savings was valid the first year of implementation, but is not valid beyond the first year because intake workload is independent of mandated timelines. As one researcher observed, *"The consumer requires the same services and total staff time whether those services are spread over one, two or four months. The required time frames for assessment affect resource requirements only when they change, increasing or decreasing backlog. When time frame mandates do not change, the equivalent to one month's workload must be completed each month to keep backlog constant as a new set of intake cases arrive."*[vii] Thus, this policy change amounts to a funding reduction since the basic workload requirements remain after the first year.

- Imposition of Unallocated OPS Budget Reductions and Developing/Implementing Expenditure Plans: Unallocated reductions are reductions or offsets to a program's budget that are not specific to, or earmarked against, an individual program or line item. Such reductions are applied to, or offset, the bottom line of the budget. The budget for regional center OPS has sustained numerous unallocated reductions over the years, some of which have been restored and others not. The first unallocated reduction in the regional centers' OPS budget occurred in FY1982-83 ($2.2 million). Budget Act language required DDS to establish expenditure priorities for regional centers to ensure they maintained expenditures within the amount budgeted.[viii] These DDS-developed priorities for controlling costs were invalidated by the state Supreme Court in their 1985 ruling in *Association for Retarded Citizens v. Department of Developmental Services.*

The next unallocated reduction occurred in FY 1991-92. This reduction was followed by unallocated reductions in each fiscal year thereafter through 1995-96. Unallocated reductions were again instituted in FY 2002-03, 2003-04, and 2004-05. Regional centers achieved their OPS budget unallocated reduction target in FY 1991-92 and following through a variety of means including, but not limited to:

- Increasing service coordinator-to-consumer caseload ratios
- Reducing qualifications for new service coordinator employees
- Employee layoffs
- Temporary regional center closures of seven to fourteen days annually with the provision of only on-call emergency services
- Relinquishing money management or representative payee services for consumers receiving SSI/SSP benefits
- Reducing work hours
- Furloughing employees
- Reducing employee training
- Increasing employees' benefit premiums
- Renegotiating lease/rental costs
- Consolidating/closing offices
- Contracting out additional services
- Reducing travel, communication, consultant, legal, and other general administrative expenses
- Stopping hiring
- Discontinuing cost-of-living/salary adjustments

The regional centers' proposals for achieving the required reductions were incorporated into expenditure plans that DDS was required to review and approve, as appropriate.

Another round of reductions to regional center budgets began again in 2009 with the passage of ABX4 9 and continued through 2012. Though many of these budget reductions used euphemisms such as "cost containment," "operational efficiencies," and "General Fund savings," they were, in effect, unallocated reductions.

Some of these reductions were temporary, in the guise of across-the-board "payment reductions" which began in February 2009 as a 3% payment reduction, was increased to 4.25% in July 2010, and then reduced to 1.25% in July 2012. These reductions came to an end on July 1, 2013.

Unallocated reductions made to the regional center OPS budget since FY 1991-92 that continue to reduce regional center budgets in the current year and future years amount to $44.0 million.[ix] This is an effective budget reduction of 7.6%. These reductions are:

• Change in Intake and Assessment timeline	$4.5 million
• FY 2001-02 unallocated reduction	$10.6 million
• FY 2004-05 "Cost Containment"	$6.0 million
• FY 2009-10 "Savings Target"	$14.1 million
• FY 2011-12 "Cost Containment"	$3.4 million
• FY 2011-12 unallocated reduction	$5.4 million

Category II: ***Actions imposing additional workload for which the regional centers received no additional - or inadequate - funding.***

Numerous legislative actions since the early 1980s have placed significant unfunded requirements upon regional centers. Also, many other new requirements have been added, with some funding attached, but frequently the funding is insufficient to comply with the new requirements. Since the adequacy of funding may be seen by some as a disputable matter, the following identify only some of the more significant unfunded requirements or mandates that have been imposed.

- Managing/Implementing the New Uniform Fiscal System: During 1984, DDS implemented the statewide Uniform Fiscal System to provide for uniform accounting procedures and centralized collection of client and fiscal data. There were numerous implementation issues and unfunded workload related to maintaining this new system.

- Performing New Vendorization Activities: DDS delegated additional vendorization workload to regional centers in FY 1985-86 through the issuance of the 'Vendor Procedures Manual.' New workload involved regional centers reviewing and approving vendor applications, and reviewing rate applications for specified programs before submission to DDS for rate setting.

- Following Up on Specialized Residential Service Facility Reviews: During FY 1985-86, DDS required the regional centers to follow up on DDS evaluations of specialized residential service facilities. Regional centers were required to absorb this additional workload.

- Change to Person Centered Planning: Passage of Senate Bill 1383 in September 1992 (effective January 1, 1993), mandated a new approach to developing individual program plans for regional center consumers. This new approach, called person centered planning, moved away from the traditional approach to service planning, guided by the professionals in the interdisciplinary team, to one where consumers and families assumed a primary role in the planning process, and where the needs and preferences of consumers and families were given much greater consideration. While this approach is preferable, developing an individual program plan using a person centered planning approach takes much longer than using the traditional approach, yet regional centers were not provided any additional resources to accommodate this increased workload.

- Administering Vouchers: In 1991, the Department adopted new regulations establishing a voucher mechanism for paying for specified services. This new approach gave families and adult consumers a direct role in procuring nursing, day care, respite, transportation, diapers and nutritional supplements. While beneficial for many who choose to obtain their services through this purchasing mechanism, the processing of billings and payments for individual families is very staff-intensive, which includes training family members on record keeping and payroll tax requirements, and for which regional centers received no additional resources to perform the increased workload.

- Collecting and maintaining information on consumers' potential eligibility for Old Age Survivors Disability Insurance and referring such individuals to the Social Security Administration and conducting triennial continuing disability reviews. The law also required that individuals residing out of home be reviewed for such eligibility at the time of every review [Wel. & Insti. Code §4657 and §4658].

- Maintaining an emergency response system that must be operational 24 hours per day, 365 days per year [Wel. & Insti. Code §4640.6(b)].

- Annually preparing and submitting service coordinator caseload ratio data to DDS [Wel. & Insti. Code §4640.6(e)].

- Having or contracting for expertise in the following areas [Wel. & Insti. Code §4640.6(g)(1) through (6)]:
    1. Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.
    2. Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.
    3. Family support expertise to assist the regional center in maximizing the effectiveness of supports and services provided to families.
    4. Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supported living arrangements.
    5. Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.

6. Quality assurance expertise to assist the regional center in providing the necessary coordination and cooperation with the Area Board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

- Employing at least one consumer advocate who is a person with developmental disabilities [Wel. & Insti. Code §4640.6(g)(7)].

- Annually conducting four monitoring visits, of which at least two are unannounced monitoring visits, of every licensed long-term health care facility, licensed community care facility, and Adult Family Home Agency home [Wel. & Insti. Code §4648(a)].

- Adding the Adult Family Home Agency program as a new living option and requiring regional centers to engage in specific activities related to selecting, monitoring, and evaluating such programs [Wel. & Insti. Code §4689.1].

- Contracting annually with an independent accounting firm for an audited financial statement, including reviewing and approving the audit report and accompanying management letter, and submitting this information to DDS before April 1 of each year [Wel. & Insti. Code §4639

- During the individual program planning process, reviewing and documenting each consumer's health status, including his/her medical, dental, and mental health status and current medications [Wel. & Insti. Code §4646.5 (a)(5)].

- Developing and updating every six months, as part of the individual program plan, a written statement of the regional center's efforts to locate a living arrangement for minor children placed out of the family home for whom the parents or guardian have requested closer proximity to the family home [Wel. & Insti. Code §4685.1 (a)].

- Developing, implementing, and reviewing annually a "memorandum of understanding" with each (as appropriate) county mental health agency to perform specified activities related to planning, coordinating, and providing services to dually-diagnosed consumers [Wel. & Insti. Code §4696.1].

- Annually preparing and submitting to DDS: (1) a current salary schedule for all personnel classifications used by the regional center, and (2) a listing of all prior fiscal year expenditures from the OPS budget for all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services [Wel. & Insti. Code §4639.5].

- Transferring responsibility for conducting initial consumer/family complaint investigations, as required pursuant to Wel. & Insti. Code §4731, from the clients' rights advocate to the regional center director [Wel. & Insti. Code §4731(b)].

- Responsibility for monitoring and paying Habilitation Services Program providers. This $150 million program, which was transferred from the Department of Rehabilitation to DDS, involves about 500 providers.

- Implementing the Family Cost Participation Plan (FCPP) and the Annual Family Program Fee (AFPF), wherein staff assesses fees to families based on specific criteria [Wel. & Insti. Code §4783 and §4785 respectively].

- Every two years screening all vendored service providers against federal and state databases to ensure vendors have not been disqualified from participating in the Home and Community Based Services (HCBS) Waiver program [Wel. & Insti. Code §4648.12].

- Implementing electronic billing for all vendored service providers [Govt. Code §95020.5 and Wel. & Insti. Code §4641.5].
- Requiring regional centers to post specific information on their internet websites [Wel. & Insti. Code §4629.5].
- Responsibility for reviewing audit reports of medium-sized and large vendors conducted by independent certified public accountants [Wel. & Insti. Code §4652.5].
- Developing Transportation Access Plans for certain consumers [Wel. & Insti. Code §4646.5(a)(6)].
- Completing comprehensive assessments for residents of developmental centers and consumers placed in settings ineligible for Federal Financial Participation and developing appropriate resources in the community [Wel. & Insti. Code §§4418.25(c)(2)(A), 4519(a), and 4648(a)(9)(C)(iii)].
- Verifying individual or family income in order to determine a consumer's eligibility for financial assistance with funding health insurance copayments and coinsurance [Wel. & Insti. Code §4659.1].
- Changing accounting firms to ensure that no accounting firm completes a required financial audit more than five times in ten years [Wel. & Insti. Code §4639(b)].
- Complete a standardized questionnaire upon a consumer's entry into supported living services and at each IPP review thereafter [Wel. & Insti. Code § 4689(p)(1)].
- Completing transition plans for all regional center consumers residing out-of-state and conduct statewide search for in-state services and development of appropriate services as needed [Wel. & Insti. Code § 4519(e)].

- Notifying the Client Rights Advocate of IPP meetings for developmental center residents [Wel. & Insti. Code § 4418(c)(2)(D)], IPP meetings for consumers to be placed in an IMD [Wel. & Insti. Code § 4648(a)(9)(C)(iv)] or who are residing in an IMD [Wel. & Insti. Code § 4648(a)(9)(C)(v)], and of writs of habeas corpus [Wel. & Insti. Code § 4801(b)].

- Completing referrals to Regional Resource Development Projects and Statewide Specialized Resource Service.

- Increased need to do Health and Safety waiver requests due to the freezing of service provider rates.

Category III: ***Inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business.***

- Failure to Update Salaries in the Core Staffing Formula

  The model for budgeting regional centers' personnel costs is formula driven. The model calculates the number and type of personnel or positions theoretically needed for a regional center to comply with its mandated obligations. A position's salary in the formula is linked to the mid-range state salary for the equivalent state position based on when the regional center position was added to the formula. Until FY 1991-92, whenever state employees received a cost-of-living adjustment, the formula was updated in the formula to maintain salary equivalency with comparable state positions. This policy of indexing regional centers' personnel budget increases to state employee cost-of-living adjustments continued through FY 1990-91. In FY 1991-92, the policy changed when the state ceased providing regional centers cost-of-living adjustments for their personnel costs. **This policy change, which has continued through the current fiscal year, is the action that has impacted the OPS budget most significantly**.

Illustrating the fiscal impact of this policy change is the regional center "Revenue Clerk" position, which is linked to the state equivalent position classification of "Accounting Technician." The annual mid-range salary for the state Accounting Technician position is currently $35,082, whereas the formula uses an annual mid-range salary of $18,397, which reflects the Accounting Technician annual mid-range salary as of FY 1990-91. Based on caseload and other factors, the budgeting formula calculates the number of positions a regional center needs to perform the specified function(s) for which the Revenue Clerk positions are allocated. The number of positions is then multiplied by the salary in the formula. In this instance, the salary remains equivalent to the state's Accounting Technician in FY 1990-91, or $18,397, which is barely half of the current annual mid-range salary for the state Accounting Technical position. Except for new positions added to the formula since it was developed, and adjustments made in the late 1990s to service coordinator salaries in response to federal audit issues, salaries in the formula have not been adjusted for 23 years. This has the same impact of not receiving a cost-of-living adjustment for 23 years.

The impact of this policy change is enormous, resulting in underfunding the OPS budgeting formula by about $288 million annually. Consequently regional centers are budgeted for their staff at only 58% of what they would be if the core staffing salaries had kept up with inflation.

- Failure to Fully Fund Mandated Caseload Ratios

According to Wel. & Insti. Code § 4640.6, regional centers are required to maintain certain caseload ratios. For consumers on the HCBS Waiver or in Early Start, the mandated caseload ratio is one Client Program Coordinator (CPC) for every 62 consumers and for those not on the HCBS Waiver or in Early Start, the required ratio is one CPC for every 66 consumers. However, due to the drastic underfunding of the core staffing formula, as discussed above, it is impossible for regional centers to hire sufficient CPCs to meet these ratios. According to the Core Staffing Schedule in the FY 2013-14 regional center budget, regional centers should have 4,148 CPCs to meet the mandated caseload ratios. However they are funded at only $34,032 per CPC. The actual mid-range salary for CPCs that the regional centers pay is $46,121. At that salary level, the regional centers can afford only 3,061 CPCs, over a thousand less than the formula indicates. This means the average caseload ratio regional centers can afford is one CPC for every 87 consumers. Had the CPC salaries in the core staffing formula kept pace with State salary increases, the budgeted salary would be about $50,340, and if it had kept pace with the Consumer Price Index it would be about $61,200.

The ability of regional centers to hire a sufficient number of CPCs to meet the required caseload ratios is further hindered by the unallocated budget reductions (discussed above), the imposition of a salaries savings factor and a fringe benefit rate of only 23.7% (discussed later).

Category IV: *Design flaws in the OPS formula.*

The existing core staffing formula was developed when the regional center operating environment was far different. In 1978, regional centers were relatively small organizations, their mandates far fewer, and funding streams less diverse. Regional centers have grown tremendously in size and complexity, and their responsibilities have expanded greatly, yet the formula has remained much the same. Those who developed the formula never contemplated a regional center managing, on average, over $196 million annually in state and federal funds, which is a greater amount than the entire regional center budget was for FY 1979-80, nor did they anticipate the average center having about 350 employees.

Specific examples of some of the deficiencies in the core staffing formula include the following:

- The organizational model embodied in the formula did not envision regional centers with hundreds of employees, therefore, staffing for the management and supervision structure for such large organizations is not provided. This problem is exacerbated at large regional centers. The formula does recognize the need for more of certain positions where the number of consumers drives the workload significantly; however, there are other positions, such as the Human Resources Manager and the Training Officer, that every regional center is allocated only one position, regardless of size. Also, large regional centers have need of additional senior and middle management personnel who are not provided for in the formula.

- The "equivalent" state positions used in the formula were determined apart from any review or input from regional centers and, therefore, lack comparability with actual regional center position responsibilities. This lack of comparability has only increased over time as regional centers have grown in size and complexity. This specific problem was identified in a 1984 DDS/ARCA-sponsored study performed by Cooperative Personnel Services, which found that the positions used in the formula were undervalued by approximately 12% on average at that time.

- The formula imposes a 5.5% salary savings requirement on all regional center positions, except for service coordinator positions, where the salary savings is 1%. The imposition of a salary savings requirement fails to account for the need to fill vacancies through overtime or contract personnel, or for the additional costs related to turnover (e.g., advertising, recruiting, and training of staff). Due to mandates and contract requirements, few regional center responsibilities can simply be postponed or neglected.

- In many instances, the use of "one per" positions (e.g., allocating funding for certain positions to every regional center regardless of size and/or programs and/or large and widespread geographic boundaries) fails to generate the appropriate number of personnel required for those positions where regional center size, demographics, and/or number of vendored programs drive the workload. Again, this reflects an assumption in the original formula, which presumed each regional center would serve approximately the same number of consumers in generally the same manner, which, at the time, were about 2,000 per center. Today the largest regional center serves about 22,000 active and high-risk consumers, whereas the smallest center serves about 3,000 consumers in a geographically large and widespread area.

One example is the Resource Developer. Each regional center is budgeted for only one regardless of the number of consumers served or the number of service providers vendored by the regional center.

- The formula uses a standard 23.7% figure for budgeting total fringe benefits. This figure has not been adjusted to account for increases in such areas as workers' compensation, health benefits, FICA, etc. By comparison, the current fringe benefit percentage used by DDS for its Headquarters personnel is 41.6%.[x]

- The state equivalent positions used in the formula are budgeted at the midpoint of what is typically a five-step state salary range. This methodology results in underfunding for every employee who remains with the regional center more than three years since there is no allowance for seniority or merit salary adjustments after the third year of service (assuming the individual was initially hired at the lowest step of the salary range).

- The formula does not recognize or account for the very significant regional variations in prevailing salary levels.

- The amount provided for regional center operating expenses and equipment per position has not been updated since FY 1985-86, when it was set at the amount used by DDS for its Headquarters employees.

The core staffing formula, therefore, suffers from a variety of deficiencies which, when combined with all the other the issues noted above, has created an enormous OPS budgetary shortfall that continues to worsen.

D. History of Efforts to Remedy OPS Underfunding - Concerns about underfunding in the regional center OPS budget are not new. ARCA has given this matter considerable attention over the years. Unfortunately, these efforts have yielded little success. The following summarizes the most significant past efforts to address the inadequacies of the OPS budgeting methodology:

1. 1981 – *Staffing Standards Task Force*. ARCA forms a Staffing Standards Task Force to *"study and prepare a 'core staffing' formula that more closely approximates the Regional Center staff responsibilities as directed in law and legal contract."* The Task Force surveys regional centers, reviews current regional center activities, and develops a "core staffing" plan. ARCA adopts the Task Force report and forwards it to DDS. DDS takes no action due to budgetary concerns.

2. 1983 – *Personnel Task Force Report*. ARCA establishes a Personnel Task Force to (1) pursue a core staffing study, and (2) coordinate a study comparing the state's classification and pay plan with that of the regional center core staffing formula. Cooperative Personnel Services (at that time an entity within the State Personnel Board) conducts the comparison classification study and issues its report in February of 1984. The report finds that the regional center position salaries lag the state equivalent positions by 12.4%. The Task Force develops a recommended staffing allocation formula reflecting the resources needed for regional centers to comply with their contractual and statutory obligations. The Personnel Task Force releases its report in February 1984, including a copy of the CPS study as an appendix. DDS, while sympathetic, is not able to gain support within the Administration to implement the report's recommendations.

3. 1989 – *Personnel Task Force Report*. Another ARCA Personnel Task Force convenes and: (1) reviews and updates information on current regional center mandates, (2) engages Cooperative Personnel Services to revise their prior compensation study with some updates, and (3) develops a report that includes a historical perspective, a task analysis for each position in the core staffing formula, a comprehensive model staffing and allocation plan using a *"slightly less than average regional center"* construct, and findings and recommendations. The report is issued in January 1990. The Cooperative Personnel Services study finds that regional center positions are underfunded by approximately 10% in comparison to comparable state positions. The ARCA Board of Directors approves a motion by the Executive Committee to prepare and submit an Executive Summary of the Task Force report to Senator Dan McCorquodale to be considered in the Senate Resolution 9 hearings. The Executive Summary and a copy of the second study conducted by Cooperative Personnel Services are transmitted to Senator McCorquodale and key legislative committee consultants. No action is taken.

4. 1999 - *Citygate Associates Study* – DDS, acknowledging serious flaws in the core staffing formula and concerned about OPS underfunding, engages a contractor to *"Identify the . . . staff that will enable Regional Centers to meet their state and federal mandates and are consistent with good business practices."* The Legislature, in the FY1998-99 Budget Act, adopts control language requiring DDS to *". . . provide the Fiscal and Policy Committees of the Legislature with the Findings of the Regional Center Core Staffing Study by no later than March 1, 1999. This study is to address the type of classification, number, qualification, and compensation required for Regional Centers to meet their state and federal mandates and to be consistent with good professional and business practices."*

   A contract is awarded to Citygate Associates in June 1998 and, with two subsequent contract amendments, the state expends $402,000 for the study. ARCA, the Department of Finance, and DDS oversee the study design and project findings. Citygate's study methodology includes a qualitative and quantitative analysis, including: ten regional forums with regional center line staff representing the range of regional center personnel; four regional forums for vendors, consumers and family members; site visits to five regional centers; background interviews with key constituents; a research literature review; a survey of regional centers; review of the draft report by regional center teams representing a cross-section of regional center personnel; and three public hearings. Citygate delivers a final report to DDS in September 1999 unveiling a new methodology for budgeting regional center staffing and operating expenses. The report identifies numerous problems with the existing budgeting formula, resulting in 24% less funding than needed to appropriately meet state and federal mandates.

The Legislature adopts additional Budget Act language in FY 1999-2000 requiring DDS, by December 15, 1999, to *". . . make recommendations to the Legislature and the Governor regarding the core staffing formula used to allocate operations funding to regional centers. These recommendations shall include consideration of, and public comments related to, the Regional Center Core Staffing Study, and shall include, but not be limited to, all of the following: (1) Salary and wage level for positions deemed necessary to retain and maintain qualified staff. (2) Regional center staff positions that should be mandated. (3) Staffing ratios necessary to meet the requirements of this chapter, including a service coordinator-to-consumer ratio necessary to appropriately meet the needs of consumers who are younger than three years of age and their families. (4) Funding methodologies. (5) Indicate the impact of staffing ratios implemented pursuant to subdivision (c) . . ."*

DDS uses the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal is supported within the Administration, but is not included in the Governor's budget because of a severe economic downturn.

5. 2001 – *ARCA Position Paper.* ARCA prepares and transmits a position paper to the director of DDS detailing regional center OPS and POS budget issues. The paper is based on a survey of all 21 regional centers. The paper and attending transmittal letter highlight the OPS underfunding issue confronting the centers and identifies the need for "serious and immediate attention." Again, no action is taken.

E. Changes in the Budgeting Formula - The original "core staffing formula" has been adjusted intermittently throughout the years, as shown in the next chart. Not included are increases associated with Community Placement Plan (CPP) efforts to move people from state developmental centers into the community, since this is a state priority that has generally been well-funded. The following are non-CPP related changes since FY 1990-91 that resulted in additional OPS funding and the reasons for these increases:

CHANGES IN THE OPERATIONS BUDGETING FORMULA

YEAR	CHANGE	FUNDING (Millions)	REASON
90-91	Funding to perform activities required by the Sherry S./Violet Jean C. Court cases.	$1.0	Court-required workload.
97-98	Establishing 21 regional center clinical teams to enhance the centers' clinical capacity.	6.1	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
97-98	Requiring regional centers to conduct quarterly monitoring for all consumers living out of home.	14.8	Same as above
98-99	Updating budgeted salaries for quarterly monitoring staff, clinical teams, and case management staff serving consumers placed from developmental centers.	5.0	Same as above
98-99	Updating base staffing levels to ensure sufficient staffing for performing quarterly monitoring visits.	3.5	Same as above
98-99	Establishing 14 additional regional center clinical teams.	4.5	Same as above
98-99	Increasing monitoring frequency of consumers with health conditions living in	5.3	New DSS Title 22 regulatory requirements.

YEAR	CHANGE	FUNDING (Millions)	REASON
	CCFs. Regional center are provided addition staff for new activities.		
98-99	Reducing CPC caseloads to 1:62 (included reduction of CPC salary savings requirement; updating CPC salaries; restoration of unallocated reduction for CPCs; and funding other essential positions). (Half-year funding)	27.9	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
99-00	Additional funds to fully implement the above reduction of CPC caseloads to 1:62.	27.9	Same as above
98-99	Establishing a consumer complaint process in statute. Regional centers each provided ½ position for new workload.	0.7	Legislation (SB 1039) establishing a consumer complaint process, i.e., Wel. & Insti. Code 4731.
98-99	Fund Essential Regional Center Positions – Information Systems manager, Personal Computer Systems Manager, Training Officer, Special Incident Coordinator, Vendor Fiscal Monitor, Human Resources Manager, and Information Systems Assistant (half-year funding)	6.7	Fund essential positions previously not included in the core staffing formula
99-00	Additional funds to fully implement the above new positions.	6.7	Same as above
99-00	Performing health status reviews of consumers during a part of the IPP process.	3.2	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
00-01	Establishing 1:45 maximum caseload ratios for service coordinators for consumers placed out of state developmental centers.	0.6	Same as above
01-02	Implementing a statewide risk management system, including regional center risk management committees.	6.7	Same as above
02-03	Establishing Federal Program Coordinators and providing unfunded rent relief.	15.2	State initiative to increase and maintain federal financial participation.
03-04	Establishing Federal Compliance Specialists and fiscal/contract documentation staff.	4.4	Same as above
03-04	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	1.4	State initiative to increase federal financial participation.
03-04	Complying with requirements of the federal Health Insurance Portability and Accountability Act (HIPPA)	1.4	Congressional enactment of HIPPA legislation.
04-05	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	2.8	State initiative to increase federal financial participation.
04-05	Funding for regional center administrative activities associated with implementing the	.6	Enactment of legislation establishing the Family

YEAR	CHANGE	FUNDING (Millions)	REASON
	Family Cost Participation Program.		Cost Participation Program.
05-06	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.8	State initiative to increase federal financial participation.
06-07	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.3	Same as above
07-08	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.1	Same as above
06-07	Funding for expansion of Autism Spectrum Disorder Initiative	1.7	State initiative to better serve consumers with autism spectrum disorder
07-08	Additional funds to implement the expansion of the Autism Spectrum Disorder Initiative.	1.8	Same as above
08-09	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	.9	State initiative to increase federal financial participation.
09-10	Fund additional case managers to participate in IPP meetings of consumers residing in state developmental centers	3.1	Pursuant to the Capitol People First lawsuit settlement

The above chart illustrates that, with a few relatively minor exceptions, all the positive adjustments to the OPS budget since FY1990-91 have been driven by actions related to preventing/minimizing the loss of federal funding, and initiatives to increase federal funding. While helpful, these increases or positive adjustments are dwarfed by the losses suffered in the OPS budget highlighted in the previous section on *Factors Leading to OPS Underfunding.*

III. THREAT TO FEDERAL FUNDING

In a 1992 oversight hearing before a Senate Budget Subcommittee, the DDS Director testified that *"the Department believes that regional centers have sustained the most serious and damaging budget reductions of all entities in the developmental services system. The Department is concerned that two years of unallocated reductions to regional centers' operations budget has severely impaired their ability to meet their existing statutory and contractual requirements . . . [and that the reduction had] . . . reduced [the] ability of the regional centers to monitor client services and care. The Department is also concerned that the diminished ability of regional centers to monitor the health and safety of vulnerable clients placed in residential care facilities, particularly* *for clients who do [not] have an involved parent, may lead to an increase in health and care problems."*[xi] The concerns expressed by Mr. Amundson were prescient and later confirmed when noted in a December 2007 Department report to the Legislature. In this report, the Department stated that, *"In 1997, the federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services (CMS)) conducted its first major review of the state's Waiver and found serious deficiencies . . . In response to these findings, the state negotiated with the federal government to implement a series of initiatives necessary to continue in the Waiver program . . . The new initiatives were designed as permanent infrastructure improvements targeted at improving the overall quality of the service system. The federal government, however, froze Waiver enrollments as of December 1997 until the state demonstrated each regional center had implemented these changes. . .* ***The cumulative impact of this enrollment freeze cost the state an estimated $933 million in lost federal funds.***[xii] [Emphasis added] *This significant funding loss underscores the importance of meeting federal quality assurance standards in the developmental services system lest the savings achieved through cost-containment measures is dwarfed by subsequent losses in federal reimbursement."*[xiii] The CMS freeze on enrolling new people in the Waiver was not fully lifted until January 2004, or nearly six years later. Due to the Department's and the regional centers' successful efforts in recent years to significantly increase federal funding, the state now has considerably more federal funding at stake should sanctions again be imposed.

One of the key issues identified by CMS during its review were the inordinately high caseloads of regional center service coordinators, which is a situation directly related to insufficient resources, since service coordinators, and their associated costs, comprise about 60% of the entire regional center OPS budget.[xiv] The CMS review noted that *"Case management activities are deficient . . ."* and that there *". . . is a decreasing level of expertise and experience among case managers caused by high turnover rates and high case loads."*[xv] The state's corrective action plan to CMS involved setting a maximum limit on Waiver caseloads and providing additional funding for regional center operations. However, regional centers now find themselves in perhaps an even more compromised position, with respect to caseload ratios and the ability to ensure consumers' health and safety, than when CMS conducted their review in 1997. For example, DDS's most recent caseload ratio survey shows that two-thirds of the regional centers are not complying with at least one or more of their statutorily required (Wel. & Insti. Code 4640.6) caseload ratios, and over one-half of the regional centers cannot meet the specific caseload ratio requirement for consumers enrolled in the Waiver.[xvi] This requirement is not only specified in statute, but it is included in the state's approved application for the Waiver. Thus, the state is not fully complying with an assurance to the federal government upon which the receipt of federal funding was predicated.

The seriousness of this situation becomes all the more evident when one considers that state law requires that service coordination be the ". . . *highest priority*,"[xvii] with respect to regional center staffing patterns. Many regional centers' inability to meet even this statutorily prioritized service delivery requirement, despite their best efforts, suggests something about the severe resource issues that exist in other important regional center operational areas.

IV. CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[xviii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has "accepted a responsibility" is directly threatened.

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ENDNOTES

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[i] Wel. & Insti. Code §4621.5

[ii] Wel. & Insti. Code §4501.

[iii] "Regional Center Operations: Unique Value-Added Services," Frank D. Lanterman Regional Center, October 13, 2008.

[iv] Based on the FY 2012-13 budget data prepared by the Department of Developmental Services, Estimates Section, May 14, 2013.

[v] These data reflect (a) budgeted amounts per the Budget Act for FY 1988-89 through 1991-92, (b) actual expenditures for OPS and POS for FY 1992-93 through 1999-00 per the Department of Developmental Services' budget charts entitled *"Regional Centers Budget History (dated May 4, 2004)"*, (c) actual budget allocations of OPS and POS to the regional centers for FY 2000-01 through 2011-12, and (d) OPS and POS budgets for FY 2012-13 per the 2013 May Revision of the 2013-14 Budget.

[vi] Wel. & Insti. Code Sec. 4642 and 4643, and Government Code Sec. 95016.

[vii] "Regional Center Core Staffing Study – Final Report," prepared by Citygate Associates for the California Department of Developmental Services, September 1999, p. III-8.

[viii] Assembly Bill 21, the Budget Act of 1982, Item 4300-101-001, Provision 8.

[ix] Department of Developmental Services, Regional Centers 2013-14 May Revision, May 14, 2013.

[x] Department of Developmental Services, Developmental Centers 2013 May Revise.

[xi] Dennis Amundson, *Testimony for the Oversight Hearing of the Senate Budget Subcommittee #3 on Health, Human Services and Labor, Department of Developmental Services*, November 5, 1992, p. 18 and 22.

[xii] "Estimate of Lost Federal Financial Participation Due to CMS Freeze on Enrollments," Department of Developmental Services, Community Operations Division, Federal Programs Section, October 23, 2007.

[xiii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 29.

[xiv] Based on the FY 2008-09 May Revision Core Staffing. Included in the 60% figure is all funding budgeted for service coordinators, service coordinator supervisory and support staff, and proportional funding for office rent and other operating expenses and equipment.

[xv] "Compliance Review of California's Home and Community Based Services Waiver Program for the Developmentally Disabled – Control Number 0129.91," Health Care Financing Administration, Regional IX, January 12, 1998, p. 27.

[xvi] Regional center caseload ratio surveys of March 2013.

[xvii] Wel. & Insti. Code §4640.6 (a).