AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER PATTY BERG, CHAIR

WEDNESDAY, APRIL 11, 2007
STATE CAPITOL, ROOM 4202
1:30 P.M.

CONSENT CALENDAR

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: CAPITAL OUTLAY REQUESTS

BACKGROUND

The administration has four requests for capital outlay, summarized as follows:

1. Porterville DC – New main kitchen/renovate 24 satellite kitchens/dining rooms

   The department requests $1.4 million General Fund for the 2007-08 budget year to prepare working drawings for the Renovation of 24 Satellite Kitchens/Dining Rooms component of a larger project. The working drawings will consist of plans for the renovation of Porterville's kitchens and dining rooms in the residences to bring them into code compliance. The purpose of this overall project is to fully equip a new single story main kitchen for the center that will increase the food production and storage capacity, provide an efficient cook/chill food preparation/delivery system and meet all health and safety codes.

2. Fairview DC– Air condition school and activity center

   The department requests $383,000 General Fund to prepare preliminary plans and working drawings for the installation of air conditioning for the Goodell School and Activity Center at Fairview DC. The project will include the installation of new fan coil units connecting to the existing chilled water system and new or replacement ducting throughout the buildings. The addition of a new mechanical room will be necessary to accommodate the additional air conditioning equipment. The warm temperatures in the buildings have been known to cause a higher incidence of unacceptable behavior such as aggression toward staff, peers, themselves, lethargy, and decreased productivity. Common complaints from both consumers and staff have been headaches, fatigue, nausea, and other ill effects as a result of the heat in the building.

3. Fairview DC – Install Personal Alarm Locating System (PALS)

   The department requests $673,000 General Fund to prepare preliminary plans and working drawings to purchase and install a new personal alarm locating system (PALS 9000) at the Fairview DC. The PALS is a staff security device, which provides a means for getting urgent help in an emergency. Each staff member carries a transmitter that allows them to signal for help when attacked by a consumer, when a consumer is involved in a physical altercation with another customer, or when a medical emergency occurs. Currently, the only staff alarm system used at Fairview is a whistle. When other employees are out of earshot of whistles, employees are required to use the telephone to call or page for help when needed for physically violent incidents involving consumers which become emergencies.

4. Porterville – Upgrade PALS

   The department requests $556,000 General Fund to prepare preliminary plans and working drawings for the installation of a PALS in the Secure Treatment Program (STP). The project will expand coverage of the PALS in the STP and will be compatible with the new 96-bed Expansion and Recreation Complex system, which is currently under construction and expected to be completed in June 2008. This project will enable the PALS in the existing STP buildings to be compatible with other PALS throughout Porterville.

ISSUE 2: CONTINUED IMPLEMENTATION OF MEDICARE PRESCRIPTION DRUG COVERAGE UNDER PART D

BACKGROUND

The federal Part D established a voluntary prescription drug benefit effective as of January 1, 2006. The federal Centers for Medicare and Medicaid (CMS) is responsible for implementing this benefit which provides new drug coverage through private Prescription Drug Plans.

As a result of Part D, drug coverage for "dual-eligible" enrollees (i.e., eligible for both Medicare and Medi-Cal) was transitioned from Medicaid (Medi-Cal) to Medicare Part D on January 1, 2006. These private Prescription Drug Plans pre-approve and authorize formularies for enrollees, may charge premiums, deductibles, or co-payments for drugs and reimburse pharmacies at negotiated rates for prescriptions filled for enrollees.

BUDGET REQUEST

The DDS is requesting an increase of $708,000 ($357,000 General Fund) to fund a total of 8 positions (7 permanent and one limited-term to June 30, 2009). Of these 8 positions, two existing limited-term positions (approved in 2005) would be made permanent, and 6 new positions would be added. These proposed positions would be used to support workload associated with the continuing implementation of Part D of the Medicare Prescription Drug Act of 2003 (Part D).

The DDS states that they have insufficient resources at the headquarters office to implement Part D. Specifically, they are requesting the following positions to manage the workload:

- Pharmacy Services Manager (currently set to expire as of June 30, 2007);
- Senior Programmer Analyst (currently set to expire as of June 30, 2007);
- Staff Programmer Analyst;
- Staff Information Systems Analyst;
- Program Technician II (two positions);
- Associate Program Analyst; and
- Staff Services Analyst (two-year limited-term to expire as of June 30, 2009).

ITEMS TO BE HEARD

5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: IHSS PROGRAM AND CASELOAD

The budget proposes nearly $1.5 billion from the General Fund for support of the IHSS program in 2007-08, an increase of $27 million (1.9 percent) compared to estimated expenditures in the current year. This increase is attributable to caseload growth partially offset by increased savings from full implementation of the quality assurance reforms enacted in 2004-05.

BACKGROUND

The In-Home Supportive Services (IHSS) program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without such assistance. An individual is eligible for IHSS if he or she lives in his or her own home—or is capable of safely doing so if IHSS is provided—and meets specific criteria related to eligibility for the Supplemental Security Income/State Supplementary Program. In August 2004, the U.S. Department of Health and Human Services approved a Medicaid Section 1115 demonstration waiver that made about 93 percent of IHSS recipients eligible for federal financial participation. Prior to the waiver, about 25 percent of the caseload were not eligible for federal funding and were served in the state-only "residual" program. The program consists of: the aforementioned IHSS Residual program, Personal Care Services Program (PCSP), and the IHSS Plus Waiver program, described separately below:

- PCSP – In 1993, the California Department of Health Services (DHS) submitted a Medicaid State plan amendment to the federal Health Care Financing Administration to include a portion of the IHSS program as a federal financial participation eligible service. This service is known as PCSP and is funded under Title XIX. These are in-home state plan services for which the State receives federal matching funds. PCSP includes personal care, domestic and related services that are not provided by a spouse or parent of a minor.

- IPW Program – Federal approval to implement the IHSS Plus Waiver was granted by the Centers for Medicare and Medicaid Services and became effective August 1, 2004. Under the IHSS Plus Waiver, the State will receive federal matching funds. IPW includes the same services as those listed above under the PCSP program and restaurant meals allowance or advance pay; the program also allows services to be provided by a spouse or parent of a minor child.

- IHSS Residual Program – Services covered by the IHSS-R program include: domestic and related services (housework, shopping for food, meal preparation, and laundry); non-medical personal care services; transportation (such as accompaniment to medical appointments); paramedical services (necessary health care activities that recipients would normally perform for themselves were it not for their functional limitations), and protective supervision (for persons whose cognitive or mental functioning poses a risk to themselves). A small segment of IHSS recipients are currently in the IHSS-R program; most of these individuals are ineligible for the PCSP Program because their immigration status is "Non-qualified Aliens". The IHSS Residual program is the State/county-funded component.

CASELOAD

IHSS has 326,120 service providers, providing over 30 million hours of service a month. In FY 2006-07, the average monthly IHSS caseload is forecast to be 374,999, represented in the three programs as follows:

- 347,767 recipients receive services under the PCSP and IPW Program.

- 27,232 recipients receive services under the IHSS Residual Program.

As part of the Governor's 2004/05 State Budget, CDSS implemented the Quality Assurance (QA) Initiative to better serve the IHSS population. The QA Initiative outlined a number of enhanced activities to be performed by CDSS, the counties, and the California Department of Health Services (DHS). The goals of the QA Initiative include improving the quality of IHSS/PCSP assessments, enhancing program integrity, detecting and preventing program fraud and abuse, and statewide uniformity in the delivery of services.

FUNDING

Approximately 99 percent of the IHSS caseload is eligible for Federal Financial Participation (FFP) due to PCSP and IPW programs. The funding for each of IHSS programs is as follows:

1. PCSP Program – Funding includes 50 percent FFP with remaining funding consisting of 65 percent State and 35 percent county.

2. IPW Waiver - Funding includes 50 percent FFP with remaining funding consisting of 65 percent State and 35 percent County.

3. IHSS Residual Program – Funding includes 65 percent State and 35 percent county.

PUBLIC AUTHORITIES/NON-PROFIT CONSORTIA

Currently, 56 of the 58 Counties operate a Public Authority (PA) or Non-Profit Consortium (NPC) as their employer of record for collective bargaining purposes for IHSS. Two counties operate as their own Employer of Record for collective bargaining purposes only. PAs and NPCs are separate entities from the county in which they operate and are considered the employer of IHSS providers for the purposes of collective bargaining over wages, hours, and other terms of employment. PA and NPC functions include but are not limited to:

- Establish an IHSS provider registry and referral system through which the IHSS providers may be referred to recipients.
- Perform provider background checks on IHSS workers.
- Provide training for workers and recipients.

The IHSS recipients retain the right to hire, fire, and supervise any IHSS worker providing services to them.

FUNDING OF PUBLIC AUTHORITIES

The total State PA/NPC participation limit is up to $11.10 for IHSS provider wages and individual health benefits, split between $10.50 per hour for wages and $0.60 cents per hour for health benefits. Each county's funding rate for their PA or NPC varies based on the IHSS provider wages and benefits approved by the State, plus additional funding for employer taxes and administrative costs. Each county's PA/NPC rate cannot exceed 200% of the current minimum wage in order to qualify for FFP.

LAO RECOMMENDATION: IHSS CASELOADS OVERBUDGETED

The LAO recommends that proposed General Fund spending for In-Home Supportive Services be reduced by $26.9 million in 2006-07 and $33.9 million for 2007-08 because the caseload is overstated.

For 2006-07, the revised budget for IHSS assumes that the caseload will grow by 6.4 percent over the previous year. As a result, the budget estimates the average number of IHSS cases to be 375,000 in 2006-07. The Governor's budget estimates that the IHSS caseload will reach 395,000 cases in the budget year, an increase of 5.4 percent over the current year.

PANELISTS

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office

ISSUE 2: FREEZE OF STATE PARTICIPATION IN PROVIDER WAGES

BACKGROUND

The budget proposes to limit state participation in provider wages and benefits. This proposal results in General Fund savings of at least $14 million in 2007-08. The federal, state, and local governments share in the cost of the IHSS program. The federal government pays for 50 percent of program costs that are eligible for reimbursement through the Medicaid Program. Under the recently approved Medicaid demonstration waiver, about 93 percent of cases receive federal funding. The state pays 65 percent and the counties pay 35 percent of the nonfederal share of provider wages.

STATE PARTICIPATION IN WAGE INCREASES

Chapter 108, Statutes of 2000 (AB 2876, Aroner), authorized the state to pay 65 percent of the nonfederal cost of a series of wage increases for IHSS providers working in counties that have established "public authorities." The public authorities, on behalf of counties, negotiate wage increases with the representatives of IHSS providers. The wage increases began with $1.75 per hour in 2000-01, potentially to be followed by additional increases of $1 per year, up to a maximum wage of $11.50 per hour. Chapter 108 also authorizes state participation in health benefits worth up to 60 cents per hour worked.

State participation in wage increases after 2000-01 is contingent upon meeting a revenue "trigger" whereby state General Fund revenues and transfers grow by at least 5 percent since the last time wages were increased. Pursuant to this revenue trigger, the state currently participates in wages of $10.50 per hour plus 60 cents for health benefits, for a total of $11.10 per hour. Based on current revenue estimates, the final trigger increasing state participation in wages to $12.10 per hour would be pulled for 2007-08. It is estimated that if all counties opted in to the highest wage level, the cost exposure to the State would be approximately $350 million.

The budget proposes to freeze state participation in wages and benefits. Such a freeze results in a savings of $14 million in 2007-08. This is because some counties already pay providers over $11.10, and absent this proposal, the state would have to increase its participation in those wages and benefits up to $12.10 per hour. Depending on the degree to, which the remaining counties would have increased wages absent this proposal, the Governor's approach would result in additional, unknown cost avoidance in 2007-08. Finally, the Governor's proposal eliminates the $350 million future exposure to the state to pay 65 percent of the nonfederal costs of all counties paying hourly wage/benefit levels of $12.10.

IHSS Hourly Wages and Benefits by County
Approved by January 10, 2007

Alameda	$11.42	Orange	$9.00
Alpine	7.50	Placer	9.60
Amador	8.85	Plumas	8.75
Butte	8.75	Riverside	9.60
Calaveras	8.98	Sacramento	11.10
Colusa	7.50	San Benito	9.50
Contra Costa	11.83	San Bernardino	9.23
Del Norte	8.75	San Diego	9.67
El Dorado	9.10	San Francisco	12.30
Fresno	9.80	San Joaquin	9.53
Glenn	7.75	San Luis Obispo	9.60
Humboldt	7.50	San Mateo	11.38
Imperial	7.50	Santa Barbara	10.60
Inyo	7.50	Santa Clara	13.30
Kern	8.55	Santa Cruz	11.10
Kings	8.60	Shasta	7.50
Lake	7.50	Sierra	8.75
Lassen	7.50	Siskiyou	7.50
Los Angeles	8.96	Solano	11.10
Madera	7.50	Sonoma	11.10
Marin	11.10	Stanislaus	8.85
Mariposa	7.75	Sutter	8.85
Mendocino	9.60	Tehama	8.10
Merced	8.10	Trinity	7.50
Modoc	7.50	Tulare	8.10
Mono	7.50	Tuolumne	7.50
Monterey	11.10	Ventura	9.60
Napa	11.10	Yolo	11.10
Nevada	8.75	Yuba	9.10

The Governor's proposal does not limit the wages paid to IHSS providers; rather, it caps state participation to the level in effect on the date the freeze is enacted. Counties that elect to pay wages above what they were paying as of the wage freeze would in effect cover the State's share and share such wage cost increases with the federal government (50 percent county and 50 percent federal). The state would continue to pay its 65 percent share of the nonfederal costs of wages up to the county wage in place on the date of the wage freeze. This means that the counties that have higher wages in place at the time of the freeze would lock in a greater degree of state participation prospectively than the counties with lower wages as of that date.

CURRENT YEAR WAGE INCREASES

The administration believes it has the authority to freeze state participation in wages to January 10, 2007 levels during 2006-07. However, the administration now indicates that it will continue to participate in post-January 10, 2007 wage increases until its urgency legislation proposal prospectively limiting state participation is enacted by the Legislature. SB 782 (Cogdill) in the current session was heard in the Senate Labor and Industrial Relations Committee on March 28, where testimony was offered, but no action was taken.

IMPACTS ON RECIPIENTS AND PROVIDERS

In the short term, the LAO assesses that freezing wages at their current levels will have minimal influence on the supply of available IHSS providers. However, in the long run, if counties decide that they cannot afford to increase wages without state participation, there may be a reduction in the supply of providers. This could impact the quality of care for IHSS recipients, as it may be more difficult to find skilled providers. Additionally, about 43 percent of IHSS providers are immediate family members, and assuming the provider lives with the recipient, a long-term wage freeze may limit the household income of the provider and the recipient.

Currently many county collective bargaining agreements contain provisions that nullify wage levels if the State removes its share of funding. A freeze in state funding would in effect drastically roll back wages, further jeopardizing the stability of caregivers providing for the elderly and disabled and possibly result in an increase in the institutionalization of these individuals, thereby substantially eroding the state's avoidance of institutionalization costs.

PANELISTS

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office
- SEIU and the Home Care Council
- Jovan Agee, United Domestic Workers of America
- Karen Keeslar, California Association of Public Authorities for IHSS
- Connie Arnold, Chair of the Sacramento IHSS Advisory Committee and Board Member of the California IHSS Consumer Alliance
- Frank Mecca, County Welfare Directors Association
- Deborah Doctor, Protection & Advocacy, Inc.
- Frances Gracechild, Independent Living Centers:, Resources for Independent Living & Co-Chair of the Quality Homecare Coalition

ISSUE 3: ASSESSMENT OF QUALITY ASSURANCE INITIATIVE

BACKGROUND

SB 1104, the social services trailer bill of 2004, created the IHSS quality assurance (QA) initiative, designed to improve the accuracy of needs assessments and program integrity. The IHSS program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without such assistance. The table below shows specific tasks for which IHSS recipients may receive assistance. The IHSS program relies on county social workers to determine the number of hours for each type of IHSS task that a recipient needs in order to remain safely in his/her own home. Typically, social workers conduct reassessments once every 12 months to determine whether the needs of a recipient have changed. After the social worker has determined the appropriate tasks, and time needed for each, a notice of action (NOA) is sent informing the recipient of the number of assigned hours for each task.

In-Home Supportive Services Task Categories	
Tasks	Examples
Domestic Services	Cleaning; dusting; picking up; changing linens; changing light bulbs; wheelchair maintenance; taking out garbage
Laundry	Sorting; washing; hanging; folding; mending and ironing
Shopping and Errands	Purchasing groceries, putting them away; picking up prescriptions; buying clothing
Meal Preparation	Planning menus; preparing food; setting the table
Meal Cleanup	Washing dishes and putting them away
Feeding	Assistance with food and fluid intake
Ambulation	Assisting recipient with walking or moving in home or to vehicle
Bathing, Oral Hygiene, Grooming	Cleaning the body; getting in or out of the shower; hair care; shaving; grooming
Routine Bed Baths	Cleaning the body
Dressing	Putting on/ taking off clothing
Medications and Assistance with Prosthetic Devices	Medication administration assistance; taking off/putting on, maintaining, and cleaning prosthetic devices
Bowel and Bladder	Bedpan/ bedside commode care; application of diapers; assisting with getting on/off commode or toilet
Menstrual Care	External application of sanitary napkins
Transfer	Assistance with standing/ sitting
Repositioning/ Rubbing Skin	Circulation promotion; skin care
Respiration	Assistance with oxygen and oxygen equipment
Protective Supervision	Ensuring recipient is not harming themselves

QUALITY ASSURANCE INITIATIVE

SB 1104 outlined a number of quality assurance (QA) activities to be performed by the DSS, the counties, and the Department of Health Services to improve the consistency and accuracy of IHSS needs assessments statewide, and enhances program integrity. A key feature of the QA initiative is improving the accuracy of assessments for service hours. This is important because the correct assignment of service hours by task is critical if recipients are to remain safely in their own homes and avoid institutionalization.

Hourly Task Guidelines. Prior to the QA initiative, social workers relied significantly on their own judgment when determining the number of service hours to provide to IHSS recipients. As a result, IHSS recipients with similar disabilities, but residing in different counties may not have been granted similar hour allocations. Another way to identify social worker variance in assigning hours is to compare the average hour allocations per case among the ten largest counties. Among California's ten largest counties in 2006-07, average hours per case ranged from 69 to 101 hours. The assumption is that these large counties are serving similar populations. Thus, differences in the average hours assigned are likely to be the result of social worker discretion and practice.

To meet the requirements of SB 1104, DSS led a workgroup composed of state representatives, county staff, legislative staff, and advocacy groups. The workgroup collected information from each county on the average number of hours granted per IHSS case. They then considered various levels of IHSS recipient ability, and developed corresponding ranges of times that would be appropriate for 12 of the 15 tasks identified by the workgroup. From this workgroup and after lengthy debate and consultation, hourly task guidelines (HTG) were created to provide social workers with a standardized tool to ensure that service hours are authorized consistently and accurately throughout the state. Due to ongoing concerns that HTG might result in substantial decreases in hours not attributed to a decrease in consumer need, SB 1104 required DSS to produce a report assessing the initial impact of HTG.

IHSS Service Hours
Vary Substantially Across
Largest Counties

2006-07

County	Average Hours Per Case	Average Monthly Cases
Santa Clara	69.6	11,202
Orange	69.7	11,557
San Diego	79.7	19,027
Los Angeles	80.6	149,806
San Francisco	82.1	16,209
California	**83.9**	**344,484**
San Bernardino	86.3	14,935
Alameda	91.6	13,279
Riverside	94.0	10,229
Sacramento	98.5	16,681
Fresno	101.1	11,019

These averages are from the IHSS Personal Care Services Program (PCSP) which is approximately 91.5 percent of the total IHSS caseload as of February 2007.

Since September 2006, HTG have been used statewide by social workers during their assessments. The guidelines help social workers to determine a recipient's level of ability to perform each IHSS task. After determining a recipient's level of ability, the social worker decides if the number of hours of assistance needed per week is within the HTG range for a particular task. The HTG do not take away the individualized assessment process, but instead require a social worker to provide a written justification if a recipient is assessed as needing hours that are outside (either above or below) the range established by HTG. These task guidelines are intended to increase the probability of consistent assessments throughout the state.

In a further effort to achieve uniformity, the IHSS Social Worker Training Academy was developed as a standardized method to educate social workers in the IHSS Program, quality assessment practices, and the proper usage of the HTG tool. Interviews with county workers suggest that HTG and uniform training will likely increase the uniformity of assessments among counties so that IHSS recipients moving from one county to another will not likely experience large increases or decreases in their hour allocations.

2006-07 LEGISLATIVE BUDGET REVIEW

In 2006, the Legislature adopted Supplemental Report Language requiring DSS to report to the Legislature quarterly on the IHSS utilization data by county, task, and client level. The data was also to report the number of exceptions by county, task and client level. Budget Bill Language was also adopted to require DSS to report at budget hearings on the impact of the IHSS QA regulations.

DSS conducted a field test in January 2006 to measure the effectiveness and usefulness of the proposed HTG "Task Tool" in assisting social workers in the provision of a comprehensive assessment/reassessment that most closely identified and met the consumer's needs. DSS worked with IHSS stakeholders in February and March of 2007 to prepare for a follow-up survey of consumers now that the HTG regulations are adopted and being used by social workers for assessments and reassessments. The status of the follow-up survey is not clear.

Stakeholders have reported to the Subcommittee that they are interested in learning:

1. How many exceptions are processed by IHSS supervisors after the social worker has completed the assessment/reassessment;

2. Does CDSS have data that compares the number of requests for appeals hearings prior to and after the adoption of HTG regulations;

3. How has the adoption of HTGs affected the average number of hours approved per IHSS case?

The LAO indicates in their February 2007 report that unaudited monthly case expenditures are running below expectations. This generates concerns in the advocacy community that adoption of HTGs are resulting in IHSS consumers receiving lower hours and may affect the ability of consumers to "ensure the health, safety, and independence of the recipient" as required in Welfare & Institutions Code 12301.2 (a)(2).

PANELISTS

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office
- Tamara Rasberry, SEIU
- Jovan Agee, United Domestic Workers of America
- Karen Keeslar, California Association of Public Authorities for IHSS
- Frank Mecca, California Welfare Directors Association

ISSUE 4: IMPLEMENTATION UPDATE ON DIRECT DEPOSIT

BACKGROUND

Although IHSS is a county administered program, the State Controller makes the payment for IHSS providers by issuing individual checks to each provider. Currently only a small number of IHSS clients that receive "advance pay" receive their funds through a direct deposit payment.

Last year's Social Services Trailer bill, AB 1808, contained a provision requiring DSS to expand its direct deposit system to all IHSS caregivers.

The department will report on the implementation status of the direct deposit program.

PANELISTS

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office
- Jovan Agee, United Domestic Workers of America

ISSUE 5: PROVIDER TRAINING AND MACR PROPOSALS

Advocates have submitted proposals regarding IHSS, which the Subcommittee is continuing to review. These proposals are described below.

BACKGROUND ON MACR

Currently, six counties operate an IHSS contract to provide services to a portion of their caseload: Butte, Riverside, San Francisco, San Joaquin, San Mateo and Santa Barbara. Under this system the county contracts with a qualified home care agency through the Invitation for Bid (IFB), Request for Proposal (RFP) or negotiation process. Contract terms can be set for a period of one to three years, with an optional one-year extension, before re-bidding is required. The DSS issues a standard IFB template, which counties can modify. Counties may contract with a non-profit or proprietary home care agency to provide all or part of their IHSS services, provided that counties with a caseload of 500 or more provide an Individual Provider employer option for recipients who make this request. Counties may also maintain multiple contracts by entering into agreements with more than one agency.

The contract agency becomes the employer of record and assumes legal responsibility for recruiting, screening, hiring, training and supervising the workforce, as well as for collective bargaining. IHSS contractors must recognize the right of recipients to recruit, select, train or reject their own provider. IHSS Contracts have proved useful and effective in serving consumers who have difficulty finding and keeping a home attendant, with consumers who need assistance in managing their care (e.g. who are not self directing), for consumers who do not want to assume the role of employer, and for those who are assessed low hours which are often more easily managed and coordinated by a single administrative entity.

The IFB establishes a range of requirements for contractors in the area of supervisory ratios, training, time frames for serving new cases, financial reporting and record keeping. Counties can modify these standards to meet local needs and priorities and to affect the hourly cost of the contract. Liquidated damages are typically assessed for non-performance in specific client service and contract compliance areas. The Invitations for Bid establish minimum standards for wages and benefits that are set by each county. Under the contract mode option, a county may contract with a city, county, or city and county agency, a local health department, a voluntary nonprofit agency, a proprietary agency, or an individual to deliver IHSS services. As the employer of record, the IHSS contractor handles IHSS provider employer/employee relations and payroll responsibilities.

The DSS establishes an IHSS Maximum Allowable Contract Rate (MACR) for each county. There are five data elements involved with this calculation, as follows:

a. Entry level wage for homecare workers in the individual county

b. Statewide entry level wage for homecare workers

c. Average wage within the individual county for homecare workers

d. Average statewide wage for homecare workers

e. Statewide average of the administrative component of existing IHSS contractors.

CDSS only updates the MACR on a periodic basis and typically their action to complete updates on MACRs follows some action through the state budget process. The MACR was not updated between 1994 and 1999. The budget subcommittees in both the Assembly and Senate urged Governor Davis to include funding for a MACR adjustment in the May Revise for fiscal year 2000/01. The final Budget Act for 2000/01 contained funding and language to implement a 10 percent in the MACR. The fiscal year 2001/02 Budget Act, Senate Bill 739 (Chapter 106, Statutes of 2001) provided State funding to increase the MACR by an additional 5.31 percent. In fiscal year 2002/03, DSS updated the MACR for the twelve counties that were using contract-mode services at that time and also established new MACRs for the remaining counties. There has been no further adjustment to the MACR since the December 18, 2002 release of All-County Letter 02-95.

MACR PROPOSAL

DSS sets a Maximum Allowable Contract Rate (MACR) for counties that use the contract mode as well as the Independent Provider (Public Authorities) mode to deliver services. The MACR, which is the rate that counties may pay a contract provider, includes allowances for wages, benefits, and overhead and must be adjusted manually by DSS. When DSS fails to adjust the rate after Public Authority providers negotiate a new wage in that county, contract mode workers will be in a de facto wage freeze. The proposed trailer bill language will automatically adjust the MACR in counties when a new wage is negotiated by Public Authority providers. This will allow IHSS providers who work for contract agencies to negotiate wage increases equal to those negotiated by IP mode providers.

Proposed Trailer Bill Language:

Add Section 12303.1 to the Welfare and Institutions Code to read:

The allowable cost of services provided under Section 12303 in each county that has negotiated or implemented a change or changes in wages or benefits for independent providers and in each county which pays independent providers the minimum wage shall be adjusted by the department by September 30 of the fiscal year following the effective date of the negotiated or implemented change in wages or benefits or the effective date of any change in minimum wage to reflect, at a minimum, the change in wages or benefits and the employer costs, including payroll taxes, directly arising from the change in wages or benefits.

TRAINING PROPOSAL

Advocates have also proposed draft trailer bill language to facilitate the use of non-state General Fund money to pay for caregiver training hours should those funds materialize. Their two aims are to:

1. Create a mechanism for providers to receive CMIPS I payment for in-service training. The current programming of the CMIPS I system does not allow for a payment line other than IHSS time-for-task services. The proposed language will direct DSS to budget for reprogramming.

2. Create statutory authority for IHSS providers to receive pay for training. Current law, like the CMIPS I pay-rolling system does not allow for a worker to be paid for other than services provided to the recipient. This language change will allow for a provider to receive wages for training.

Proposed Trailer Bill Language:

The language would amend 12301.6 of the Welfare and Institutions Code to do the following:

- *Require the department, through all county letters, to inform Public Authorities, non-profit consortiums, and contract agencies providing IHSS services in counties if it learns of funding opportunities to provide additional paid provider training beyond the training required in current law.*

- *Require the department to pay particular attention to identifying funding that would pay for transition training for new providers.*

- *Require that If the representative of providers and an employer of record, through collective bargaining, agree that the employer of record shall use new funds to provide additional training beyond that required by current law, the agreement should ensure that the providers are paid through their payroll system.*

- *Require that enactment of paid provider training be independent of the CMIPS II procurement.*

- *Permit compensation for training using new funds to be authorized for any provider of in-home supportive services who provides transitional training to, or receives transitional training from, another provider of in-home supportive services in order to best meet the individual needs of a consumer who is changing providers.*

PANELISTS

- Bob Naylor, Addus Health Care
- Tamara Rasberry, SEIU
- Karen Keeslar, CAPA
- Jovan Agee, UDW/AFSCME:
- Curtis Earnest, SEIU/Local 6434

ISSUE 6: PROVIDER RATE PROPOSAL

BACKGROUND

Currently, DSS practice is to approve rate requests on a year-to-year basis, one issue at a time. Many counties negotiate multi-year wage and benefit packages which detail multiple steps over the life of the agreement.

The California Association of Public Authorities (CAPA) for IHSS proposes to include trailer bill language to authorize counties to submit consolidated rate packages for the Public Authority or Non-Profit Consortium that reflects all approved changes in wages and benefits. CAPA contends that the State could then approve multiple rates for an individual Public Authority or Non-Profit Consortium that reflect the specific dates when wages and/or benefits are slated to be changed pursuant to the provisions of an approved collective bargaining contract.

CAPA states that this proposal:

- Reduces both the paperwork and processing time at both the county and state levels.
- Provides additional information to the State that would assist in developing fiscal estimates of costs associated with known IHSS wage and/or benefit changes.
- Maintains the requirement for rate changes to be subject to the availability of funding.

Proposed Trailer Bill Language:

Add Section 12306.15 to the Welfare and Institutional Code:

12306.15. A county may submit consolidated rate packages for the public authority or nonprofit consortium to the department for multiple rate approvals. The documentation shall contain information, including wages, benefits and related expenditures, that contain increases and adjustments necessary to implement the terms and conditions of multi-year collective bargaining agreements or collective bargaining agreements that contain more than one change or adjustment within a one-year period. The department may approve Public Authority or nonprofit consortium multiple rates that contain phased-in or staged changes subject to the availability of funding.

PANELISTS

- Karen Keeslar, California Association of Public Authorities for IHSS
- Robert Harris or Curtis Earnest, SEIU

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: COMMUNITY SERVICES PROGRAM AND PURCHASE OF SERVICE

OVERVIEW OF DEPARTMENT RESPONSIBILITIES

California provides community-based services to approximately 220,000 citizens with developmental disabilities and their families through a statewide system of 21 regional centers. Developmental Disability is defined by the Lanterman Developmental Disabilities Services Act as originating before 18 years of age, continues or can be expected to continue indefinitely, constitutes a substantial handicap and includes mental retardation, cerebral palsy, epilepsy, and autism. The definition can include other handicapping conditions similar to mental retardation but not solely physical in nature. Regional Centers are private, nonprofit agencies under contract with DDS for the provision of various services and supports to people with developmental disabilities. As a single point of entry, regional centers provide diagnostic and assessment services to determine eligibility; convene person-centered planning teams to develop an individual program plan ("IPP") for each eligible consumer; and either provide or obtain from generic agencies appropriate services for each consumer in accordance with the IPP in order to ensure the maximum flexibility and availability of appropriate services and supports for persons with developmental disabilities. In addition to the regional centers, DDS currently operates five developmental centers and two community based facilities.

Unlike most other public social services or medical services programs, services are generally provided to the developmentally disabled at state expense without any requirements that recipients demonstrate that they do not have the financial means to pay. The Lanterman Act establishes the state's responsibility for ensuring that persons with developmental disabilities, regardless of age or degree of disability, have access to services that sufficiently meet their needs and goals in the least restrictive setting. Individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes that are designed to meet their medical and behavioral needs. Slightly more than 1 percent live in state-operated, 24-hour facilities.

The budget proposes $4.3 billion (all funds) for support of DDS programs in 2007-08, which is a 5.7 percent increase over estimated current-year expenditures. General Fund expenditures for 2007-08 are proposed at $2.6 billion, an increase of almost $37 million, or 1.4 percent, above the revised estimate of current-year expenditures. In addition, the revised 2006-07 budget proposes a $106.4 million ($71.2 million General Fund) increase from the enacted Budget to address adjustments for employee compensation, caseload and service utilization as well as the effect of the change in the minimum wage.

Of the total amount proposed for 2007-08, $3.6 billion ($2.2 billion General Fund) is for services provided in the community through Regional Centers, $712.3 million ($393.6 million General Fund) is for support of the state Developmental Centers, and $40.1 million ($26.4 million General Fund) is for state headquarters administration.

Proposed Budget for Department of Developmental Services:

Summary of Expenditures (dollars in thousands)	2006-07	2007-08	$ Change	% Change
Program Source				
Community Services Program (RC's)	$3,314,749	$3,566,049	$251,300	7.6
Developmental Centers	$730,629	$712,268	-$18,361	-2.5
State Administration	$40,084	$40,106	22	0.1
Total, Program Source	**$4,085,462**	**$4,318,423**	**$232,961**	**5.7**
Funding Source				
General Fund	$2,572,111	$2,608,617	$36,506	1.4
Federal Funds	$55,144	$55,411	$267	3.6
Public Transportation Account	$0	$143,993	$143,993	100
Program Development Fund	$2,019	$2,012	-$7	-0.3
Lottery Education Fund	$489	$489	$0	0
Developmental Disabilities Services	$41	$0	-$41	-100
Reimbursements: including Medicaid Waiver, Title XX federal block grant and Targeted Case Management	$1,455,658	$1,507,901	$52,243	3.6
Total Expenditures	**$4,085,462**	**$4,318,423**	**$232,961**	**5.7**

Department of Developmental Services—Demographics Data from 2004

Table 1 **Age**	**Number of Persons**	**Percent of Total**	***Table 2*** **Residence Type**	**Number of Persons**	**Percent of Total in Residence**
Birth to 2 Yrs.	22,601	11.2%	Own Home-Parent	144,023	71.6 %
3 to 13 Yrs.	57,793	28.7%	Community Care	26,442	13.1%
14 to 21 Yrs.	33,697	16.8%	Independent Living /Supported Living	17,333	8.7%
22 to 31 Yrs.	28,365	14.1%	Skilled Nursing/ICF	8,783	4.4%
32 to 41 Yrs.	22,812	11.3%	Developmental Center	3,231	1.6%
42 to 51 Yrs.	20,298	10.1%	Other	1,239	0.6%
52 to 61 Yrs.	10,635	5.3%			
62 and Older	4,850	2.4%			
Totals	***201,051***	***100%***		***201,051***	***100%***

BACKGROUND ON REGIONAL CENTERS

The Community Services program provides community-based services to clients through 21 nonprofit corporations known as regional centers (RCs) that are located throughout the state. The RCs are responsible for eligibility determinations and client assessment, the development of an individual program plan, and case management. They generally pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by counties, cities, school districts, and other agencies. The RCs also purchase services, such as transportation, health care, respite, day programs, and residential care provided by community care facilities. The department contracts with the RCs to provide services to more than 212,155 clients each year.

The budget proposes $3.6 billion from all funds ($2.2 billion General Fund) for the support of the Community Services Program in 2007-08. This represents a $47 million General Fund increase, or 2.2 percent, over the revised estimate of current-year spending. The increase is a result of caseload growth, higher utilization rates for services, the effect of the increase in the minimum wage, and other program changes. Of the total $3.6 billion in funding proposed for RC programs in 2007-08, $501 million is for RC operations and $3.1 billion is for the purchase of services.

PURCHASE OF SERVICE

The cost to the state of operating regional centers for persons with developmental disabilities has continued to escalate at a rapid pace with total spending projected to increase by almost $1.7 billion, or about 89 percent, between 2000-01 and 2007-08. In this analysis we examine recent caseload and program spending trends, assess the Governor's caseload projections, identify an opportunity to draw down additional federal funds ($11 million in the current year), and recommend the Legislature increase oversight of the department's rate reform effort.

The RCs provide services to clients through two mechanisms. First, RCs purchase services directly from vendors. These services are commonly referred to as "purchase of services." Secondly, RCs assist their clients in obtaining services from public agencies. These services are commonly referred to as "generic services." We discuss both types of services further below. The budget for purchase of services consists of ten main service categories, plus one additional category referred to as "other adjustments." (A more detailed description of these categories is provided on page C-162 of our Analysis of the 2005-06 Budget Bill.) Figure 1 shows the Governor's proposed spending plan for these purchase of services categories in 2006-07 and 2007-08.

Regional Centers Purchase of Services Funding By Service Category

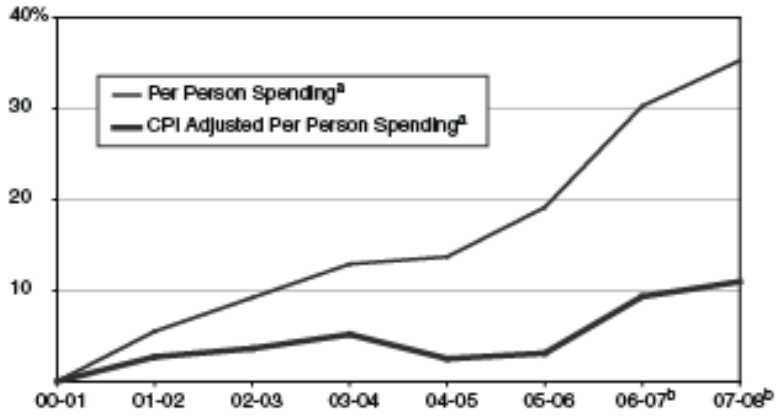
(All Funds, Dollars in Millions)

Service Category	2006-07a	2007-08a	Difference	Year-to-Year Percent Change
Day programs	$700	$754	$54	7.7%
Community care facilities	688	770	82	11.9
Support services	488	551	63	12.9
Miscellaneous	268	312	44	16.4
Transportation	203	214	11	5.4
In-home respite	165	180	15	9.1
Habilitation services	148	150	2	1.4
Health care	83	91	8	9.6
Out-of-home respite	48	49	1	2.1
Medical facilities	18	18	—	—
Other adjustments b	—	-44	-44	N/A
Totals	**$2,809**	**$3,045**	**$236**	**8.4%**

Figure 2

Regional Center Spending Up Significantly

Percent Change Since 2000-01



[a]Data adjusted to reflect programmatic changes.
[b]Reflects Governor's revised estimate for 2006-07 and the budget proposal for 2007-08.
CPI: Consumer Price Index

GENERIC SERVICES

Under state law, generic services are defined as those being provided by federal, state, and local agencies which have a legal responsibility to serve all members of the general public and that receive public funds for providing such services. There are more than a dozen different generic services that are regularly accessed by RC clients. For example, medical services for an eligible developmentally disabled person might be provided through the Medi-Cal health care program for the poor. City or county park and recreation programs also provide generic services for developmentally disabled clients. State law requires that RCs access generic services first and make purchase of services only when generic services are unavailable.

Under the federal Home and Community-Based Services (HCBS) waiver, federal funds can be drawn down to pay for about one-half the costs of certain community-based services for individuals at risk of institutionalization. The 2007-08 budget plan assumes that RC programs will draw down $818 million in federal funds under the HCBS waiver.

OVERALL SPENDING AND COST PER CLIENT

Between 2000-01 and 2007-08, total spending is forecast to increase by almost $1.7 billion if the administration's budget plan were adopted as proposed. During the same period, spending per person, after adjusting for inflation, would go up 11 percent and unadjusted spending per person would go up by 36 percent. Between 2000-01 and 2007-08, the RC caseload is projected to grow from about 163,613 to almost 221,000, an average annual growth rate of almost 4.4 percent. The caseload trend is shown in the table below.

Several key factors appear to be contributing to ongoing growth in the RC caseload. Medical professionals are identifying persons with a developmental disability at an early age and referring more persons to DDS programs. Improved medical care and technology has increased life expectancies for individuals with developmental disabilities. The RC caseload growth also reflects a significant increase in the diagnosed cases of autism, the causes of which are not fully understood.

In accordance with past practice, the 2007-08 budget plan reflects DDS' updated projections for the number of RC clients for the current and budget years. The budget plan indicates that the actual caseload in the RC system in 2006-07 is tracking very closely to the original budgeted level. Specifically the average annual caseload for the current year is estimated at 212,155, or just 70 clients less than the estimate of 212,225 that was the basis for the RC system's appropriations in the 2006-07 Budget Act. The budget plan further estimates that the average annual RC caseload will grow to almost 221,000 in 2007-08, a year-to-year increase of 8,445 clients or 4 percent.

Regional Center Caseload Growth Trend

Fiscal Year	Average Annual Population Caseload	Increase From Prior Year Amount	Increase From Prior Year Percent
2000-01	163,613	8,651	5.6%
2001-02	172,714	9,101	5.6
2002-03	182,175	9,461	5.5
2003-04	190,030	7,855	4.3
2004-05	197,355	7,325	3.9
2005-06	203,823	6,468	3.3
2006-07a	212,155	8,332	4.1
2007-08a	220,600	8,445	4.0

As described above, the administration proposes to increase the level of current-year funding provided for RC purchase of services by about $33 million General Fund. This further adjustment reflects updated expenditure data on utilization and caseloads for RC purchase of services. For 2007-08, the Governor's budget proposes to increase spending for the RC system by about $251 million including an increase of about $46.5 million from the General Fund. This increase mainly reflects estimated growth in caseloads, costs, and the utilization of services by RC clients.

CURRENT YEAR DEFICIENCY REQUEST

DDS requests a General fund augmentation to fund a projected deficiency in the Purchase of Services (POS) portion of the Community Services program. The deficiency results from two adjustments: (1) an increase of $18,340,000 related to the minimum wage increase effective January 1, 2007, and (2) an increase of $33,432,000 related to updated POS service utilization and caseload projections. These two adjustments result in a total deficiency of $51,772,000 General Fund.

On the POS deficiency, DDS determined there were increases in expenditures in the fourth quarter of 2005-06 that were inconsistent with the expenditure trends in previous years. Consequently, increased expenditures of $49,971,000 ($33,432,000 General Fund) were not captured in the POS expenditure projection included in the 2006 Budget Act. The increased POS costs are due to increases in the number and cost of services provided to consumers who are older, more medically fragile, and those with autism.

Funding for this deficiency request will be pursued through a Supplemental Appropriations Bill.

LAO RECOMMENDATION

Based on the most recent information available, it appears the caseload is potentially overbudgeted by roughly $14 million General Fund in the current year and $15 million General Fund in the budget year. However, the department has indicated that in some cases in the past, lower-than-anticipated caseload costs have been offset by increases in utilization. It is possible that the reduction in caseload will be offset by an increase in utilization cost. The LAO recommends that the Legislature require the department to report at budget hearings on the specific causes for increased utilization and costs. In our view, without accurate information about what is causing increased utilization and costs, the Legislature lacks the information it needs to assess the causes of the rapid growth in the RC program and determine which policies would be most effective to contain these costs.

The LAO notes that in its 2006-07 Analysis, it recommended directing the Department of Finance's Office of State Audits and Evaluations to conduct an audit to evaluate the accuracy and the consistency of the purchase of services data now being reported by the RCs. Because the accuracy and consistency of these data are now uncertain, the state lacks tools that are needed to exercise strong fiscal oversight over RC spending. An improvement in the way expenditure data are reported has additional potential benefits. It could improve the quality of the data used by DDS for budget forecasts, so that its budget request to the Legislature could more closely match the actual funding required to support community services programs. The administration has indicated that it will provide updated information on the overall RC caseload trend, change in the mix of RC clients, and trends in the cost and utilization of services at the time of the May Revision. The LAO will continue to monitor caseload trends and will recommend appropriate adjustments, if necessary, in May when DDS' updated budget request is presented to the Legislature.

PANELISTS

- Department of Developmental Services
- Department of Finance
- Legislative Analyst's Office

ISSUE 2: RATE REFORM AND COST CONTAINMENT FOR RC SERVICES

BACKGROUND

The Legislature has taken some actions in recent years to slow growth in state costs for the RC system. Beginning in 2003-04 and continuing through 2006-07, it acted to control costs by adopting legislation imposing rate freezes and other cost-control measures on selected community services. The rate freezes and cost-containment measures were intended to be temporary actions to help address the state's serious fiscal problems while allowing time to consider permanent and ongoing strategies to help contain RC costs such as rate reform.

Historically, there has been significant variation in the way that rates are set for the RC vendors who provide services, and the rate-setting approach overall has lacked a rational and consistent approach. The 2004-05 Budget Act provided four permanent staff positions and $500,000 in one-time funding for contract resources to enable DDS to develop standardized rates for certain types of RC vendors. As part of its review process, DDS was to evaluate the existing rate-setting methodology, identify inadequacies and drawbacks in the way rates were set, identify, and develop any statutory and regulatory changes found to be necessary, and implement and monitor a revised rate-setting methodology. The rate reform activities approved by the Legislature were intended to be part of a more comprehensive cost-containment program for the RC system.

COST CONTAINMENT PROPOSALS

The administration proposes to continue several different cost containment actions for 2007-08 that were enacted as part of the Budget Acts of 2002, 2003, 2004, 2005, and 2006. These cost containment actions have been previously adopted by the Legislature in lieu of more sweeping and restrictive actions previously proposed by Governor Davis and Governor Schwarzenegger. In total, these cost containment measures are proposed to save about $250 million ($172.7 million General Fund) for 2007-08.

The cost containment actions proposed to be continued by the Administration are discussed individually below. All of these proposed actions require trailer bill legislation.

1. Delay in Assessment (RC operations) (-$4,500,000 General Fund): Through the Budget Act of 2002, trailer bill language was adopted to extend the amount of time allowed for the Regional Center's to conduct assessment of new consumers from 60 days to 120 days following the initial intake. The Governor proposes to continue this extension through 2007-08 through trailer bill language. This is the same language as used in previous years.

2. Calculation of Case Management Ratios (RC Operations) (-$32.8 million or -$16.2 million General Fund): Through the Budget Act of 2003, trailer bill language was adopted to reduce the average RC case manager to consumer ratio from one to 66 (one Case Manager to 66 consumers). Previously, the ratio was one to 62. The Governor proposes to continue this extension through 2007-08 through trailer bill language. This is the same language as used in previous years.

3. Non-Community Placement Start-Up Suspension (-$6 million General Fund): Under this proposal, a Regional Center may not expend any purchase of services funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. The administration's proposed trailer bill language would continue this freeze through 2007-08. The Legislature did provide $3 million (General Fund) for this purpose in 2006-07.

4. Freeze on Rate Adjustments for Day Programs, In-Home Respite Agency and Work Activity Programs (-$3.9 million or -$2.9 million General Fund): The rate freeze means that providers who have a temporary payment rate in effect on or after July 1, 2007 cannot obtain a higher permanent rate, unless the RC demonstrates that an exception is necessary to protect the consumers' health or safety. It should be noted that these programs did receive rate increases in the Budget Act of 2006. As such, their rates for 2007-08 would be frozen at these levels, unless otherwise adjusted as noted.

5. Freeze Service Level Changes for Residential Services (-$47.4 million or -$28.4 million General Fund). This proposed trailer bill language would provide that RCs can only approve a change in service level to protect a consumer's health or safety and the DDS has granted written authorization for this to occur. This action maintains rates at the July 1, 2007 level.

6. Elimination of Pass Through to Community-Care Facilities (-$3.2 million, or $1.9 million General Fund): The SSI/SSP cost-of-living-adjustment that is paid to Community Care Facilities by the federal government is being used to off-set General Fund expenditures for these services for savings of $3.2 million ($1.9 million General Fund).

7. Contract Services Rate Freeze (-$160.6 million, or -$190.7 million General Fund): Some RCs contract through direct negotiations with providers for certain services in lieu of the DDS setting an established rate. Continuation of the rate freeze would mean that RCs cannot provide a rate greater than that paid as of July 1, 2007, or the RC demonstrates that the approval is necessary to protect the consumer's health or safety. The administration's proposed trailer bill language is the same as last year's, with a date extension to include 2007-08.

8. Habilitation Services Rate Freeze (-$2.2 million, or -$2.8 million General Fund): The Habilitation Services Program consists of the (1) Work Activity Program (WAP), and (2) Supported Employment Program (SEP). The WAP services are primarily provided in a sheltered setting and are reimbursed on a per-consumer-day basis. SEP enables individuals to work in the community, in integrated settings with support services provided by community rehabilitation programs. The administration's proposed trailer bill language would continue the rate freeze into 2007-08.

9. Non-Community Placement Start-Up Suspension (-$6 million): Under this proposal, a Regional Center may not expend any Purchase of Services funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. The administration's proposed trailer bill language would continue this freeze through 2007-08.

With respect to the startup of new programs, the administration notes that funding would be provided to protect consumer's health and safety or to provide for other extraordinary circumstances as approved by the DDS. Limits on this funding were first put into place in 2002. It should be noted that in the Budget Act of 2006, the Legislature did appropriate $3 million (General Fund) for these purposes.

RATE REFORM PROGRESS TO DATE

The rate reform process has generally focused on those services for which rates are set through negotiations between RCs and service providers. Over a multiyear period, several RCs have been surveyed to obtain specific information about how they determine rates for 16 different services provided to RC clients. The last of three waves of surveys were sent out to the RCs in January 2006.

The DDS has developed a regulations package for rates for supported living services that is currently in the formal regulatory review process. (Supported living services consist of a broad range of services to developmentally disabled adults who choose to live in homes they own or lease in the community.) The DDS planned to circulate an initial regulations package for comment in January 2007 regarding some of the other rates included under the reform effort. At the time this analysis was prepared, these regulations were not yet available for comment.

As noted above, DDS was provided $500,000 in one-time funding for contract resources to enable DDS to develop standardized rates for certain types of RC vendors. In November 2005, DDS awarded a contract to a consultant to provide assistance with analyzing data and evaluating findings and recommendations regarding certain services purchased by RCs. The consultant completed a report and provided it to DDS in the fall of 2006.

Cost containment activities include the continuation of specified rate and service level freezes, the family cost participation program, development of a Self Directed Services Waiver, revisions to the Supported Living Services regulations and the Rate/Service Code Standardization project.

In order for the Department to begin to develop alternatives to the temporary cost containment measures, it is important to understand how the particular interventions impact utilization and cost. The Department of Developmental Services has contracted with Acumen LLC to analyze data in order to provide expert assistance to help inform policy discussions. With the DDS mission and these goals in mind, the contractor will provide the necessary levels of expertise to review the current caseload and utilization information in order to:

1. Correlate caseload information to utilization and, therefore, costs;

2. Examine the demographics of the population to identify important characteristics that significantly impact costs now and in the future;

3. Explore how the specific cost-containment measures influence utilization; and

4. Prepare a report documenting the analysis, methodology, and conclusions.

The Department anticipates having the report in item 4 above by May.

LAO RECOMMENDATION

LAO recommends that the Legislature require DDS to report at budget hearings on the timeline for implementation of revised rate-setting methodologies for RC services to ensure reasonable progress is made towards implementing rate reform. Specifically, the department should report on the services that are under study for rate reform, the timeline for proposing revised regulations packages and other measures, and the estimated savings for implementing rate reform for specified services. This will provide the Legislature with the information it needs as it deliberates on the continuation of temporary cost-containment measures.

PANELISTS

- Department of Developmental Services
- Department of Finance
- Legislative Analyst's Office
- Bob Baldo, Association of Regional Center Agencies

ISSUE 3: DEVELOPMENTAL CENTERS PROGRAM

BACKGROUND

The department operates five DCs, and two smaller leased facilities, which provide 24-hour care and supervision to approximately 2,600 clients. All the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment. More than 7,300 permanent and temporary staff serve the current population at all seven facilities.

The budget proposes $712 million from all fund sources ($393 million General Fund) for the support of the DCs in 2007-08. This represents a net decrease of $9.9 million General Fund, slightly more than 2 percent below the revised estimate of current-year expenditures. The DC budget plan includes the following proposals:

- **Agnews DC Closure (discussed later in this agenda).** The budget plan continues to assume the closure of the Agnews DC in June 2008. In 2007-08, DC expenditures decrease by $10.4 million ($5.6 million General Fund) to reflect decreased staffing costs as Agnews' population is relocated into community placements or to other DCs. The RC budget would provide $50.7 million ($37.9 million General Fund) to reflect the costs of providing community-based services to former Agnews residents.

- **Employee Compensation.** The budget plan also proposes $33.1 million ($19.2 million General Fund) in 2007-08 for increased employee compensation and benefits.

The population of California's developmental centers (DCs) has decreased over time while costs per consumer have increased. The two main drivers of increased costs per consumer are: 1) the changing nature of the DC population and associated required staffing; and 2) the maintenance of the aging DC infrastructure and facilities.

The decrease in the use of institutions began when the community-based system was initiated in 1969 under the newly established Lanterman Mental Services Act, now called the Lanterman Developmental Disabilities Services Act (Lanterman Act). The Lanterman Act promotes the provision of services in the least restrictive environment and emphasizes community settings as the preferred living option for most consumers. The total DC population declined dramatically as the community system expanded, falling from a high of 13,355 individuals in 1968 to about 2,800 today. Declining populations made it possible for the state to cease operating five facilities. Modesto State Hospital was closed in 1970, DeWitt State Hospital in 1972, Mendocino State Hospital in 1973, Stockton Developmental Center in 1995, and Camarillo State Hospital and Developmental Center in 1996. When DDS split from the Department of Health Services in 1978-79, there were eight facilities serving 9,259 consumers. Today, with

the opening of two small community facilities (Sierra Vista in Yuba City and Canyon Springs in Cathedral City), there are seven state-operated facilities serving approximately 2,800 individuals with developmental disabilities.

The development of community services as an alternative to institutional care in California mirrors national trends that support the development of integrated services and the reduced reliance on state institutions. There has been a reduction in the national population of large state facilities of almost 70 percent in the last 25 years. Most states, including California, have reduced the population of their state facilities by over half since 1990. Since 1960, 185 large state facilities have closed across the nation.

As the overall population at the DCs declines, the remaining population is shifting to two primary groups—individuals who have resided in the developmental centers for many years who are aging and requiring increasingly complex medical care; and young adult males with predominantly mild or moderate intellectual disabilities who are admitted through the judicial system. Individuals in the latter group reflect the majority of admissions to DCs today and require an enhanced level of staffing to provide all needed services and ensure a safe environment for all. Consumers in this group include adolescents and adults with severely challenging behavior and/or criminal charges requiring treatment services in controlled settings. This group also frequently has a secondary mental health diagnosis. In fact, between 1996 and present, the percentage of the DC population with a psychiatric diagnosis has more than doubled (from 23 percent to 49 percent). A related increase during the same time is the percentage of the DC population taking psychotropic medications—from 31 percent in 1996 to 43 percent today. Between 1996 and present, the percentage of the DC population functioning in the mild or moderate range of mental retardation has also nearly doubled—from 13 percent to 25 percent. (The percentage of people functioning in the severe or profound range of mental retardation has decreased from 86 percent in 1996, to 74 percent today.)

More than one third of the DC population is over the age of 52, and the aging population is further reflected in the increased percentage of the population older than 41: from approximately 47 percent in 1996 to approximately 66 percent today. In recent years, several individuals at Sonoma Developmental Center have lived past the age of 100. With an older population, there is an emergence of age-related and lifestyle conditions that are similar to those found in the general population, including diabetes, cancer, cardiac problems, strokes, dementia, arthritis and osteoporosis. The service focus is shifting accordingly. Staff training is focusing on issues of aging and end of life care; providing more nursing, mobility engineering and adaptive equipment; moving from active training programs to leisure activities; converting residences from intermediate care units to skilled nursing; and providing specialized programs such as hospice.

The number and type of personnel required to serve this challenging population is driven by state licensing staffing requirements and also the need to maintain federal certification to qualify for federal financial participation.

HEADQUARTERS BUDGET PROPOSAL

The budget proposes $40 million from all funds ($26 million General Fund) for support of headquarters. About 62 percent of headquarters funding is for support of the community services program, with the remainder for support of the DC program.

CURRENT CENSUS

Summary of Developmental Center Budget Year Population (Average)

Facility	Revised Current Year 2006-07	Budget Year 2007-08	Difference
Agnews DC	202	82	-120
Canyon Springs (community-based)	61	53	-8
Fairview DC	603	563	-40
Lanterman DC	503	488	-15
Porterville DC	700	673	-27
Sierra Vista (community-based)	46	49	3
Sonoma DC	719	681	-38
Total	**2,834**	**2,589**	**-245**

Information on the cost per consumer in the DCs is included on a chart that is attached to this agenda.

PANELISTS

- Department of Developmental Services
- Department of Finance
- Legislative Analyst's Office

ISSUE 4: AGNEWS CLOSURE AND MOVE TO COMMUNITY

OVERVIEW

The Governor's budget reflects various adjustments related to the administration's closure of the Agnews Developmental Center by June 30, 2008. These adjustments are reflected in both the Regional Center item and Developmental Center item of the Budget Bill due to the transitioning of consumers from Agnews to other living arrangements. Overall, the budget proposes a net increase to the developmental services system of $40.3 million ($32.3 million General Fund) due to the anticipated transition of 145 consumers from the Agnews Developmental Center into the community. This net figure includes increases for the Regional Center budget and decreases for the Developmental Centers budget.

Specifically, the Regional Center budget is projected to increase by $50.7 million ($37.9 million General Fund) for the costs of providing services to consumers in the community. The budget for the DCs is projected to decrease by $10.4 million ($5.6 million General Fund); reflecting reduced staffing costs associated with the reduction in the number of Agnews residents. The proposed adjustments are consistent with the administration's updated plan provided to the Legislature on January 10, 2007, as required by statute. The administration will be updating the Agnews plan at the time of the Governor's May Revision. However, the principal components of the Agnews plan are expected to remain the same.

The plan to close Agnews Developmental Center was developed over a three-year period and formally submitted to the Legislature in January 2005. Enabling legislation to support the implementation of critical elements of the plan has been enacted, including Assembly Bill 2100 (Steinberg), Statutes of 2004, Senate Bill 962 (Chesbro), Statutes of 2005, Senate Bill 643 (Chesbro), Statutes of 2005, and Assembly Bill 1378 (Lieber), Statutes of 2005. The Agnews Developmental Center Plan closure is different than the two most recent closures of Developmental Centers—Stockton DC in 1996 and Camarillo DC in 1997—both of which resulted in the transfer of large numbers of individuals to other state-operated facilities. In contrast, the Agnews Plan relies on the development of an improved and expanded community service delivery system in the Bay Area that will enable Agnew's residents to transition and remain in their home communities.

Among other things, the DDS proposes to achieve this improved and expanded community service delivery system by:

- Establishing a permanent stock of housing dedicated to serving individuals with developmental disabilities;
- Establishing new residential service models for the care of developmentally disabled adults;

- Utilizing Agnew's state employees on a transitional basis in community settings to augment and enhance services including health care, clinical services and quality assurance; and
- Implementing a Quality Management System (QMS) that focuses on assuring that quality services and supports are available in the community, including access to health care services.

Administration's Fiscal Summary—Agnews Developmental Center

Component	Revised CY 2006-07	Budget Year 2007-08	Difference
1. Agnews DC Base Budget			
Total Dollars	**$83.3 million**	**$73.8 million**	**-$9.3 million**
General Fund	($44.2 million)	($39.3 million)	($4.9 million)
Staff Positions	1,057 staff	975 staff	-82 staff
Beginning Year Residents	280 people	161 people	-119 people
2. Placements into the Community			
Total Dollars	**-$5.7 million**	**-$14.9 million**	**-$9.3 million**
General Fund	(-$3 million)	(-$8 million)	(-$5 million)
Placements	-113 people	-145 people	-32 people
3. Consumer Transfers to Other DCs			
Total Dollars	**$0**	**$-430,000**	**$-430,000**
Transfers		-10 people	-10 people
4. State Employees in the Community			
Total Dollars	**$5.4 million**	**$9.2 million**	**$3.8 million**
Clinical Staff	$1.2 million	$2.1 million	$895,000
Direct Support Services Staff	$3.5 million	$5.3 million	$1.8 million
Support Staff	$0	$449,000	$449,000
Operating Expenses	$616,000	$1.3 million	$694,000
5. Staff Costs for Closure Plan			
Total Dollars	**$716,000**	**$4.9 million**	**$4.2 million**
Staff Transition Costs	$378,000	$628,000	$250,000
Overtime- Consumer Escort	$338,000	$0	$-338,000
Costs for Lump-Sum Buyout	$0	$4.3 million	$4.3 million
6. Facility Preparation	$0	$73,000	$73,000
7. Consumer Relocation Costs	$0	$105,000	$105,000
8. Agnews Staffing Plan	$366,000 (5 positions)	$731,000 (10 positions)	$365,000 (5 positions)
Total Developmental Center Costs			
Total Dollars	**$83.8 million**	**$73.4 million**	**-$10.4 million**
General Fund	($41.8 million)	($36.3 million)	(-$5.6 million)
Staff Positions	980 staff	812.5 staff	-167.5 staff
Year Ending Resident Population	161 people	0	-161 people

It should be noted that the Governor's May Revision will likely make technical adjustments to the above components as more up-to-date information is obtained. The key adjustments as noted in the table above are discussed below:

- Agnews Budget Base. This includes the costs related to the base operations of Agnews DC including personal services, operating expenses and equipment costs.

- Placements into the Community. This includes the savings resulting from the relocation of Agnews residents into the community.

- Consumer Transfers to Other DCs. This includes the savings resulting from the transfer of 10 Agnews residents to other Developmental Centers.

- Staff Costs for Closure Plan. This includes costs for staff transition, staff training, staffing escorts for transportation of consumers, and related aspects.

- Facility Preparation. This includes the costs associated with preparing Sonoma to receive Agnew's residents.

- Consumer Relocation Costs. This includes costs associated with relocation of consumers, such as moving vans, transportation vehicles, and associated expenditures.

- Agnews Staffing Plan. This includes costs for non-level-of-care staff in various program areas to ensure adequate staff is maintained during the closure process, as well as maintaining the health and safety of residents.

BAY AREA HOUSING PLAN

A cornerstone of the Agnews closure plan is the development of sufficient community capacity to support the transition of Agnew's consumers into the communities that are close to their families. New service and support options are being created that provide choices for each person and reflect the needs of the individual. The acquisition and development of housing is a critical element. Over 75 percent of the current Agnew's residents will move into Bay Area Housing Plan (BAHP) homes. According to the DDS' most recent housing development plan, a total of 195 consumers are anticipated to reside in BAHP homes as noted in the table below. As of April 1st, 30 homes have been purchased and 8 are in escrow. All 62 homes will be purchased by July 2007.

There are several critical steps to the BAHP roll-out, including the acquisition of properties, closure of escrow, working with local zoning and building requirements which can vary across the various jurisdictions (i.e., 13 different cities and towns, plus county requirements), obtaining providers to operate the homes and provide services, obtaining licensing approval, and working closely with consumers and their families.

Summary of Bay Area Housing Plan (For all three Regional Centers)

Type of Home	Number of Homes	Number of Residents
"SB 962" Homes	23	94
Specialized Residential Home	27	71
Family Teaching Home	9	19
Residential Care Facility--Elderly	3	11
Total	**62**	**195**

The enactment of Assembly Bill 2100 (Steinberg), Statutes of 2004 and Senate Bill (Chesbro), Statutes of 2005, authorized the DDS to approve proposals from the Bay Area Regional Centers (i.e., San Andreas RC, RC of the East Bay, and Golden Gate RC) to provide for, secure, and assure the payment of leases for housing for people with developmental disabilities. Specifically, by Regional Center, the following can be noted from the DDS' most recent plan:

- Golden Gate Regional Center. It is anticipated that a total of 41 consumers will reside in BAHP homes. With (1) 12 consumers living in "SB 962" Homes; (2) 26 consumers living in Specialized Residential Homes; and (3) three consumers living in Residential Care Facility for the Elderly facilities.

- San Andreas Regional Center. It is anticipated that a total of 105 consumers will reside in BAHP homes. With (1) 56 consumers to be living in "SB 962" Homes; (2) 26 consumers living in Specialized Residential Homes; (3) 19 consumers to be living in Family Teaching Homes; and (4) four consumers in Residential Care Facility for the Elderly.

- Regional Center of the East Bay. It is anticipated that a total of 49 consumers will reside in BAHP homes. With (1) 26 consumers living in "SB 962" Homes; (2) 19 consumers living in Specialized Residential Homes, and (3) four consumers living in Residential Care Facility for the Elderly.

The Budget Act of 2004 provided $11.1 million (General Fund) for the pre-development costs associated with acquisition and development of housing to implement the BAHP. These funds can be expended through June 30, 2010 in order to liquidate any encumbrances associated with the BAHP. In September 2005, the Department of Finance submitted the BAHP and the expenditure plan to the Joint Legislative Budget Committee (JLBC) for review. This plan was approved. A key component of this plan is a partnership between the DDS, the housing developer—Hallmark Community Services, the three Bay Area Regional Centers, and the Bay Area non-profit housing development corporations. Through this partnership, they have secured the necessary agreements for bond financing with the California Housing Finance Agency (CalHFA) and construction financing with the Bank of America. These funds are used to acquire properties and either renovate or construct "SB 962" Homes, Family Teaching Homes, and Specialized Residential Homes.

COMMUNITY RESIDENTIAL SERVICES

To address the needs of Agnew's residents, various new models for community-based residential services have been structured. These are briefly described below.

- "SB 962" Homes. Senate Bill 962 (Chesbro), Statutes of 2005, directed DDS to establish a new pilot residential project designed for individuals with special health care needs and intensive support needs. Examples of health services that can be provided in this type of home include, but are not limited to, nutritional support; gastrostomy feeding and hydration; renal dialysis; and special medication regimes including injections, intravenous medications, management of insulin, catheterization, and pain management. Nursing staff will be on duty 24-hours per day. In addition, an Individual Health Care Plan will be developed and updated at least every six months, and at least monthly face-to-face visits with the consumer by a Regional Center nurse will be done. This pilot is a joint venture with the Department of Social Services (DSS) and will serve up to 120 adults, with no more than five adults residing in each facility. This pilot is to be limited to individuals currently residing at Agnews. An independent evaluation of the pilot will be submitted to the Legislature by January 1, 2009.

- Specialized Residential Homes. These homes are designed for individuals with behavioral challenges or other specialized needs, and will serve from three to four consumers per home. These homes provide 24-hour on-site staff with specialized expertise to meet the unique needs of the individuals. These homes have the capability for on-site crisis response. It should be noted that when a majority of the consumers living in this model of home turns age 60, the home will need to be re-licensed as a Residential Care Facility for the Elderly (RCFE) (as required by state statute). Therefore, all BAHP Specialized Residential Homes will be constructed to address the physical plan requirements for an RCFE licensure.

- Family Teaching Homes. Among other things, Assembly Bill 2100 (Steinberg), Statutes of 2004, added a new "Family Teaching Home" model to the list of residential living options. This new model is designed to support up to three adults with developmental disabilities by having a "teaching family" living next door (usually using a duplex). The teaching family manages the individual's home and provides direct support when needed. Wrap-around services, such as work and day program supports, are also part of this model.

MOVEMENT FROM AGNEWS

According to the DDS, as of mid-February, 115 consumers have transitioned from Agnews Developmental Center to the community. One consumer who had moved was returned to Agnews. None of the 115 individuals who have moved have been admitted to another Developmental Center. As of late March, 244 consumers are residing at Agnews.

Pre-Placement Activities. The DDS Coordinator of Consumer Services is meeting with each resident of Agnews to discuss their individualized choices for living options. The DDS states that this coordinator and support staff typically meet with 24 residents per month. Appointments are scheduled with residents one month prior to their Individualized Program Plan (IPP) meeting. The estimated completion date for this project is September 2007. The DDS states that placement decisions for each consumer are made by an interdisciplinary planning team and reflect the needs of the individual. If a resident is recommended for transition to the community, community-based services are identified and a comprehensive transition process is coordinated by state staff, including the following:

- Day visits to community service providers including the proposed residence, supervised by staff who know the consumer well;

- Overnight visits or weekend visits to the residential placement if the transition is proceeding successfully; and

- A minimum of 15 days prior to community movement, the planning team meets to ensure that all services, including medical services, are ready to help ensure a smooth and safe transition.

If problems arise or it appears that community providers are not able to meet the consumer's needs, the process is delayed or stopped until identified problems can be resolved.

"Post-Placement" Monitoring. Upon an individual's move to a community living arrangement, state staff and Regional Center staff are to closely monitor the placement to ensure a smooth transition. Key monitoring activities include the following:

- State staff provide follow-up with the consumer at five days, 30 days, six months, and 12 months after the move;

- Regional Center staff conducts face-to-face visit every 30 days for the first 90 days after the move and as determined by the Individual Program Plan thereafter;

- State staff, in coordination with RC staff, provide additional visits, supports and onsite training to the consumer and service provider as needed to address the individual's service needs;

- For the first year following transition from a Developmental Center, consumers receive enhanced Regional Center case management. For Agnews Developmental Center residents, the enhanced case management is for two years;

- A Quality Assurance Council, consisting of family members, consumers, and providers has been convened to review and monitor the quality of services provided to consumers who have moved from Agnews;

- Medically fragile consumers transitioning from Agnews to homes licensed by the Department of Social Services for consumers with special health care needs will be visited by a nurse at least monthly, or more frequently as appropriate. In addition, these consumers will be seen by a physician at least every 60-days or more frequently if specified in the consumer's healthcare plan;

- For every individual who has moved from a Developmental Center since April 1995, an independent contractor evaluates the consumer's quality of care, programs, health and safety, and satisfaction; and

- The Organization of Area Boards conducts a Life Quality Assessment once every three years for every consumer living in an out-of-home community setting. These assessments assist in ensuring that people are receiving the services they need.

HEALTH CARE FOR THOSE TRANSITIONED FROM AGNEWS

The broad provision of health care services, including health, behavioral health and dental, to individuals transitioning from Agnews is of critical concern and is the utmost of importance. As noted in the Administration's Agnews Plan for Closure (latest report of January 2007), 54 percent of the Agnews residents have significant health and extensive personal care needs, and 25 percent are persons with significant behavioral needs. Though the Specialized Residential Homes and the "SB 962" Homes, as well as certain other existing models of care such as Intermediate Care Facilities-DD, provide certain specialized health care needs in residence, additional health care services need to be accessed and provided in the community.

The DDS states that they have both short-term and longer-term strategies they are working on with respect to providing health care, including primary care, specialized care, specialized therapies, behavioral health, dental care and vision care.

The three key aspects to their effort to address these needs are as follows:

- Assuring that the comprehensive health needs of each Agnews resident are assessed and a comprehensive individualized health plan is developed prior to any transition;

- Providing medical services to support the transition of Agnews residents to community settings; and

- Developing and implementing a service strategy that assures access to a comprehensive array of health services after the closure of Agnews and ongoing.

DDS states that each resident of Agnews will have a comprehensive individualized heath plan. This "Health Transition Plan" specifically states how each health need will be met following transition, as well as the provider of each service. In addition, the section below outlines the present efforts being undertaken by the DDS, the three Bay Area Regional Centers and community providers. These various efforts are considerable and are continuing as community resources are identified.

However, the administration has not yet developed a longer-term health care strategy. Specifically, the DDS and DHS are working with local health care providers who provide Medi-Cal Managed Care services, including the (1) Alameda Alliance for Health, (2) Santa Clara Family Health Plan, and (3) Health Plan of San Mateo, to provide a permanent "health care home" for transitioning Agnew's residents. The administration does state that both the Health Plan of San Mateo and Santa Clara Family Health Plan have "special needs plans" (for people who are Medicaid and Medicare eligible) and Alameda is working towards obtaining this designation. But the detailed specifics of how the administration intends to proceed in working out all of the arrangements with

affected consumers and their families, as well as the arrangements with the above referenced health plans are still in flux.

The administration states that they are proceeding with the following steps to solidify a longer-term health care strategy:

- Identify Medical Service Needs of Individuals Transitioning from Agnews (By April 20, 2007). The DDS and Regional Center of the East Bay are developing a matrix that identifies consumer service needs and clarifies the entity/organization that is responsible for each service. The directors of the three health plans will then meet with Agnews physicians to clarify service needs and to assess their interest in continuing to provide services after the Agnews Developmental Center closure

- Refine Health Care Strategy (By April 30, 2007). The DDS, DHS, three Regional Centers, and three health plans will meet to review service needs, funding and implementation strategies to assess next steps and to identify any remaining barriers.

- Develop Funding Strategy for Health Plans. First, the DDS and DHS will meet by April 30, 2007 to review available cost and utilization data for purposes of establishing an "interim rate" to be paid to the health plans for health care services provided to the consumers. Second, the DHS will then need to determine whether the payment strategy for the health plans will require an amendment to their existing contracts (they all contract under the Medi-Cal Managed Care Program), or whether a new contract is necessary. The DHS states that it is likely they will provide an interim rate and then calculate a final settlement to pay the health plans actual costs. The final methodology will need to be agreed to by the health plans as well.

- Additional Engagement of Consumers and Advocates in Process (By May 15, 2007). The three Regional Centers will facilitate health plan meetings with consumers, families and advocates in their area. These meetings will be designed to be "listening sessions" to better understand concerns and needs and to provide an orientation for receiving services through one of the health plans.

- Review Implementation Strategies in Other Areas (By April 6 and May 30, 2007). DDS is to provide information regarding similar projects in other areas, most notably Minnesota and Massachusetts, to the health plans (by April 6, 2007). The DDS, DHS, health plans and three Regional Centers will then meet with two County Organized Healthcare Systems—CalOPTIMA of Orange County, and Health Plan of San Mateo—to identify implementation issues and strategies (by May 30, 2007).

It should be noted that both CalOPTIMA and the Health Plan of San Mateo currently serve individuals who have significant health care issues, including individuals who are aged, blind, and disabled.

As part of their Individual Program Plan (IPP) process prior to transitioning from Agnews, each Agnews' resident will receive a comprehensive nursing and risk assessment which is comprised of over 60 health-related items. This assessment is then used to develop a Health Transition Plan that is incorporated into the IPP. The Health Transition Plan specifically states how each health need will be met following transition from Agnews, as well as the provider of each service.

AGNEWS OUTPATIENT CLINIC

In March 2006, the DDS expanded the Agnew's license to provide outpatient medical services to individuals with developmental disabilities who reside in the community (both individuals who have transitioned from Agnews, as well as other individuals with developmental disabilities living in the surrounding area). Medical staff from Agnews is used to provide the services. Based on recent data, this outpatient clinic at Agnews has provided over 230 services to a total of 185 consumers. The most frequently uses services are dental (accessed 128 times), primary medical care, psychiatry and neurology.

According to the DDS, this outpatient clinic will likely end its operation on June 30, 2008, consistent with the identified Agnews Developmental Center closure date. They note that several factors ultimately determine the longevity of the Outpatient Clinic past the June 30, 2008 closure date, including the following:

- The outpatient clinic will only be licensed and operational as long as Agnews is able to maintain its General Acute Care Hospital license (or make other agreed to arrangements with the Department of Health Services Licensing and Certification Division);

- The staffing capacity at Agnews must be able to support the continued operation of the outpatient clinic; and

- The timing for when the DDS is able to transition outpatient clinic services to the community by partnering with an existing community provider.

BEHAVIORAL HEALTH SERVICES

As part of the transition planning, the behavioral health needs of each Agnew's resident are assessed and intervention strategies are identified as appropriate. Behavioral health services will be provided through various means including the following:

- "Community Intervention Response Team (CIRT)". San Andreas Regional Center and Agnews have developed a response team to provide consultation, training, and support to service providers in need of services to transition Agnews' consumers. Agnews has dedicated four state staff who receives support from other professional staff (such as psychologists, psychiatrists, pharmacists, and nurses) as needed for this purpose. When a request for service is received, the CIRT assesses the need and deploys staff and resources as appropriate. The staff completes an assessment of the individual's needs, reviews intervention strategies, and works with the community planning team in the development and implementation of training and treatment plans. The CIRT is being replicated at Golden Gate RC and the RC of the East Bay.

- Community Mental Health Services ("generic" service). Contingent upon an individual's needs certain behavioral health services can be accessed through County Mental Health Plans. The three Regional Centers are working with their local County Mental Health Plans (San Francisco, Santa Clara, Alameda and other counties as appropriate) to coordinate mental health services as appropriate. Memorandums of Understanding (MOUs) exist between these entities with respect to protocols and other matters.

- Pending Acute Psychiatric Facility. The three Regional Centers have contracted with Telecare Incorporated to develop an acute psychiatric facility that will be available for persons who are experiencing a behavioral crisis and require short-term treatment and stabilization services. The facility will have a capacity to serve 15 persons.

ORAL HEALTH CARE AND DENTISTRY SERVICES

The provision of oral health care is of critical concern since many dental services for this medically fragile population require sedation. As noted from the Agnews Outpatient Clinic data, dental services are in high demand and are difficult to obtain from traditional dental care providers. The DDS and Bay Area Regional Centers have proceeded with the following actions to address these needs:

- Oral Health Assessment of Individuals. An oral health screening examination will be conducted of each Agnew's resident by the Regional Center Dental Coordinator. These assessments are to be used for transition planning and for referrals to community resources. The DDS also states that each individual will be up-to-date with their dental care services prior to leaving Agnews and that dental services will remain available during the transition period through the Agnews outpatient clinic (while available).

- "Community Mapping of Available Services". Each Regional Center has collected information about oral health providers within their geographical area. This mapping project has identified community clinics, dental offices and hospitals that might be sources of treatment for individuals with developmental disabilities. Follow-up is being done with these providers.

- Survey of Dentists and Dental Hygienists. The RCs contracted with the University Of the Pacific (UOP) School of Dentistry who has completed a survey of all the dentists and dental hygienists in the Bay Area (600 responded). These professionals will be targeted for further follow-up as sources of care.

- Continuing Education for Professionals Who Treat Individuals with DD. UOP is collaborating with the three Regional Centers to provide low-cost continuing education courses for oral health professionals (Spring 2007 first training scheduled). It is anticipated that the attendees will be better prepared to treat individuals with developmental disabilities. Training resources are also being provided by UOP for direct care community staff (who are non-dental professionals) so they can learn to support good dental hygiene that will promote dental and physical wellness.

- Establishing Partnerships for Sedation Dentistry Services. Sedation is often needed when providing dental care and services to individuals with developmental disabilities. San Andreas RC has established a partnership with Sutter Health and Dominican Hospital for these purposes. East Bay RC and Golden Gate RC are working with UOP to identify similar partnerships in their geographical areas.

CAL OPTIMA AND REGIONAL CENTER OF ORGANGE COUNTY

After many years of development, Cal OPTIMA (the County Organized Healthcare System of Orange County) is recognized as having a very viable network of health care services for individuals with significant health care needs, including individuals with developmental disabilities. Cal OPTIMA coordinates the provision of health care services to most Medi-Cal enrollees using managed care principles. Enrollees of Cal OPTIMA are provided services through one of the subcontracting health plans or through Cal OPTIMA "Direct". Through the "Direct" program, enrollees with special health care needs—such as those with dual eligibility (Medi-Cal and Medicare eligible)—receive health care services through a fee-for-service system of providers.

Cal OPTIMA is noted for having strong partnerships with their health plan members, the Regional Center of Orange County, as well as with local non-profit groups and advocacy organizations that provide assistance to diverse individuals, including people with developmental disabilities.

SENATE ACTION

The following actions were taken on April 9, 2007 in the Senate Budget Subcommittee No. 3 on Health and Human Services regarding this item and consumers transitioned from Agnews as a result of the impending closure:

1. Increase the Regional Centers Operations budget by $503,000 ($126,000 General Fund) and 4 positions for the three Bay Area Regional Centers for the health care community specialists;

2. Adopt the following trailer bill language regarding health care protocols; and

3. Required the DHS and DDS to report back at the May 7th Sub. 3 hearing to further discuss the longer-term health care strategies for consumers, including the outpatient clinic.

Proposed Trailer Bill Language

Add Section 4474.4 to the Welfare and Institutions Code as follows:

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

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

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

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

PANELISTS

- Department of Health Services
- Department of Developmental Services
- Department of Finance
- Legislative Analyst's Office
- Protection and Advocacy, Inc.
- Keep Our Families Together
- Santi Rogers, San Andreas Regional Center
- Jim Burton, East Bay Regional Center
- Jim Shorter, Golden Gate Regional Center

ISSUE 5: ICFs/DD-CN

BACKGROUND

The population of the DCs has declined steadily over the last 20 years. The continuing decline in the population of the DC system is partly the result of the 1994 Coffelt v. Developmental Services lawsuit settlement, which required the state to make more community-based residential services available as alternatives to institutions. The DCs initially downsized in population by about 2,000 in response to the Coffelt settlement. The administration is currently implementing its plan to close Agnews DC, by July 2008.

The downsizing of the DCs is also partly a response to federal policies that promote community-based alternatives and a recent federal court decision. Prompted in part by the June 1999 U.S. Supreme Court decision L.C. & E.W. vs. Olmstead ("Olmstead"), California, and a number of other states are seeking alternatives to institutional care. In the Olmstead case, the U.S. Supreme Court ruled that keeping persons who could transition to a community setting constituted discrimination under the Americans with Disabilities Act, notwithstanding state resources and consumer preference.

Many of the developmentally disabled individuals that reside in Agnews and other DCs are medically fragile and may require regular skilled nursing assessments and interventions due to unstable medical conditions. In response to the needs of these individuals, and a policy of providing services to the developmentally disabled in the least restrictive setting whenever possible, the Legislature in recent years has approved two pilot programs that are describe below.

ICFS/DD-N PILOT PROGRAM

Chapter 845, Statutes of 1999 (AB 359, Aroner), allows for implementation of ICFs/DD-CN under a pilot program. The ICFs/DD-CN provide skilled nursing supervision to clients who have continuous need for skilled nursing care. Residents of ICF/DD-CN require frequent observation and intervention for unstable medical conditions.

The ICF/DD-CN pilot program operates under a waiver approved by the federal CMS that was originally approved in 2001. Six facilities, each with six beds, are currently operating under the waiver and serve, on average, about 35 individuals. The waiver is due to expire on September 30, 2007. The DHCS expects the CMS to grant a waiver extension from October 1, 2007 through September 30, 2009.

The ICF/DDs are often located in the community, sometimes in single-family houses, and provide residential services for the developmentally disabled including 24-hour personal care. In the analysis of the 2004-05 Budget Bill (page C-185), we described how the state could draw down additional federal funds to offset the state costs of day programs and transportation services provided to RC clients residing in ICFs/DD by modifying the ICF/DD rate and implementing other related changes.

Specifically, in order to capture these additional federal funds, the state would have to redefine the ICF/DD program as an "all-inclusive service." Currently the ICFs/DD are paid a rate based only on the specific nursing care services they provide. Additional services that a client may receive such as transportation or a day program are generally paid for separately by the RC or provided through a generic service provider. Under this option, ICFs/DD would be redefined to be an all-inclusive service and the responsibility for providing day programs, transportation, and other assistance (in cases where generic services were unavailable) would shift from the RC to the ICFs/DD. In turn, these services would be reflected in the rates paid to ICFs/DD.

Budget Plan Assumes Savings in 2007-08. The state plan is an agreement between the federal Center for Medicare and Medicaid Services (CMS) and the state regarding the operation of the state's Medi-Cal Program. The Department of Health Care Services (DHCS) is pursuing a revision to the Medi-Cal state plan to include coverage and payment for day program and nonmedical transportation services for RC clients residing in ICFs/DD. The budget plan assumes (1) approval of the state plan amendment and an increase of $44 million in federal funds in 2007-08 and (2) a commensurate reduction in state General Fund support for day program and nonmedical transportation services. The budget plan does not assume any savings in 2006-07.

CURRENT YEAR OPPORTUNITY

In some cases, once a state plan amendment is approved by the federal CMS, states may submit claims and draw down federal funds retroactively to the date of submission. For example, if the DHCS submitted the proposed state plan amendment to the federal CMS in April of 2007, and it was approved in July of 2007, the state may be able to submit claims for federal reimbursement going back to the date when the state plan amendment was originally submitted.

Based on discussions with DHCS, the department has been working on developing a state plan amendment for about two years. Given the time DHCS has spent on developing this state plan amendment, we believe that it is reasonable to assume that the department will be able to submit it to the federal CMS by April.

LAO Recommendation: We recommend the Legislature assume that the state plan amendment will be submitted by DHCS to the federal CMS in April of 2007 and that it will be approved. We estimate that this would result in an additional $11 million in federal reimbursements for 2006-07. We recommend that the Legislature recognize a commensurate amount of state General Fund savings in the current year for RC purchase of services.

SB 962 HOMES

Adult Residential Facility for Persons With Special Health-Care Needs (ARFPSHN). Chapter 558, Statutes of 2005 (SB 962, Chesbro), allows for implementation of a new type of licensed residential care facility under a pilot program. Although ARFPSHNs would provide continuous skilled nursing services similar to those provided by ICFs/DD-CN, they would provide fewer hours of continuous skilled nursing services than ICFs/DD-CN. The pilot program would allow for up to five residents to be placed in each facility, with a program total of a 120 beds. Unlike ICFs/DD-CN, which are privately owned and operated facilities, ARFPSHNs would be owned by a nonprofit entity. The state would contract out the provision of care for residents of these facilities. At the time this analysis was prepared, no ARFPSHN had begun operations although a few ARFPSHNs are expected to begin operations by July 2007. The pilot program is due to sunset January 1, 2010, unless extended in statute.

REPORTING REQUIREMENTS

Chapter 558 requires DDS to contract with an independent agency or organization to evaluate the ARFPSHN pilot program and prepare a written report to the Legislature by January 1, 2009. There is currently no requirement for a report to the Legislature evaluating the ICF/DD-CN pilot program. However, it is noted that DHCS has requested $250,000 total funds ($125,000 General Fund) to contract with an independent agency or organization for a final assessment of the cost-effectiveness and feasibility of making the ICF/DD-CN model a permanent new provider type.

GOVERNOR'S PROPOSAL

The 2007-08 Governor’s Budget proposes three positions, on a two-year limited term basis, for DHCS state operations to ensure compliance with waiver requirements and develop the State Plan Amendment to add the ICF/DD-CN as a state benefit.

LAO COMMENT AND RECOMMENDATION

We take no issue with the Governor's request for positions or for the funding request for a final assessment of the ICF/DD-CN pilot program. We note that state law requires that a report be provided to the Legislature regarding the effectiveness of the ARFPSHN pilot program. However, no such reporting requirement exists for the ICF/DD-CN pilot program although DHCS is requesting funds for a consultant to evaluate the program. Without a report evaluating the effectiveness of the ICF/DD-CN pilot program the Legislature will likely have insufficient information to determine whether this model for residential services should be discontinued, maintained, or expanded.

In order to better evaluate how residential models can best serve the needs of medically fragile DDS clients; the Legislature needs to be fully informed about the cost-effectiveness of the two pilot programs currently underway. Given that DHCS will contract for an evaluation of the ICF/DD-CN, we recommend the evaluation be provided to the Legislature and that the evaluation assess the same issues addressed by the ARFPSHN evaluation.

We recommend the Legislature adopt supplemental report language directing the Department of Health Care Services to submit a report based on a comprehensive evaluation of the Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing pilot program. This will help ensure the Legislature has sufficient information upon which to base decisions about the future of this pilot program.

The following Supplemental Report Language is consistent with this recommendation:
It is the intent of the Legislature that the Department of Health Care Services (DHCS) shall submit a report to the Legislature evaluating the Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing (ICF/DD-CN) pilot program. This evaluation and subsequent report in writing shall at minimum address the following: (1) the number, business status, and location of all the treatment facilities; (2) the number and characteristics of the residents served; (3) the effectiveness of the pilot program in addressing residents' health care and intensive support needs; (4) the extent of residents' community integration and satisfaction; (5) the consumers' access to, and quality of, community-based health care and dental services; (6) the types, amounts, qualifications, and sufficiency of staffing; (7) the costs of all direct, indirect, and ancillary services; and (8) recommendations for improving the ICF/DD-CN model. The DHCS shall report its findings on this matter by January 1, 2009 to the Chair of the Joint Legislative Budget committee and the chairs of the fiscal committees of both houses of the Legislature.

PANELISTS

- Department of Health Services
- Department of Developmental Services
- Department of Finance
- Legislative Analyst's Office
- Bob Baldo, Association of Regional Center Agencies

ISSUE 6: TECHNICAL CORRECTION TO THE GOVERNOR'S BUDGET – FUND SHIFT (SPRING LETTER)

BACKGROUND

The Subcommittee is in receipt of a Finance Letter requesting a fund shift to correct a technical error within the Developmental Centers budget (Item 4300-003-0001). Specifically, the General Fund amount needs to be decreased by $5 million and the Reimbursements need to be increased by $5 million. These Reimbursements are received from the Department of Health Services through the Medi-Cal Program, and as such, reflect the availability of some federal funds.

This technical adjustment is necessary because the funding spilt for salary increases within the Developmental Centers item was incorrectly calculated in the Governor's budget released on January 10, 2007.

ISSUE 7: SALARY ENHANCEMENTS FOR MENTAL HEALTH PROFESSIONALS IN DCS (SPRING FINANCE LETTER)

BACKGROUND

The Subcommittee is in receipt of a Finance Letter requesting an increase of $6.9 million ($4 million General Fund) to increase the salaries for certain mental health classifications in facilities operated by the DDS, including the five DCs, Sierra Vista Community Facility and Canyon Springs Community Facility. The Finance Letter provides funding for the budget year. These increases are necessary to retain and hire key professional staff to provide mental health care, treatment and supervision.

The administration states that these salary increases will be effective as of April 1, 2006. Any current year expenditures will be funded within existing resources which are available due to vacancies (i.e., no additional appropriation for the current year is necessary).

The DDS states that the proposed salary increases will bring salaries and wages for incumbents in these classifications to: (1) five percent less than CA Department of Corrections and Rehabilitation (CDCR) for Psychiatrists and Senior Psychologists, and (2) 18 percent less than salaries paid to CDCR for all other mental health-related classifications including: Unit Supervisors, Psychiatric Technicians, Rehabilitation Therapists, and Clinical Social Workers.

EFFECT OF CDCR SALARY INCREASES

In January 2007, the CDCR increased salaries for mental health classifications as a result of the Coleman v. Governor Schwarzenegger federal court order. In less than three months, the DDS lost a total of 98 employees in Coleman-related classifications. The Coleman-related classifications include Psychiatrists, Medical Directors, Unit Supervisors, Psychologists, Social Workers, Rehabilitation Therapists and Psychiatric Technicians. These are key classifications that are required for treatment and direct provision of mental health services, or the supervision of direct services to consumers for licensing and certification and for the overall health and safety of consumers.