Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE No. 3 AGENDA

Chair, Senator Ellen M. Corbett

Senator Bill Monning
Senator Mimi Walters

March 27, 2014
9:30 a.m. - John L. Burton Hearing Room 4203

PART A

Staff: Peggy Collins

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the agenda unless otherwise directed by the Chair.

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4300 Department of Developmental Services (DDS)

Department Overview

The Department of Developmental Services (DDS) oversees the provisions of services and supports to approximately 267,042 persons with developmental disabilities and their families, pursuant to the provisions of the Lanterman Developmental Disabilities Services Act (Division 4.5 of the California Welfare and Institutions Code). For the majority of eligible recipients, services and supports are coordinated through 21 private, non-profit corporations, known as regional centers (RCs). The remaining recipients are served in four state-operated institutions, known as developmental centers (DCs) and one state-leased and operated community facility. The regional center caseload is expected to increase from 265,709 in the current year to 273,643 in the budget year (a three percent increase); and the number served in state-operated facilities is expected to decrease from 1,333 in the current year to 1,110 in the budget year (a 16.7 percent decrease).

Eligibility: To be eligible for services and supports through a regional center or in a state-operated facility, a person must have a disability that originates before their 18th birthday, be expected to continue indefinitely, and present a substantial disability. As defined in Section 4512 of the California Welfare and Institutions Code, this includes an intellectual disability, cerebral palsy, epilepsy, and autism, as well as conditions found to be closely related to intellectual disability or that require treatment similar to that required for individuals with an intellectual disability. A person with a disability that is solely physical in nature is not eligible.

Infants and toddlers (age 0 to 36 months), who are at risk of having a developmental disability or who have a developmental delay, may also qualify for services and supports (see Early Start discussion later in the agenda).

Eligibility is established through diagnosis and assessment performed by regional centers.

Governor's Budget: The following chart from the DDS "Regional Center Local Assistance Estimate for Fiscal Year 2014-15," provides a summary of the proposed 2014-15 budget, the various fund sources, caseload, and authorized positions, as it compares to the proposed revised 2013-14 budget.

DEPARTMENT OF DEVELOPMENTAL SERVICES
2014-15 Governor's Budget

(Dollars in Thousands)

	2013-14	2014-15	Difference	
Community Services Program				
Regional Centers	$4,385,940	$4,636,758	$250,818	*
Totals, Community Services	**$4,385,940**	**$4,636,758**	**$250,818**	
General Fund	2,472,574	$2,634,203	$161,629	
Dev Disabilities PDF	5,908	5,808	-100	
Developmental Disabilities Svs Acct	150	150	0	
Federal Trust Fund	48,655	48,771	116	
Reimbursements	1,857,913	1,947,086	89,173	
Mental Health Services Fund	740	740	0	
Developmental Centers Program **				
Personal Services	$474,741	$442,163	-$32,578	
Operating Expense & Equipment	47,566	58,145	10,579	
Staff Benefits Paid Out of Operating Expense & Equipment	33,669	25,677	-7,992	
Total, Developmental Centers	**$555,976**	**$525,985**	**-$29,991**	
General Fund	$305,162	$274,546	-$30,616	
Federal Trust Fund	510	394	-116	
Lottery Education Fund	403	403	0	
Reimbursements	249,899	250,642	743	
Headquarters Support				
Personal Services	$34,648	$36,063	$1,415	
Operating Expense & Equipment	5,111	$4,661	-450	
Total, Headquarters Support	**$39,759**	**$40,724**	**$965**	
General Fund	$25,340	$25,941	$601	
Federal Trust Fund	2,525	2,518	-7	
PDF	286	321	35	
Reimbursements	11,220	11,508	288	
Mental Health Services Fund	388	436	48	
Totals, All Programs	**$4,981,675**	**$5,203,467**	**$221,792**	
Total Funding				
General Fund	$2,803,076	$2,934,690	$131,614	
Federal Trust Fund	51,690	51,683	-7	
Lottery Education Fund	403	403	0	
Dev Disabilities PDF	6,194	6,129	-65	
Developmental Disabilities Svs Acct	150	150	0	
Reimbursements	2,119,032	2,209,236	90,204	
Mental Health Services Fund	1,128	1,176	48	
Caseloads				
Developmental Centers	1,333	1,110	-223	
Regional Centers	265,709	273,643	7,934	
Authorized Positions				
Developmental Centers	4,910.5	4,464.5	-446.0	
Headquarters	374.5	381.5	7.0	

* The Governor's Budget will not reflect a $613,000 reduction of Federal Funds due the reallocation of Early Start, Part C funds. ** The Developmental Centers funding is understated by $986,282 due to an error in costing and will be corrected in May Revise 2014-15.

The **Legislative Analyst's Office (LAO)** finds both the developmental center and community services caseload estimates to be reasonable.

Question for DDS:

- *Please briefly describe the overall developmental disabilities system and the factors driving increases in consumers and utilization. How do these changes relate to trends in the past few years?*

DDS Headquarters

The Governor's budget provides $40.7 million ($25.9 million General Fund (GF)) for DDS headquarters, a $1.4 million ($0.9 million GF) increase over the enacted 2013-14 budget. The increases are attributable to increase in employee compensation costs approved through collective bargaining and changes in retirement contribution rates ($.5 million [$.3 million GF]) and the two Budget Change Proposals (BCPs) discussed below.

ISSUE 1: Establish Existing Limited-Term CEA II Position as Permanent BCP #1

DDS is requesting $160,000 ($108,000 GF) to convert 1.0 CEA II, Assistant Deputy Director, Office of Federal Programs and Fiscal Support, position from limited-term to permanent. This position was established in 2010-11, and reapproved in 2012-13, as a two-year limited-term position, pending further review of the workload associated with federal funding requirements. In May 2013, CalHR approved the permanent establishment and level of this position.

This position was initially established for the purpose of seeking and implementing new sources of federal financial participation (FFP). Currently, DDS draws down approximately $1.8 billion in federal funding under such programs as the Home and Community-Based Services (HCBS) waiver; 1915 (i) State Plan Amendment (SPA); Money Follows the Person Grant; and the Early Start Program (through the Department of Education). Additionally, pursuant to SB 468 (Emmerson), Chapter 683, Statutes of 2013, DDS is required to apply for federal Medicaid funding for the Self-Determination Program by December 31, 2014.

This position is responsible for the directing and overseeing of 46.5 staff positions that perform ongoing program development, implementation, administration, and monitoring of federal programs and ensuring compliance with complex federal regulations and requirements. The position reports to the Deputy Director over the Community Services Division.

Questions for DDS:

- *Please discuss how federal funding participation (FFP) in the community services budget has changed over the last decade.*
- *What impact does increased FFP have on DDS and regional center administrative oversight and reporting duties?*

Staff Comment and Recommendation: DDS has significantly increased its reliance on federal funding to support state programs serving persons with developmental disabilities. With this increased reliance, come increased federal requirements to monitor service delivery. No issues have been raised with this proposed. APPROVE BCP #1.

ISSUE 2: Vendor Audit Positions BCP # 3

DDS is requesting $897,000 ($605,000 GF) for 7.0 limited-term auditor positions to meet workload associated with increased demand for vendor audits and associated recovery of funds.

The DDS Vendor Audit Section was established in 2004-05, along with 16 audit positions, to audit service providers who are vendored by regional centers, receive payments in excess of $100,000, and/or provide services to consumers in multiple regional center catchment areas. In 2008-09, 7.0 audit positions and 1.0 office technician position were eliminated as part of the required 10 percent "across-the-board" budget balancing reductions.

In 2010, the CA State Auditor (CSA) released an audit[1] of DDS and regional centers that reported nearly half of regional center employee respondents did not feel safe to report suspected impropriety and that DDS did not, at that time, log, track, nor have a written process for such complaints. In response, DDS administratively established a "Whistleblower Complaint Process", including contract requirements that regional centers institute whistleblower policies and processes consistent with the DDS directive. Under this process, DDS investigates complaints alleging fraudulent fiscal activity for a vendor who received prior year annual payments above $100,000 (which may involve an audit). Additionally, any complaint alleging fraudulent activity or misuse of state funds by a regional center is referred to the DDS' Audits Branch.

In 2011, SB 74 (Committee on the Budget), Chapter 9, Statutes of 2011, further refined the monitoring and review of provider administrative costs. Among the changes adopted through AB 74 was a requirement that all regional center contracts or agreements with service providers limit administrative costs to 15 percent; strengthened regional center policies on contracting and conflict-of-interest reporting requirements, requirements for regional centers to post specified information on the website, and a requirement for independent audit/review for contractors that receive over $250,000 for services to regional centers and independent audits for contractors that receive over $500,000 for services to regional centers.

According to DDS, as of December 31, 2013, the Vendor Audit Section had an "unduplicated backlog" of whistleblower complaints of 27 vendors, primarily relating to unsupported or fraudulent billings.

Questions for DDS:

- *Please describe the audit process and the timeframe for the completion of an audit?*
- *What percentage of audits resulted in funding recoupments? How much has been recouped since the unit was established?*
- *Would additional positions result in increased recoupments in the budget year?*
- *Why are these positions proposed to be limited-term?*

Staff Comment and Recommendation: Leave open.

[1] "Department of Developmental Services: A More Uniform and Transparent Procurement and Rate-Setting Process Would Improve the Cost-Effectiveness of Regional Centers," California State Auditor, August 24, 2010.

Developmental Centers

DDS operates four state institutions, known as developmental centers (DCs), and one smaller state-leased and operated community facility that care for adults and children with developmental disabilities. The Governor's budget for the DCs includes $526 million ($275 million GF) to serve an estimated average of approximately 1,110 residents in 2014-15 (excluding Lanterman Developmental Center). Compared with last year's enacted budget, this includes an anticipated decline of 223 residents, 339.5 authorized state staff positions, and $29.9 million ($30.6 million GF) in funding.

California has served persons with developmental disabilities in state-owned and operated institutions since 1888. At its peak, the developmental center system housed over 13,400 individuals in seven facilities. Of the four remaining developmental centers, the oldest is Sonoma Developmental Center (1891) and the youngest is Fairview Developmental Center (1959).

Facility	Location	Year Opened	Population as of 3/12/14
Fairview Developmental Center	Costa Mesa	1959	320
Lanterman Developmental Center	Pomona	1927	80
Porterville Developmental Center	Porterville	1953	411[2]
Sonoma Developmental Center	Eldridge	1891	454
Canyon Springs Community Facility	Cathedral City	2000	52

The decline in developmental center use is consistent with the development of a community-based network of services and supports that promote successful integrated living in California communities and reflects national trends that support reduced reliance on institutions and greater support for community-based integrated services, directed in part by changes in state and federal law, and multiple court cases, including the United States Supreme Court's 1999 decision in *Olmstead v. L.C., et al.*

Numerous changes to the regional center planning and service development process have further reduced use of developmental centers. Person-centered planning has resulted in more appropriate and successful community-based services and supports for individuals who utilize regional center services. Additionally, regional centers have used an annual community planning and placement (CPP) allocation, $67 million (total funds) in the current year, to develop community-based services and supports for individuals moving out of a developmental center, and to deflect new placements into developmental centers. On average, 175-200 individuals move out of developmental centers to the

[2] 168 residents in the Secure Treatment Program (STP); 243 residents outside the STP.

community each year.

Statutory changes adopted as part of the 2012-13 state budget, AB 89 (Committee on Budget), Chapter 25, Statutes of 2012, in part a response to a new trend of increasing developmental center placements, restricted new developmental center admissions, except under specified conditions, including commitments under the state's Incompetent to Stand Trial statute. Additionally, individuals who are in crisis can be placed temporarily at the Fairview Developmental Center.

The declining DC population, its aging infrastructure, and fixed costs has led to increasingly high per resident costs associated with maintaining this model of residential care.

Question for DDS:

- *Please briefly describe the budget proposal for developmental centers.*

ISSUE 1: Closure Process for Lanterman Developmental Center

Governor's Budget: The Governor's budget for the Lanterman Developmental Center (LDC), which is in the process of transitioning its residents into community-based placements as part of a closure process, currently houses 80 residents[3]. The budget assumes a net decrease of $22.7 million ($12.0 million GF) related to position reductions, staff separation costs, enhanced staffing adjustments, and post-closure activities. LDC's residential population is expected to be zero by December 31, 2014.

Background: In January 2010, DDS proposed the closure of Lanterman Developmental Center (LDC), and a closure plan was adopted along with the Budget Act of 2010. The LDC closure plan borrowed heavily from the process employed to close Agnews Developmental Center (ADC), including the use of Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHN); improved health care through managed care plans for persons transitioning from LDC to the community; implementation of a temporary outpatient clinic at LDC to ensure continuity of medical care and services as individuals transfer to new health care providers; and the use of LDC staff to provide services in the community to former LDC residents. Since the approval of the closure plan, 261 LDC residents have transitioned to community living arrangements and 95 remain at LDC (as of February 1, 2014). The Governor's budget assumes all remaining residents will have transitioned to the community by January 1, 2015.

Prior to transition, a comprehensive assessment is conducted for each resident and services and supports are identified. The department and 12 regional centers involved in the closure process use Community Placement Plans as one tool to help them identify and develop necessary community-based resources. Selected community providers work closely with LDC staff to prepare for the transition.

As part of the transition, DDS visits consumers who have moved into community residences at five days, 30 days, 90 days, and six and 12 months after the move. Regional center staff also visits at regular intervals and provide enhanced case management for the first two years after the move. Special incidents, including hospitalizations and other negative outcomes, are tracked by DDS, and individuals who move from Lanterman into the community are asked to participate in a National Core Indicator (NCI) study. The NCI study uses a nationally validated survey instrument that allows DDS to collect statewide and regional center-specific data on the satisfaction and personal outcomes of consumers and family members.

The following chart describes the type of community placements that have occurred for LDC movers, as of February 1, 2014:

Community Care Facility (CCF)	231
Intermediate Care Facility (ICF)	12
Supported Living Services	5
Family Home/Other	2
Congregate Living Health Facility	2
Family Teaching Homes (FTH)	3
Long-Term Sub-Acute	6

[3] Based on 3/14/14 census report

As of December 1, 2013, 230 of the 242 individuals who have moved from LDC (not including the six individuals in long-term sub-acute facilities), have a day service activity, as illustrated by the following chart.

Service Category	Program Types	Number participating
Community-based day service	Behavior management program; community integration training program; adult development center; adult day health center; community activities support services, creative arts program, activity center	176
Home-based day service	Day services provided by residential facility; in-home/mobile day program	38
Work Activity Program (WAP)	Rehabilitation WAP	5
Other	Program support group-day service; personal assistance; adaptive skills trainer; adult day care; day program incorporated into supporting living service.	11

Staffing: As of February 2, 2014, 708 employees remain at LDC. This includes the 88 enhanced positions provided in the 2012-13 budget. DDS implemented its first phase of staff reductions in January 2013. On March 5, 2014, DDS announced the second phase of staff reductions. DDS has provided various activities and supports to mitigate the impact of closure on LDC staff. These efforts include various employee forums, the establishment of a Staff Options and Resource Center on the LDC campus to provide computer work stations to assist in searching for employment and professional development, reference materials related to self-help and career development, postings for state and local employment opportunities, on-line courses for resume writing and job-seeking enhancement tools, for mock interviews, guest speakers, and career workshops. Additionally, LDC has worked with the California Employment Development Department's Los Angeles County Rapid Response Coordinator and the Los Angeles Urban League Pomona WorkSource Center. The following chart shows the status of employee separation, as of December 1, 2013.

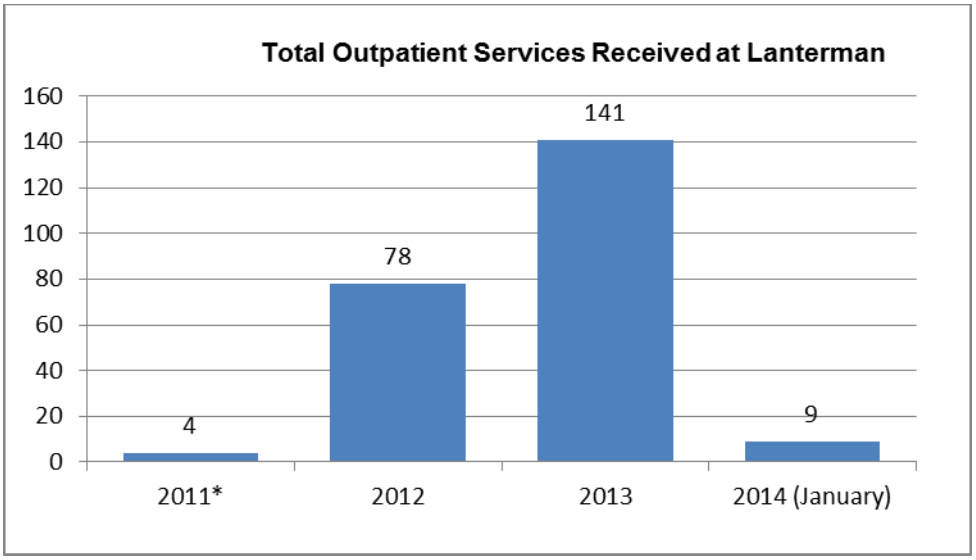
Transfer	286
Retirement	187
Resignation	85
Limited-Term Expired	8
Layoff	15
Other	32

The following chart shows employee separations by classification, as of December 1, 2013.

Level of Care Professional	69
Level of Care Nursing	276
Non-Level of Care	268

A component of the LDC closure process is the establishment of the Community State Staff (CSS) Program. As initially approved in SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, this program authorized LDC employees to work in the community with former LDC residents, through a contract with a regional center or direct service provider, while remaining state employees, for up to two years following the closure of LDC. AB 89 (Committee on Budget), Chapter 25, Statutes of 2013, removed the two-year limitation. An employee survey conducted in October 2012 identified 102 employees who had interest in the CSS Program. However, as of March 14, 2014 only 12 employees have accepted positions through the CSS Program (four staff are currently working in the community; six staff have projected start dates within 30 days; two staff do not yet have start dates).

LDC Outpatient Clinic: SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, authorized the operation of an outpatient clinic at LDC to provide health and dental services to individuals who move from LDC, in order to ensure the continuity of medical care as these individuals transfer to new health care providers in the community. This clinic will operate until DDS is no longer responsible for the property. The following chart[4] shows the total services received at the LDC Outpatient Clinic.



[4] DDS, March 11, 2014

Questions for DDS:

- *Please provide an update on the status of the LDC closure process.*
- *What are the characteristics of the remaining residents and what is their status relative to a selected community home?*
- *Please describe the utilization of the LDC clinic, compared to the utilization of the Agnews Developmental Center (ADC) clinic, during and following its closure.*
- *Please describe the Community State Staff Program. How has its utilization differed from the program established during the ADC closure?*
- *Please describe the layoff process, and the employment-related services provided to LDC staff.*
- *Once all residents have moved from LDC, what are the staffing requirements of LDC in warm shutdown? How long do you anticipate warm shutdown will last?*

ISSUE 2: Decertification of Sonoma Developmental Programs

Governor's Budget: Sonoma Developmental Center (SDC) houses approximately 454[5] residents with developmental disabilities. The decertification of four ICF units at SDC has cost the General Fund $1.4 million in lost federal funds each month, for a total $15.7 million in the current year. However, the Governor's budget assumes full federal financial participation will commence again in July 2014. DDS was provided an additional $7 million ($4 million GF) in the current year to implement a plan of correction. Budget year costs associated with the required plan are proposed to be $9.2 million ($5.1 million GF).

Background: State DC's are required to meet federal standards set by the federal Centers for Medicare and Medicaid Services (CMS), in order to receive federal financing participation under the Medicaid program. In January 2013, four out of 10 Intermediate Care Facility (ICF) units at Sonoma Developmental Center (SDC) were withdrawn from federal certification by DDS, in response to notice that the federal government was moving to decertify the larger group of ICF units. These actions came on the heels of widely reported revelations of multiple instances of abuse, neglect, and other lapses in caregiving at the institution. The loss of federal certification for these units at SDC, and the loss of associated federal funding, has cost the state General Fund approximately $1.4 million each month. The chart below shows SDC population by facility type.

Sonoma DC Information	July 24 2013	Nov 1 2013	Feb. 1 2014
Total Population	**483**	**469**	**460**
In Nursing Facility (NF)	208	202	200
In Intermediate Care Facility (ICF)	275	267	260
In non-certified homes	103	97	95

In partial response to these quality-of-care concerns, the 2013-14 budget included a $2.4 million increase ($1.3 million GF) that would allow the facility to hire approximately 36 additional direct care staff, in order to allow staff who serve as shift leads to focus on supervision, without being counted toward required ratios of direct care staff to clients.

In March 2013, DDS entered into a Program Improvement Plan (PIP) agreement with the state Department of Public Health (DPH), which was accepted by the federal Centers for Medicare and Medicaid Services. As a condition of the PIP, DDS contracted with an outside consultant to conduct a root cause analysis of the problems at SDC and develop an action plan to ensure SDC is in compliance with federal and state licensing and certification requirements.

On October 31, 2013, the DPH accepted the SDC action plan and the Department of Finance submitted a request to the Joint Legislative Budget Committee for current year supplemental funding of $3.6 million GF ($7.2 million total funds). According to the Governor's budget, the full year costs associated with the action plan at SDC will be $9.2 million ($5.1 million GF). The action plan includes the opening of a new ICF unit, 118.5 new staff positions, three new wheelchair transport vehicles, and extensive staff training. Should these efforts sufficiently correct the identified deficiencies, federal financial participation will be restored. The Governor's budget assumes this will occur in July 2014.

[5] Based on 3/14/14 census report

The charts[6] below show the progress in hiring new staff and attrition of existing staff.

New Hires
March 2013 - January 31, 2014

Total Hires	New	RA's	Total
New LOC – Nursing	106	9	**115**
New LOC – Professional	23	3	**26**
New NLOC – Clinical	36	3	**39**
New NLOC - Administrative	26	4	**30**
Total	**191**	**19**	**210**

SDC Internal Hires
30
1
51
39
121

Separations
March 2013 - January 31, 2014

Separations	Total Separations
LOC – Nursing	81
LOC – Professional	18
NLOC – Clinical	33
NLOC - Administrative	20
Total	**152**

Despite these efforts, SDC's licensed-to-unlicensed staff ratio remain well below that of other DC's. SDC's ratio was at 65 percent licensed to 35 percent unlicensed, as of January 1, 2014. LDC and PDC are at 83 percent licensed to 17 percent unlicensed and FDC is at 88 percent licensed to 12 percent unlicensed.

Legislative Analyst's Office (LAO) Recommendation: The LAO finds it reasonable for the budget to assume restoration of federal funding beginning July 1, 2014, and finds the Governor's "budget request to be reasonable and appropriate, as the funding will enable DDS to make improvements at Sonoma DC that are needed to restore federal funding and comply with federal certification requirements." The LAO further recommends that "the Legislature require the department to report at budget hearings on its progress in implementing the changes at Sonoma DC, with particular attention to the status of filling needed positions for licensed medical professionals and other staff."

[6] DDS, 3/14/14

Questions for DDS:

- *Please briefly describe the circumstances that led to the decertification of the four ICF units at SDC.*

- *Please describe the requirements of the corrective action plan and progress toward implementation.*

- *Please discuss the challenges of reducing the SDC licensed-to-unlicensed staff ratio.*

- *Please describe the process for regaining certification and federal financial participation at SDC.*

- *What is the status of the comprehensive assessments required for all residents at SDC? How have these assessments informed placement decisions for residents, both within SDC and appropriateness for community placement?*

- *The problems identified by the licensing survey at SDC are not new to this facility. Have the changes that have been implemented in response to the action plan impacted the culture at SDC in a way that could result in sustainable improvements?*

ISSUE 3: Decertification Risk at Remaining Developmental Centers

Governor's Budget. Fairview Developmental Center (FDC) has approximately 320 residents[7] with developmental disabilities. Porterville Developmental Center has approximately 411[8] residents with developmental disabilities, 168 of which reside in the Secure Treatment Program (STP). Canyon Springs is a state-leased and operated ICD/MR residential facility. It serves approximately 52 residents[9] with moderate to mild intellectual disabilities, who may have mental health treatment needs, and who are transitioning out of a developmental center.

Background: DPH recertification surveys at FDC, PDC, and LDC found ICF units at each facility to be out of compliance with federal requirements. Like the issues at SDC, areas of non-compliance include treatment plans, protection of residents, client health and safety, and client rights. In January, DDS and DPH reached an agreement to avoid decertification, and maintain federal funding of approximately $4.1 million each month. The agreement will require the development of a root-cause analysis and action plan for PDC and FDC, similar to what was required at SDC. For LDC, the agreement requires DDS to contract with an independent monitor to provide oversight, among other requirements. The costs to implement these action plans are not yet known but anticipated to have both current year and budget year implications. The Governor's budget assumes DDS and DPH will resolve these issues and that no loss of federal funds will occur.

In January 2014, DPH conducted a recertification survey at Canyon Springs Residential Facility (CSRF) and found the facility to be out of compliance with federal requirements regarding resident protections and identified a number of deficiencies. On February 24, 2014, DDS was notified of DPH's intent to decertify CSRF. DDS has submitted a plan of correction to respond to the survey findings and an informal request for reconsideration to DPH.

Questions for DDS:

- *Please describe the issues that led to the DPH survey result findings at Fairview, Lanterman, and Porterville developmental centers and how they may have differed from the issues identified at Sonoma Developmental Center?*

- *Please describe the status of developing the root cause analysis and the action plan at Fairview and Porterville developmental centers. Does DDS anticipate there will be costs in the current year?*

- *Please provide the status of the required monitor at Lanterman Developmental Center. Will the monitor have a role or impact in the process of moving residents into community settings? Do you anticipate there will be current year costs?*

- *Please describe the issues identified in the recent non-compliance notice related to Canyon Springs residential facility. What types of actions are proposed in the plan of correction that has been submitted to DPH? What is the timeline for resolution of this issue?*

[7] Based on 3/14/14 census report
[8] Based on 3/14/14 census report
[9] Based on 3/14/14 census report

ISSUE 4: Deferred Maintenance Projects

Governor's Budget: The Governor's budget provides $100 million GF for deferred maintenance projects under specified departments. Of this amount, $10 million is proposed to be allocated to DDS. The Governor proposes a new process (Control Section 6.10) for allocation of these funds that would require the Department of Finance (DOF) to review and approve department projects and submit to the Joint Legislative Budget Committee for review, 30 days prior to allocating the funds.

According to DDS, these funds will be used to replace or retrofit the boilers at SDC, FDC, and PDC. These boilers do not meet local air quality management regulations for emissions, and may be subject to fees. For example, PDC was billed an emissions fee of $41,715 in 2012-13 for non-compliance, retroactive to 2009. The cost of replacing or retrofitting these boilers is estimated at $10.7 million.

On March 20, 2014, the Senate Budget and Fiscal Review Subcommittee No. 4, voted unanimously to reject the proposed Control Section 6.10 and directed the Administration to come back with a proposal that allows the Legislature to approve funding for individual department's deferred maintenance projects through the regular budget process.

Concurrent with the release of the January budget, the Governor released his five-year infrastructure plan. This plan identifies no infrastructure needs for the state's developmental centers.

Questions for DDS:

- *Please describe the need for replacing or retrofitting the boilers at SDC, FDC, and PDC. What are the ramifications of not replacing the boilers?*

- *Although the Governor's five-year infrastructure plan does not identify any infrastructure needs at the state developmental centers, these facilities range in age from 55 to 126 years old. What significant infrastructure or delayed maintenance needs will need to be addressed in the near future?*

- *Has the infrastructure at these facilities been updated to optimize new technologies? For example:*

    - *Do electrical systems fully support the needs of residents and staff?*

    - *Are security and medical emergency alert systems updated?*

    - *Does facility design reflect licensing and certification requirements for new facilities? For example, would the dorm-like design in many residential units, where bedrooms are separated by partial walls, meet existing licensing requirements?*

ISSUE 5: CA Health and Human Services Agency Report on the Future of Developmental Centers – Presentation by Secretary Diana S. Dooley

On January 13, 2014, the Secretary of the California Health and Human Services Agency released her "*Plan for the Closure of Developmental Centers in California"* (Plan). The Plan was developed pursuant to trailer bill language adopted last year that required the Secretary to submit to the Legislature a master plan for the future of DCs by November 15, 2013; and to submit to the Legislature, by January 10, 2014, the Administration's resulting plans to meet the needs of all current residents in DCs. The Plan submitted January 13th meets the requirements of the master plan; however, more specific plans to implement the recommendations of the master plan have not yet been submitted.

The Plan was developed in consultation with a task force comprised of a broad cross-section of system stakeholders, including individuals with developmental disabilities, family members, regional center directors, consumer rights advocates, labor representatives, legislative representatives, and DDS staff. The Plan provides six consensus recommendations of the task force and the Secretary, as follows:

> *"Recommendation 1: More community style homes/facilities should be developed to serve individuals with enduring and complex medical needs using existing models of care.*
>
> *Recommendation 2: For individuals with challenging behaviors and support needs, the State should operate at least two acute crisis facilities (like the program at Fairview Developmental Center), and small transitional facilities. The State should develop a new "Senate Bill (SB) 962 like" model that would provide a higher level of behavioral services. Funding should be made available so that regional centers can expand mobile crisis response teams, crisis hotlines, day programs, short-term crisis homes, new-model behavioral homes, and supported living services for those transitioning to their own homes.*
>
> *Recommendation 3: For individuals who have been involved in the criminal justice system, the State should continue to operate the Porterville DC-STP and the transitional program at Canyon Springs Community Facility. Alternatives to the Porterville DC-STP should also be explored.*
>
> *Recommendation 4: The development of a workable health resource center model should be explored, to address the complex health needs of DC residents who transition to community homes.*
>
> *Recommendation 5: The State should enter into public/private partnerships to provide integrated community services on existing State lands, where appropriate. Also, consideration should be given to repurposing existing buildings on DC property for developing service models identified in Recommendations 1 through 4.*
>
> *Recommendation 6: Another task force should be convened to address how to make the community system stronger."*

Questions for the Secretary and/or DDS

- *The 2012-13 budget trailer bill required the submission of two documents: a master plan and a subsequent, more detailed, plan to meet the needs of current DC residents. Are you anticipating submitting the more detailed plan with the May Revision?*

- *How do you think existing resources, such as CPP funds, can be better utilized to support these recommendations?*

- *What statutory changes will be necessary to support these recommendations?*

- *Previous discussions about maintaining clinic and specialized equipment resources of the developmental centers have been thwarted by concerns of maintaining federal funding. Yet to some degree, this issue was partially resolved with the limited continuation of the clinics, post-closure, at Agnews Developmental Center. Is the agency or department exploring how this issue can be resolved to the benefit of community members who would benefit from these resources?*

- *Fairview Developmental Center is the site of an existing public/private partnership providing integrated services on existing state lands (Harbor Village). A second project at Fairview has stalled due to concerns raised by the Department of General Services. Is DDS working with the Department of General Services to resolve these concerns so this project, and potentially others like it, can move forward?*

- *The final recommendation of the report calls for another task force. What do you envision will be the role of this task force and the time frame for it to complete its work?*

Staff Comment and Recommendation: Leave OPEN the DC budget, pending May Revision.

Community Services

Services and supports for eligible persons with developmental disabilities and their families are provided through nonprofit private corporations, known as regional centers, that contract with DDS. There are 21 regional centers located throughout California, serving caseloads ranging from 3,035 to 26,996. Regional centers provide diagnosis and assessment of eligibility at no charge. Eligible individuals and their families are assigned a case manager or service coordinator to help develop a plan for services and supports, pursuant to an individual program plan, and assist in locating the necessary service providers in order to implement the plan.

Although most services and supports are free, regardless of age, parents whose adjusted gross family income is at or above 400% of the federal poverty level (FPL), and who are receiving qualifying services through a regional center for their children under the age of 18, may be assessed an Annual Family Program Fee (AFPF). Additionally, there is a requirement for parents to share the cost of 24-hour out-of-home placements for children under the age of 18. There may also be a co-payment requirement for other selected services.

Governor's Budget: The Governor's budget includes $4.6 billion ($2.6 billion GF), to serve 273,643 individuals in the community, an increase of $255.3 million ($155.2 million GF) over the enacted 2013-14 budget. The following chart illustrates proposed changes in the DDS community services budget.

	Enacted 2013-14 Budget	Adjusted 2013-14 Budget	Proposed 2014-15 Budget	Requested
Operations (OPS)	$562,059,000	$563,801,000	$579,183,000	$17,124,000
Purchase-of-Services (POS)	$3,799,754,000	$3,802,307,000	$4,037,874,000	$238,120,000
Early Start/Part C: Other Agency Costs	$17,606,000	$17,829,000	$17,698,000	$92,000
Prevention Program	$2,003,000	$2,003,000	$2,003,000	$0
Total	**$4,381,422,000**	**$4,385,940,000**	**$4,636,758,000**	**$255,336,000**

The Governor's budget projects a total regional center community caseload of 273,643 as of January 31, 2015, an increase of 8,546 (3.1 percent) over the 2013-14 enacted budget. The following chart shows changes in regional center caseloads.

	Enacted 2013-14 Budget	Revised 2013-14 Budget	Governor's Budget	Change
Active (aged 3 and older)	234,702	234,702	241,748	7,046
Early Start (Birth through 2 years)	30,395	31,007	31,895	1,500
Total	**265,097**	**265,709**	**273,643**	**8,546**

ISSUE 1: Regional Center Operations

The Governor's budget provides $579.2 million ($407.5 million GF) for regional center operations (OPS), an increase of $17.1 million ($25.2 million GF) over the enacted 2013-14 budget. This reflects an increase in core staffing funding of $13.6 million; an increase in community placement plan (CPP) staff funding of $.9 million; a decrease in the savings target related to staffing of $2.1 million; a decrease in staff funding related to the LDC closure of $.9 million; an increase in funding for case managers necessary to meet federal Home and Community-Based Services (HCBS) waiver requirements of $.5 million; and relatively small increases to contracts for Client Rights Advocacy Services, Quality Assessments, Direct Support Professional Training, and the Foster Grandparent/Senior Companion Programs. Additionally, the Governor's budget provides a small increase to address the minimum wage change. Generally, increases in the regional center OPS budget over the last several years have primarily reflected increases in caseload and requirements associated with federal funding.

Adjustment for Early Start Eligibility Reductions. The 2009-10 budget act included reductions in the Early Start Program (discussed later in this agenda). An associated reduction of $2.1 million (GF) in the regional center operations budget was made in 2010-11. It is unclear at the time of finalizing this agenda, what occurred in fiscal years 2011-12 and 2012-13. The Governor's budget includes a $2.1 million GF increase to correct this error in the budget year, and moving forward.

Questions for DDS:

- *Please clarify in what fiscal years this double-counting occurred and when DDS became aware of it.*

Unallocated Reductions. Throughout the years of budget reductions, regional center operations have been asked to absorb unallocated reductions, specifically, $10.6 million in 2001-02 and $5.4 million in 2011-12. These reductions have been cumulative and are proposed for continuation in the budget year. In addition to unallocated reductions, regional centers operations budgets have been reduced in multiple years to reflect savings associated with various "cost containment measures" implemented to reduce expenditures.

Questions for DDS:

- *How has DDS monitored the impact of these reductions on the quality and stability of regional center services funded through the operations budget?*

Core-Staffing Formula. A core staffing formula is the primary driver of regional center funding. With few exceptions, this formula has not been updated since 1991. As a result, regional centers are provided funding for positions that is far below what they are actually paying. For example, the core staffing formula provides $60,938 for a regional center executive director position when, in fact, regional centers are paying between a low of $123,787 and a high of $279,732 (excluding benefits, retirement, bonuses, and other allowances). Other examples of core staffing formula allocations for key positions are highlighted in the following chart:

Position	Core-Staffing Formula Allocation
Physician	$79,271
Behavioral Psychologist	$54,972
Client Program Coordinator	$34,032
High-Risk Infant Case Manager	$40,805
Chief Counsel	$46,983
Human Resources Manager	$50,844

Additionally, as regional center administration requirements have changed pursuant to new laws, regulations or contractual requirements, the staffing formula has not always been adjusted to reflect these new responsibilities.

Questions for DDS:

- *Why hasn't the core staffing formula been updated?*
- *What has the impact of the outdated core staffing formula, and other regional center OPS reductions, had on the ability of regional centers to meet required caseload staffing ratios?*
- *Does the department assess how the core staffing formula relates to current hiring practices of regional centers, recruitment and retention rates, and whether existing regional center staff complements are sufficient to meet regional center contractual and legal obligations?*

Community Placement Plans (CPP). The Governor's budget provides $68.3 million ($55.3million GF) in CPP funding, an increase of $865,000 ($2.4 million GF) over the enacted 2013-14 budget. Under the CPP process, regional centers provide a plan to DDS, based on their estimates of the resources necessary for individuals moving from a developmental center to the community in a given fiscal year, and for individuals at risk of placement in a developmental center. CPP-funded regional center activities include resource development, assessments, placement, crisis service teams, and program start-up, as well as traditionally funded services and supports for the first year of placement.

In response to concerns that regional centers were lagging in providing timely comprehensive assessments of developmental center residents, the Legislature required all such assessments be completed by December 31, 2015. According to DDS, 48 percent of all initial comprehensive assessments have been completed, and are being updated during the IPP. According to DDS, based on

regional center projections, 75 percent of current DC residents will have had their initial assessment completed by June 30, 2014.

Questions for DDS:

- *Please walk through the process for determining the amount of CPP appropriated each year and how allocations are made to regional centers.*

- *How does DDS determine the number of assessments each regional center should accomplish in a given fiscal year and when those assessments should occur?*

- *How does DDS ensure that the service and support needs identified in a comprehensive assessment are identified or developed so the value of the assessment remains current and serves the purpose for which it was conducted?*

- *How were CPP funds utilized to support the closures of Agnews and Lanterman developmental centers, and did this impact residents in other DCs who were appropriate for moving to the community?*

- *How is utilization of CPP funds monitored and success measured?*

- *What happens when a regional center does not meet its goals relative to CPP funding?*

- *What happens to unspent CPP at the end of a fiscal year?*

Issue 2: Purchase-of-Services (POS)

The Governor's budget provides $4.038 billion ($2.225 billion GF) for the purchase of services (POS) in community settings by regional centers. This is an increase of $238.1 million ($130.1 million GF) over the enacted 2013-14 budget. Regional centers purchase services for consumers and their families from approved vendors, based on needs identified through a person-centered planning process. Generally, regional centers first seek to coordinate the provision of a service through private insurance or through a "generic" service provided by other state, county, or city agencies, school districts, or other agencies. There is little limitation on the types of services and supports a regional center may purchase due to the individualized need determination process, but the majority of regional center-purchased services and supports are residential care provided in a community care or health facility or support services for individuals in supported living arrangements; day and work programs; transportation; respite; health and behavioral health services.

There are multiple ways that rates are set for providers of community-based services. These include, but are not limited to:

- Rates set by DDS, based on cost statements.
- Rates established in statute or regulation.
- Rates established by negotiation between a regional center and a provider.

Minimum Wage Increase. Assembly Bill 10 (Alejo), Chapter 351, Statutes of 2013, increases the state minimum wage from $8.00 to $9.00, effective July 1, 2014; and increases it again to $10.00, effective July 1, 2016. The Governor's budget provides an increase of $110.1 million ($69.3 million GF) in POS to reflect this change.

Although the Administration has not provided detailed documentation on the assumptions behind this proposed funding increase, draft trailer bill language (TBL) would allow minimum wage adjustments to (1) work activity programs, community-based day programs, and in-home respite service agencies that demonstrated to DDS that they employ minimum wage workers; and, (2) providers who have a rate negotiated with a regional center if they demonstrate to the regional center that they employ minimum wage workers. Additionally, the Governor's budget includes minimum wage increases of $3.6 million for supported employment programs (SEP). However, after further consideration, DDS has determined that it does not have enough visibility into the composition of the SEP hourly rate to know whether a minimum wage increase is warranted. Therefore, they have withdrawn proposed TBL for SEP, and will adjust funding in the May Revision.

Provider organizations argue that the Governor's proposal falls short of making adjustments to reflect the real impact the minimum wage increase will have on their programs. For example, providers cite California Labor Code § 515 as requiring certain supervisorial staff to be paid twice the minimum wage under defined circumstances. They additionally argue that a minimum wage increase necessitates increases for staff above the minimum wage to maintain the differentials earned through seniority and promotion within their agencies.

Legislative Analyst's Office (LAO) Recommendation: The LAO recommends approval of the Governor's proposal to provide $110 million for DDS compliance with the new minimum wage requirements. They further recommend the Legislature create a separate appropriation to fund this expenditure to ensure funds are used for the intended purpose.

Questions for DDS:

- *Please describe how the minimum wage adjustment will be allocated and approved across program types?*
- *How was this level of appropriation determined?*
- *Please describe how you determine which service categories would be eligible for this increase?*
- *For programs with regional center negotiated-rates, how will you ensure the adjustments are implemented as you intend?*

Federal Overtime Changes: The United States Department of Labor recently made regulatory changes to federal Fair Labor Standards (FLSA) to require overtime compensation for service providers previously exempt. Among the services purchased by regional centers, supported living programs, in-home respite programs, and personal assistance services will likely be impacted. The Governor's budget provides $7.5 million ($4 million GF) to address this federal change.

Pursuant to the proposed trailer bill language submitted by the Administration, the Governor's budget would provide a 2.25 percent rate increase for in-home respite service agencies; personal assistants and supported living services (SLS). According to DDS, this level of funding increase is intended to support the hiring of additional staff to ensure employees do not work overtime, except in emergency circumstances. Additionally, many regional center consumers also receive services from In-Home Supportive Services (IHSS) workers. The impact of FLSA on IHSS services was discussed at a previous subcommittee hearing.

DDS states that it based the 2.25 percent rate increase on the fact that the Department of Social Services (DSS) anticipates 1.5 percent of expenditures will be attributed to overtime in the IHSS program and because there are unique difference between IHSS and regional center services, such as the need for 24 hour care in SLS and personal assistant services, that will drive costs up for regional centers.

For regional center consumers who rely on both IHSS and a regional center-funded service that utilize the same worker, this issue may be particularly complex. There is, yet unresolved, concern that the overtime rule may apply across the IHSS and regional center systems, if the same worker is employed in both systems. Even if this is not the case, it is possible that the Administration's approach to prohibit the payment of overtime in most circumstances could result in shifting costs to regional centers. For example, if a worker who currently provides 50 hours in the IHSS services to a consumer, and another 20 hours as a regional center-funded personal assistant to the same consumer, will the prohibition of overtime in IHSS result in additional pressure to increase hours paid by the regional center? Additionally, as generic services, such as IHSS, are generally utilized first, the cost of overtime

for an individual who uses both IHSS and regional center services, when necessary in an emergency situation, may be more likely to fall on the regional center.

Legislative Analyst's Office (LAO) Recommendation: The LAO finds it reasonable to assume that vendors will incur increased administrative costs to mitigate the fiscal impact of overtime pay for home care workers. However, because of data limitations, the LAO is uncertain whether a 2.25 percent rate increase is the right amount. They therefore recommend that the department report to the Legislature on the results of the rate increase on impacted vendors in order to assess whether a 2.25 percent increase is the right amount on an ongoing basis.

Questions for DDS:

- *Please describe the fiscal assumptions behind your estimate.*
- *Does DDS believe there is an issue for individuals who are employed by both the IHSS and regional centers relative to when overtime requirements are triggered?*
- *Does DDS know how many regional center consumers will be impacted by the changes in IHSS overtime?*
- *Does DDS know how many regional consumers utilize a family member for IHSS and/or regional center-funded services that will be impacted by changes in overtime?*
- *How does DDS envision "emergencies" to be defined relative to the payment of overtime.*
- *Has DDS assessed the capacity of SLS, In-home respite, and personal assistant services to hire additional workers?*
- *Is DDS concerned about the impact on consumers who utilize family members as providers of these deeply personal services?*

Impact of Multi-Year Reductions on Community Services and Supports. Most community-based service providers have not received a rate increase since 2006. Residential care providers (ARM), day programs, and traditional work programs received a three percent rate reduction in February 2009, which expired in July 2012. These providers receive an additional rate reduction of 1.25 percent in July 2010, which expired in July 2013. Since 2008, providers whose rate is set through negotiations with individual regional centers have had their rate limited to the median rate for the year 2007. These providers were also subject to the three percent and 1.25 percent rate reductions discussed above. Supported work providers, whose rate is set in statute, received a 24 percent rate increase in 2006, but it was subsequently reduced 10 percent in 2008.

Other changes further skewed the relationship between costs and reimbursement rates. These include:

- Exceptions to rate freezes, and reductions, justified through a "health and welfare" waiver.
- Prohibition on use of POS for program "start-up" costs.
- Implementation of a uniform holiday schedule.

- Implementation of addition administrative functions, including required audits, for providers.

Although these actions may have provided necessary fiscal relief to the state budget, the cumulative impact has been to substantially distort the relationship between rates paid for services and the actual cost of these services and, in some cases, have created a disparity in payments to programs providing similar services. Additionally, system preferences for service models have changed in the ensuing years but rates have not changed to reflect the costs of these new, preferred models. For example, ARM rates are based on six-person homes. However, regional centers increasingly prefer four person homes. Likewise, smaller day and work programs are generally viewed as more effective than the larger, congregate models.

Questions for DDS:

- *How does the wide variation in current rate-setting methodologies, and the effect of the rate freezes and rate reductions that have occurred in past years, impact the ability to measure appropriateness of rates and their impact on the quality and stability of community-based services?*
- *Do you have any concerns that the rate reduction scheduled to be imposed on Intermediate Care Facilities for Persons with Developmental Disabilities (under the DHCS budget) will have an impact the access to, or stability of, these services?*

Early Start Program. The Early Start Program was established in 1993, in response to federal legislation ensuring that early intervention services to infants and toddlers with disabilities and their families are provided in a coordinated, family-centered system of services that are available statewide. Provided services are based on a child's assessed developmental needs and the family's concerns and priorities, as determined by each child's Individualized Family Service Plan (IFSP) team.

In 2009, the Legislature adopted significant changes to the Early Start Program in order to reduce expenditures by $41.5 million (GF). These changes included:

- Removing "at-risk" infants and toddlers under 24-months from eligibility.

- Requiring toddlers aged 24-months or greater to have more significant delays across a large number of domains in order to be eligible for services.

- Discontinuation of the provision of services in the Early Start Program that are not required by the federal government, with the exception of durable medical equipment. The services no longer provided are child care, diapers, dentistry, interpreters, translators, genetic counseling, music therapy, and respite services not related to the developmental delay of the infant or toddler.

As a part of the changes to the Early Start Program, a prevention program was established for infants and toddlers who are "at risk" but no longer qualify for the Early Start Program. The Prevention Program provides safety net services (intake, assessment, case management, and referral to generic agencies) for eligible children from birth through 35 months. In 2011, DDS proposed, and the Legislature adopted, additional changes to the Prevention Program. Specifically, the required functions of the program were limited to information, resource, outreach, and referral and the program

was transferred from the regional centers to the Family Resource Centers, through a contract with DDS.

Questions for DDS

- *Can you quantify the number of infants and children who have been denied services due to the changes adopted in 2009?*

- *How does DDS measure impact of reductions on access, quality of services, system pressures that may emerge later for infants and children who are denied services?*

Insurance Co-Pays and Deductibles. The 2013-14 state budget included trailer bill language to allow regional centers to make health insurance co-pays and co-insurance payments, on behalf consumers and their families, for the services identified as necessary in an IPP, under defined circumstances. Specially, these payments may be made when:

a. It is necessary to ensure that the consumer receives the service or support.

b. When health insurance covers the service in whole or part.

c. When the consumer or family has income that does not exceed 400 percent of the federal poverty level (FPL).

d. When there is no third party who is liable to pay the cost.

Under extraordinary circumstances, when needed to successfully maintain the child at home or adult consumer in the least restrictive setting, regional centers may make these payments for individuals and families who exceed the income threshold. At the time of adoption, DDS estimated that roughly 50 percent of consumers or families have incomes below 400 percent of FPL.

The adopted trailer bill also prohibited pay by regional centers of insurance deductibles (the amount the insured must spend on covered health services before insurance benefits can be utilized), as it can be difficult to link insurance deductibles to a specific service or family member.

Prior to adoption of this trailer bill, there was inconsistency across regional centers as to when and if they would pay insurance-related costs. Some regional centers paid all the costs of co-pays, co-insurance and insurance deductibles, without reference to consumer or family income, for services identified as necessary in an IPP. Others paid only certain portions of these insurance costs, while still others paid no insurance costs. The regional centers that paid these insurance costs did so under the assumption that, without such insurance coverage, the full cost of the service would fall to the regional center to pay.

The discussion around standardizing policies for the payment of insurance co-pays, co-insurance, and insurance deductibles was triggered by the shift of payment responsibility for behavioral health treatment from regional centers to private insurers following the passage of SB 946 (Steinberg), Chapter 650, Statutes of 2011. This new law requires insurers and health plans to provide coverage of behavioral health treatment for persons with autism spectrum disorders (ASD). As these services may be required with great frequency, often 3-5 times per week, the amount of insurance co-pays, co-

insurance and insurance deductibles requested to be paid for by regional centers increased significantly.

For many families, who had no share-of-cost when the service was funded by the regional center, the insurance-related costs they are required to pay can be substantial.

Regional centers were provided an appropriation of $9.9 million (GF) to cover the costs of insurance co-pays and co-insurance for the 2013-14 budget year, and the same amount is proposed for the budget year. At a recent hearing of the Senate Select Committee on Autism and Related Disorders, DDS reported that in the first six months of this fiscal year, approximately $1.9 million had been spent on co-pays and co-insurance for all health services. Of that, $240,000 appeared to be for behavioral health treatment for persons with ASD. However, DDS cautions that this data is incomplete due to the short time period since enactment of the budget trailer bill and associated implementation of new uniform reporting sub-codes for regional centers.

Questions for DDS:

- *Even if the data is incomplete at this time, do you think it is likely that regional centers will utilize the full $9.9 million appropriation in the current year on insurance co-pays and co-insurance payments for eligible consumers and families? If not, what is your best estimate?*

- *Can you estimate the cost of including insurance deductibles as an allowable regional center purchase, under the same restrictions placed on the payment of co-pays and co-insurance?*

- *Can you ascertain the savings associated with the avoidance of full service costs due to the payment of co-pays and co-insurance?*

- *Do you know the number of consumers/families who qualified under the extraordinary circumstances exception?*

Staff Comment and Recommendation: Leave OPEN the community services budget, pending May Revision.