EXECUTIVE DIRECTOR REPORT

June 3, 2017

I. A. FY 2017-2018 BUDGET UPDATE

- **Attachment #1:** Department of Developmental Services FY 2017-2018 Governor's May Revision Budget Highlights
- **Attachment #2:** ARCA Analysis of FY 2017-2018 Governor's May Revision Budget
- **Attachment #3:** Annual Budget Process Flow Chart

Governor Brown released his May Revise Budget Proposal on May 11, 2017. The Governor's May Revision Budget is an update to his initial budget proposal released on January 10, 2017 for the fiscal year that begins on July 1, 2017 and ends on June 30, 2018. The Governor's May Revision bodes well for the Developmental Services System by providing $335.5 million in additional funding in FY 2017-2018 compared to FY 2016-2017 for caseload growth in the regional center system. The total number of individuals with developmental disabilities in the community served by regional centers is expected to increase from 303,599 in the current year to 317,837 in FY 2017-2018. The total budget for the Department of Developmental Services (DDS) in FY 2017-2018 is estimated to be $6.9 billion total funds ($4.2 billion General Fund).

Additionally, in compliance with Welfare and Institutions Code Section 4474.15(a), DDS has prepared its "Plan for Crisis and Other Safety Net Services in the California Developmental Services System" (Safety Net Plan). The plan provides background

information on the Developmental Services System, details stakeholder input and guidance received on the need for a safety net of services, and proposes new service options to broaden the continuum of service options to support individuals with the most challenging service needs. In alignment with the Safety Net Plan, the May Revision proposes $7.5 million General Fund in FY 2017-2018 to establish the following:

- Two state-operated, 24/7 mobile acute crisis teams
- Two acute crisis homes to relocate and expand Stabilization, Training, Assistance and Reintegration services in Northern California
- Intensive wrap around services for individuals transitioning out of secure treatment

These funds are in addition to $13.7 million in existing funds DDS proposes to allocate to accomplish the following:

- Develop intensive wrap around services for persons with co-occurring developmental disabilities and mental health needs
- Renovate two existing homes at Fairview Developmental Center near Harbor Village to relocate and expand Southern STAR services
- Develop four vendor operated homes to provide step down services for individuals with co-occurring developmental disabilities and mental health needs
- Develop two vendor operated homes to provide step down services for individuals transitioning from the Porterville Secure Treatment Program.

The Governor's May Revise Budget also includes a proposal based on a mandate from the Centers for Medicaid and MediCare Services (CMS) to transition children (under age 21) who currently receive Behavioral Health Treatment Services through

the regional centers and do not have an Autism Spectrum Disorder diagnoses to receive these services through Medi-Cal Managed Care Plans (MCPs). This change will impact approximately 6000 children statewide and approximately 283 children in the Tri-Counties area. TCRC will work in collaboration with the local Medi-Cal managed Care Plans and service providers to transition these individuals in a manner that will not disrupt their services **(Attachments #1-#2)**.

Since the release of the Governor's May Revise Budget, it has been going through review by the Legislature in the Budget Subcommittees in the Assembly and in the Senate. Both the Assembly and the Senate Budget Subcommittees have included new proposals in addition to the proposals included in the Governor's May Revise Budget that positively impact the Developmental Services System. The new proposals include restoration of camp services and social recreation services, as well as removal of the cap on respite services that were put in place during the Great Recession. These were all items that the stakeholders in the Developmental Services System advocated for throughout the budget process this year. Additionally, the Assembly and the Senate Budget Subcommittees have also proposed convening a stakeholder group to explore better ways to change service provider rates versus using the current cumbersome health and safety waiver and unanticipated rate adjustment process. Finally the Assembly Budget Subcommittee has proposed providing an additional $17 million in Operations funding to regional centers to address the need to hire additional Service Coordinators in order to meet federally mandated caseload ratios.

The next step in the process is for the Assembly and the Senate full Budget Committees to hold overview hearings and accept the reports from their various subcommittees. Any differences that exist between the Assembly version of the

Budget and the Senate version of the Budget will be sent to the Budget Conference Committee for resolution, by or before June 12, 2017. Once all the differences between the Assembly and the Senate versions of the Budget are resolved, a final vote will be taken by the Assembly and the Senate, by or before midnight June 15, 2017 upon which the Budget Bill will be sent to Governor Brown who has until midnight June 30, 2017 to sign the budget bill. At this time we do not anticipate there will be any delays in a timely enactment of a budget for FY 2017-2018 **(Attachment #3)**

B. DDS SELECTS CONTRACTOR TO CONDUCT REGIONAL CENTER SERVICE PROVIDER RATE STUDY

- **Attachment #4:** Department of Developmental Services Selects Contractor to Conduct Long Awaited Regional Center Provider Rate Study

DDS recently announced that it intends to contract with Burns and Associates, a Phoenix based consulting firm, to conduct a long awaited regional center service provider rate study and to provide recommendations to the Legislature by March 1, 2019. A rate study was part of the recommendations included in the Special Session bill last year, ABX 2 1 to address the on-going funding crisis impacting services for persons with developmental disabilities served by regional centers and the community based service providers. A rate study when completed and submitted to the Legislature could have significant short and long term impact on service provider rates and community based services for persons with developmental disabilities and their families. It is imperative that advocates are involved throughout the process to provide input and review the findings and recommendations made in the rate study. TCRC will monitor this process very closely and will participate whenever the opportunity is presented **(Attachment #4).**

II. SELF DETERMINATION PROGRAM

- **Attachment #5:** DDS Self Determination Program – FAQ (revised 9.15)
- **Attachment #6:** Disability Rights California Self Determination Program – FAQ
- **Attachment #7:** Similarities and Differences Between Traditional Regional Center Service Provision and the New Self-Determination Program
- **Attachment #8:** December 2015 Letter from Centers for Medicare and Medicaid Services
- **Attachment #9:** Self-Determination Enrollment Process
- **Attachment #10:** TCRC Self-Determination Informational Flyer
- **Attachment #11:** TCRC Self-determination Advisory Committee 2017 meeting calendar

In October of 2013, Governor Brown, signed into law SB 468 (Emmerson /Beal /Mitchel /Chesbro) authorizing the implementation of the Statewide Self-Determination Program that offers a voluntary, alternative to the traditional way of providing regional center services. The Self Determination Program is intended to provide individuals served by the regional center and their families more freedom, control, and responsibility in choosing services and supports to help them meet objectives in their Individual Program Plan **(Attachments #5-#7)**. It will most likely take several years for the Self Determination Program to be fully in place. Securing federal funding is necessary in order to implement the Self-Determination program.

The Department of Developmental Services (DDS) met the deadline as outlined in SB 468 and submitted the Home and Community Based Services application on December 31, 2014 seeking funding for Self-Determination to the Center for Medicare and Medicaid Services (CMS). Subsequently, CMS asked follow-up questions related to recently enacted federal regulations and policies regarding public input for Waiver applications and federal requirements for Home and Community Based Settings (HCBS). The Department, in conjunction with the Department of Health Care Services, had a number of discussions with CMS and provided the follow-up information CMS requested. The Self-Determination Waiver Application was formally resubmitted to the Centers for Medicare and Medicaid Services (CMS) on September 29, 2015.

On December 11, 2015, CMS sent a letter to the State asking questions about, and requesting more information on, specific sections in the Self-Determination Waiver Application (**Attachment #8**). The Department of Developmental Services (DDS) continues to work through the Department of Health Care Services to provide written responses to answer questions from CMS and secure approval of the waiver. DDS is in communication with CMS to clarify some of the concepts in the Self-Determination Waiver. Of the 180 questions posed to DDS in December 2015, all but a few have been clarified with CMS. The remaining questions have to do with the Financial Management Services (FMS) part of the program. Currently, the state is trying to work out some details regarding the qualifications and the functions of Financial Management Service providers. Once DDS finalizes the remaining questions, the application will be formally submitted to the Centers of Medicare and Medicaid Services (CMS).

The Self-Determination stakeholder workgroup has developed an assessment process for service settings that are selected by the Self Determination Program participants to determine their compliance with the HCBS settings rule. They have completed a

tool that clarifies those service settings that do not qualify (i.e., services provided in nursing facilities) and also those service setting that do qualify (i.e., services provided in integrated community settings such as the city library).

Once federal approval of matching funds is authorized, the program will be available in every regional center. For the first three years, the number of participants in the Self- Determination Program is capped at 2,500 individuals throughout the state. Recent legislation allows for an increase of these participants to include people moving from Developmental Centers. After the three year phase-in period, the program will be available to all eligible persons served and families on a voluntary basis with no limit on the number of participants. TCRC will have 114 individuals or families enrolled in the program for the first three years. This includes the 15 individuals who are currently in our Self-Determination pilot project plus an additional 99 people that TCRC will be able to add under the new program. The process for selecting and enrolling participants in the first three years is described in the Self-Determination Enrollment Process (**Attachment #9**).

Federal approval of the Waiver application is just one of the many steps that must be taken prior to the implementation of the Self-Determination Program. The Self-Determination Program stakeholder advisory group identified the following steps as necessary for a fair and equitable process for enrollment.

Outreach — Those served by the regional center and their families must be made aware of Self-Determination as an option to traditional services. To assist with the provision of widespread outreach and awareness of the Self-Determination Program, the workgroup developed an informational video that features some of the individual's and their families currently in the self-determination pilot project as well as those who are interested in the Self-Determination Program. This video has been posted on the Department of Developmental Services (DDS) website at: https://www.dds.ca.gov/SDP . The Self Determination video is now available in

additional languages with more to be added. TCRC along with the Self-Determination Advisory chairpersons, developed an information flyer that was included in the POS annual statements mailed out to all persons served by TCRC. This flyer was also given to our Service Coordinators, Family Resource Centers and Peer Advocacy Team to make available to our community **(Attachment # 10).**

Information — Individual's served by the regional center and/or their families must be informed about the Self-Determination Program, including the new opportunities and increased responsibilities. Those interested in the Self-Determination Program will be required to attend and participate in an informational/pre-enrollment meeting covering topics identified by the Department, including, information regarding the principles of self-determination, the role of the financial management services provider and the development of an individual budget. The state workgroup has developed training materials to be distributed to all Regional Centers that will be used during these informational / orientation meetings. In June at the Statewide Consumer Advisory Committee, DDS will present the modules developed for Self-Determination. These include the History and Principles of Self-Determination, Roles and Responsibilities, Independent Budgets /Budget Management, Person-Centered Planning, Self-Determination Program Services, Participant Rights, Fiscal Management Services (FMS), and the role of the Independent Facilitator. Starting in late July through early August, DDS will be holding multiple training sessions for regional centers throughout the state on these modules. Once TCRC has received training on these materials, we will develop our outreach plan to hold informational nights about Self-Determination.

In the Spring 2016 issue of the TCRC Tri-line newsletter, there was an article on Self Determination that provides an overview of the program. In addition, TCRC's website is set up for anyone to receive an email notification when new information is posted. To receive email notifications go to the Self Determination page of the TCRC website and click on the "Get News, Notices and Announcements by email"

link. Click on "Join our email List", provide the information requested and select the box next to Self Determination.

Additionally, anyone interested in obtaining more information about the Self Determination Program and would like to be notified once the Self Determination Pre-Enrollment Information meetings are scheduled can contact TCRC by email: self-determination@tri-counties.org .

Selection for the first three years of the Self-Determination Program— For those who attend one of the informational meetings, they will be given a verification form to complete. At the end of the meeting, they will be asked if want to be considered for enrollment at which time, they will complete the form and submit back to the regional center. This choice can be changed at any time by notifying the regional center. Regional centers will forward to the Department the names of those who have participated in an informational/pre-enrollment meeting and are interested in participating in the Self-Determination Program. The Department will send a confirmation to those who have submitted their names for participation in the program and are currently developing a process for those interested, and/or their families, to verify via the DDS website that their name has been forwarded for consideration. The Department will then randomly select the participants based on the following demographic factors within each regional center: age, gender, ethnicity and disability diagnosis. Individual's not initially selected will remain on the interest list for potential future openings.

Local Volunteer Advisory Committees — As required by law, each regional center must establish a Local Volunteer Advisory Committee to ensure effective implementation of the Self-Determination Program and facilitate the sharing of best practices and training materials. In collaboration with the Central Coast office of the State Council, we reviewed the applications from those interested in serving on the committee and selected the membership with a focus on multicultural diversity requirements and geographic area representation.

The primary responsibility of the committee is to provide oversight of the Self-Determination program at Tri-Counties Regional Center. The committee will review the development, implementation and on-going progress of the Self-Determination program and determine if we are meeting the requirements of the law. In addition, the committee will make on-going recommendations for improvements to the program to both Tri-Counties Regional Center and the Department of Developmental Services. Our Self-Determination Advisory Committee is meeting on a quarterly basis and all meetings are open to the public (**Attachment #11**).

TCRC's Self-Determination Advisory Committee has been meeting on a quarterly basis in Santa Barbara. Our next meeting will be on Tuesday, June 27, 2017 and telephone conferencing will be available. For more information, you can visit our website at www.tri-counties.org or email: self-determination@tri-counties.org.

In addition to our local advisory committee, there is a Statewide Advisory committee in which the chair and co-chair of TCRC's advisory committee participates. In these meetings, there is a sharing of what has worked / what has not between regional centers to develop best practices throughout the state.

TCRC is also actively participating on the Self-Determination Committee through the Association of Regional Center Agencies (ARCA) to provide feedback to the Department of Developmental Services (DDS) on the waiver and obtain input and direction from DDS on the timing and implementation of the various components of the program.

As we wait for more information, TCRC has formed an internal work group consisting of Omar Noorzad, Executive Director; Lorna Owens, CFO; Diva Johnson, Director of Community Development; Pam Crabaugh, Director of Services and Supports; Eulalia Apolinar, Assistant Director of Services and Supports SB/SLO Counties; Sha Azedi, Assistant Director of Services and Supports Ventura County; Cheryl Wenderoth, Assistant Director of Federal Programs; Mary Beth Lepkowsky,

Assistant Director of Training and Organizational Development; and Jennifer Lucas, State Council on Developmental Disabilities Central Coast Office. The group will be working together on a variety of activities in preparation for the Self-Determination Program.

These include:

- Participation in our local advisory committee.
- Guidelines on participant eligibility, selections and enrollment
- Self-Determination services and definitions
- Budget setting and tracking.
- Fiscal Management Services (FMS)
- Training
- Person-Centered Planning
- Community outreach
- Monitoring of the Self-Determination program
- Billing and payment procedures

TCRC continues to post updated information about the Self Determination Program on the TCRC website to keep the community informed about the status of the Self Determination Program.

III. Q&A

ATTACHMENT 1

Department of Developmental Services

May Revision Highlights

Edmund G. Brown Jr.
Governor
State of California

Diana S. Dooley
Secretary
California Health and Human Services Agency

Nancy Bargmann
Director
Department of Developmental Services

May 2017

DEPARTMENT OF DEVELOPMENTAL SERVICES
MAY REVISION HIGHLIGHTS

The Department of Developmental Services (Department or DDS) is responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring that more than 300,000 persons with developmental disabilities receive the services and support they require to lead more independent and productive lives and to make choices and decisions about their lives.

California provides services and supports to individuals with developmental disabilities two ways. The vast majority of people live in family homes or other community settings and receive state-funded services that are coordinated by 21 non-profit corporations known as regional centers. In contrast, a small number of individuals live in three state-operated developmental centers (DCs) and one state-operated community facility. The number of individuals with developmental disabilities in the community served by regional centers (consumers) is expected to increase from 303,599 in the current year, to 317,837 in 2017-18. The number of individuals living in state-operated residential facilities is estimated to be 495 on July 1, 2018.

SAFETY NET PLAN

In compliance with Welfare and Institutions Code Section 4474.15(a), the Department has prepared its "Plan for Crisis and Other Safety Net Services in the California Developmental Services System" (Safety Net Plan). The plan provides background information on the developmental disabilities services system, details stakeholder input and guidance received on the need for a safety net of services, and proposes new service options to broaden the continuum of service options to support individuals with the most challenging service needs.

In alignment with the Safety Net Plan, the May Revision proposes $7.5 million General Fund (GF) in 2017-18 to establish the following:

- Two state-operated, 24/7 mobile acute crisis teams,
- Two acute crisis homes to relocate and expand Stabilization, Training, Assistance and Reintegration (STAR) services in Northern California, and
- Intensive wrap-around services for individuals transitioning out of secure treatment.

These funds are in addition to $13.7 million in existing funds the Department proposes to allocate to accomplish the following:

- Develop intensive wrap-around services for persons with co-occurring developmental disabilities and mental health needs,
- Renovate two existing homes at Fairview DC near Harbor Village to relocate and expand Southern STAR services,
- Develop four vendor-operated homes to provide step-down services for individuals with co-occurring developmental disabilities and mental health needs, and
- Develop two vendor-operated homes to provide step-down services for individuals transitioning from the Porterville Secure Treatment Program.

The Safety Net Plan also proposes trailer bill language to amend Government Code Section 14670.35 to authorize an amendment to the existing ground lease for property at Fairview DC, known as Harbor Village, to renovate and maintain the two Southern STAR homes.

MAY REVISION SUMMARY

The May Revision includes $6.9 billion total funds ($4.2 billion GF) for the Department in 2017-18; a net increase of $270.2 million ($187.8 million GF) over the updated 2016-17 budget, or a 4.1% increase.

FUNDING SUMMARY
(Dollars in Thousands)

	2016-17	2017-18	Difference	Percentage Change
BUDGET SUMMARY				
Community Services	$6,052,632	$6,388,088	$335,456	5.5%
Developmental Centers	539,948	465,983	-73,965	-13.7%
Headquarters Support	52,670	61,414	8,744	16.6%
TOTALS, ALL PROGRAMS	**$6,645,250**	**$6,915,485**	**$270,235**	**4.1%**
GENERAL FUND				
Community Services	$3,580,955	$3,796,228	$215,273	6.0%
Developmental Centers	376,132	348,179	-27,953	-7.4%
Headquarters Support	34,817	35,266	449	1.3%
GF TOTAL, ALL PROGRAMS	**$3,991,904**	**$4,179,673**	**$187,769**	**4.7%**

For more detail, see Budget Summary and Funding Charts on pages 6 and 7.

COMMUNITY SERVICES PROGRAM

2016-17

The May Revision projects the total community caseload at 303,599, reflecting an increase of 152 consumers from the 2017 Governor's Budget. The May Revision also updates total funding to $6.1 billion ($3.6 billion GF). This reflects a net decrease of $12.3 million ($22.5 million GF increase) as compared to the Governor's Budget for regional center Operations (OPS) and Purchase of Services (POS). This decrease includes the following:

Caseload and Utilization

$15.7 million net decrease ($19.5 million GF increase) in regional center OPS and POS as follows:

- OPS increase of $0.7 million ($1.5 million GF decrease)
- POS decrease of $16.4 million ($21 million GF increase)

The increase in OPS is due to increased regional center caseload and Intermediate Care Facility-Developmental Disabled (ICF-DD) Administration Fees, slightly offset by a minor adjustment in Federal Compliance resulting from a decrease in consumers eligible for Home and Community Based Services (HCBS). The

decrease in POS is the net difference of adjustments for all POS budget categories based on updated expenditure trends. The increase in GF is due to a decrease in HCBS Waiver eligible expenditures and the reduction of anticipated reimbursements from the Department of Health Care Services (DHCS) for behavioral health treatment (BHT) fee-for-service costs.

Assembly Bill (AB) 10 Minimum Wage Increase, Effective January 1, 2016
$31.7 million decrease ($19.3 million GF decrease) due to updated actual expenditures.

Transition of BHT Services to DHCS
$29.8 million increase ($14.2 million GF increase) reflecting a decrease in savings estimated for transitioned consumers based on updated actual expenditures.

Alternative Residential Model (ARM) 4-Bed Rate
$5.2 million decrease ($3.0 million GF decrease) based on updated, actual expenditures coming in lower than previously projected.

ABX2 1 (Assembly Bill 1, 2nd Extraordinary Session, Ch 3, Statutes of 2016)
$10.5 million increase ($6.2 million GF increase) reflecting updated expenditure estimates for Direct Care Staff Wages and Benefits, increases for POS Administrative Costs, and other targeted increases for Respite, Transportation, Supported Living, and Independent Living.

2017-18
The May Revision estimates the total community caseload at 317,837 consumers, reflecting an increase of 554 consumers over the caseload estimated in the 2017 Governor's Budget. The Department estimates total funding of $6.4 billion ($3.8 billion GF), reflecting a net decrease of $35.7 million ($42.7 million GF decrease) from the Governor's Budget. This decrease is comprised of:

Caseload and Utilization
$37.3 million decrease ($47.2 million GF decrease) in regional center OPS and POS as follows:

- OPS increase of $2.4 million ($6.9 million GF decrease)
- POS decrease of $39.7 million ($40.3 million GF decrease)

The net OPS increase results from increases in caseload and ICF-DD Administration Fees, with a minor decrease in Federal Compliance resulting from a decrease in consumers eligible for HCBS. The decrease in POS reflects the net difference of adjustments for all POS budget categories based on updated expenditure trends.

Operations – Policy Adjustment
$1.3 million increase ($1.0 million GF increase) to fund 0.5 psychologists per regional center to assess children with an Autism Spectrum Disorder (ASD) diagnosis and provide a recommendation by a psychologist for BHT services.

Assembly Bill (AB) 10, Chapter 351, Statutes of 2013, Minimum Wage Increase
$33.6 million decrease ($20.6 million GF decrease) reflecting updated actual expenditures for each POS budget category.

Transition of BHT Services to DHCS
$29.8 million increase ($14.2 million GF increase) resulting from a decrease in savings expected from the transition based on updated, actual costs for transitioned consumers.

BHT Transition - Consumers without an ASD Diagnosis
$3.3 million GF decrease in expenditures for consumers without an ASD diagnosis who will transition to Medi-Cal Managed Care beginning January 1, 2018.

ABX2 1 (Assembly Bill 1, 2nd Extraordinary Session, Ch 3, Statutes of 2016)
$1.8 million net increase ($1.1 million GF increase) reflecting updated expenditure estimates for Direct Care Staff Wages and Benefits, increases for POS Administrative Costs, and other targeted increases for Respite, Transportation, Supported Living, and Independent Living.

Safety Net Resources
$5.6 million GF increase to develop two Stabilization, Training, Assistance and Reintegration (STAR) acute crisis facilities in Northern California, and establish intensive transition services to promote successful community transitions for those leaving secured treatment.

DEVELOPMENTAL SERVICES PROGRAM

2016-17
The May Revision reflects an ending DC population on June 30, 2017 of 793 residents, an increase of 33 residents over that estimated in the Governor's Budget. The additional residents are a result of fewer placements due to delays in resident transitions to the community and the availability of Community Placement Plan (CPP) residential resources. The Department expects to correct these placement delays in 2017-18.

The May Revision updates the Governor's Budget to $539.9 million ($376.1 million GF), an increase of $10.1 million ($7.6 million GF) reflecting incremental changes approved through the collective bargaining process and are included in Item 9800, Employee Compensation Adjustments.

2017-18
The May Revision proposes a total of $466 million ($348.2 million GF), a net increase of $16.2 million ($18.2 million GF increase) from the Governor's Budget. The net increase is comprised of the following adjustments:

Employee Compensation
$10.5 million increase ($7.8 million GF) reflecting incremental changes approved through the collective bargaining process and included in Item 9800, Employee Compensation Adjustments.

DC Operations Expenditure Increase
$12.1 million net increase ($8.5 million GF) to retain 136.3 positions due to technical corrections to the staffing calculations and adjusted resident population. The adjustment in resident population results in the need to operate one Intermediate Care Facility (ICF) unit at Fairview longer than estimated in the Governor's Budget, which also limits the reduction of staffing and associated Operating Expenses and Equipment (OE&E) costs.

Transfer of Community State Staff Program (CSSP) Reimbursement Authority to the Headquarters Program
$8.3 million decrease in reimbursements to transfer authority for the CSSP to Headquarters.

Safety Net Mobile Acute Crisis
$1.9 million GF and 14.5 positions to operate two Mobile Acute Crisis Unit teams in California. These teams will be an additional service provided by the Northern and Southern Stabilization, Training, Assistance, and Reintegration (STAR) homes at Sonoma and Fairview.

HEADQUARTERS PROGRAM

2016-17
The May Revision reflects an increase to the 2016-17 Headquarters' operations funding of $1.5 million ($1.0 million GF increase) for Employee Compensation adjustments approved through the collective bargaining process and included in Item 9800. The total updated 2016-17 Headquarters budget is $52.7 million ($34.8 million GF).

2017-18
The May Revision proposes total Headquarters operations funding for 2017-18 of $61.4 million ($35.3 million GF). This is a net increase of $9.1 million ($0.5 million GF) over the Governor's Budget, reflecting the following adjustments:

Employee Compensation
$0.8 million increase ($0.5 million GF) reflecting an incremental increase from the Governor's Budget for employee compensation adjustments approved through the collective bargaining process and included in Item 9800.

Transfer of CSSP Reimbursement Authority from the DC Program
$8.3 million increase in reimbursement authority ($0 GF) from the DC Program.

CAPITAL OUTLAY
The May Revision proposes no changes for 2016-17 or 2017-18.

2017 May Revision
Funding Summary
(Dollars in Thousands)

	2016-17	2017-18	Difference
BUDGET SUMMARY			
COMMUNITY SERVICES	$6,052,632	$6,388,088	$335,456
DEVELOPMENTAL CENTERS	539,948	465,983	-73,965
HEADQUARTERS SUPPORT	52,670	61,414	8,744
TOTALS, ALL PROGRAMS	**$6,645,250**	**$6,915,485**	**$270,235**
FUND SOURCES			
General Fund	$3,991,904	$4,179,673	$187,769
Reimbursements: Totals All	2,592,944	2,675,359	82,415
Home and Community-Based Services (HCBS) Waiver	*1,646,437*	*1,725,969*	*79,532*
Medicaid (HCBS) Waiver Administration	*14,000*	*14,105*	*105*
Medicaid Administration	*16,030*	*16,029*	*-1*
Targeted Case Management	*190,303*	*195,934*	*5,631*
Targeted Case Management Admin.	*6,277*	*6,276*	*-1*
Medi-Cal	*160,245*	*122,771*	*-37,474*
Title XX Block Grant	*213,421*	*230,974*	*17,553*
ICF-DD/State Plan Amendment	*60,964*	*60,964*	*0*
Quality Assurance Fees (DHCS)	*10,788*	*10,788*	*0*
1915(i) State Plan Amendment	*231,394*	*237,727*	*6,333*
Money Follows the Person	*8,337*	*11,396*	*3,059*
Early Periodic Screening Diagnosis & Treatment	*26,119*	*26,368*	*249*
Behavioral Health Treatment FFS	*0*	*7,430*	*7,430*
Other	*8,629*	*8,628*	*-1*
Federal Trust Fund	55,892	55,855	-37
Lottery Education Fund	294	294	0
Program Development Fund (PDF)	2,870	2,913	43
Mental Health Services Fund	1,196	1,241	45
Developmental Disabilities Svs Acct	150	150	0
Behavioral Health Treatment	0	0	0
AVERAGE CASELOAD			
Developmental Centers (ending population)	793	495	-298
Regional Centers	303,599	317,837	14,238
AUTHORIZED POSITIONS			
Developmental Centers	4,125.2	3,786.8	-338.4
Headquarters	421.5	428.5	7.0

2017 May Revision
Program Highlights
(Dollars in Thousands)

	2016-17	2017-18	Difference
Community Services Program			
Regional Centers	$6,052,632	$6,388,088	$335,456
Totals, Community Services	**$6,052,632**	**$6,388,088**	**$335,456**
General Fund	$3,580,955	$3,796,228	$215,273
Program Development Fund (PDF)	2,537	2,537	0
Developmental Disabilities Svs Acct	150	150	0
Federal Trust Fund	52,981	53,258	277
Reimbursements	2,415,269	2,535,175	119,906
Mental Health Services Fund	740	740	0
Behavioral Health Treatment	0	0	0
Developmental Centers Program			
Personal Services	$472,872	$398,045	-$74,827
Operating Expense & Equipment	67,076	67,938	862
Total, Developmental Centers	**$539,948**	**$465,983**	**-$73,965**
General Fund	$376,132	$348,179	-$27,953
Federal Trust Fund	285	0	-285
Lottery Education Fund	294	294	0
Reimbursements	163,237	117,510	-45,727
Headquarters Support			
Personal Services	42,816	54,105	11,289
Operating Expense & Equipment	9,854	7,309	-2,545
Total, Headquarters Support	**$52,670**	**$61,414**	**$8,744**
General Fund	$34,817	$35,266	$449
Federal Trust Fund	2,626	2,597	-29
PDF	333	376	43
Reimbursements	14,438	22,674	8,236
Mental Health Services Fund	456	501	45
Totals, All Programs	**$6,645,250**	**$6,915,485**	**$270,235**
Total Funding			
General Fund	$3,991,904	$4,179,673	$187,769
Federal Trust Fund	55,892	55,855	-37
Lottery Education Fund	294	294	0
PDF	2,870	2,913	43
Developmental Disabilities Svs Acct	150	150	0
Reimbursements	2,592,944	2,675,359	82,415
Mental Health Services Fund	1,196	1,241	45
Behavioral Health Treatment BHT	0	0	0
Totals, All Funds	**$6,645,250**	**$6,915,485**	**$270,235**

ASSOCIATION OF REGIONAL CENTER AGENCIES
ANALYSIS OF THE FY 17-18 MAY REVISION
MAY 11, 2017

FY 2016-2017 (Current Year)

1. CASELOAD

The November Estimate projected the regional center community caseload to be 303,447 consumers as of January 31, 2017. The May Revision estimate is 303,599, an increase of 152 consumers (.05% increase). The 152 increase is comprised of 72 Early Start consumers and 80 Active consumers.

2. PURCHASE OF SERVICE - $ 13 Million Decrease (0.25% Decrease)

- Caseload and Utilization
  $ 16.4 million decrease (0.34% decrease) to various Purchase of Services category adjustments based on updated expenditure trends.

- Assembly Bill (AB) 10 Minimum Wage Increase, Effective January 1,2016
  $31.7 million decrease (25.4% decrease) due to updated actual expenditures.

- Transition of BHT Services to DHCS
  $29.8 million increase (23.3% increase) reflecting a decrease in savings estimated for transitioned consumers based on updated actual expenditures.

- Alternative Residential Model (ARM) 4-Bed Rate
  $5.2 million decrease (11.4% decrease) based on updated, actual expenditures coming in lower than previously projected.

- ABX2 1(Assembly Bill 1, 2nd Extraordinary Session, Ch 3, 2016 Statutes)
  $10.5 million increase (2.6% increase) reflecting updated expenditure estimates for direct care staff wages and benefits, increases for POS administrative costs, and other targeted increases for respite, transportation, supported living, and independent living.

3. OPERATIONS - $.7 Million Increase (0.11% Increase)

- Caseload Growth
  $0.7 million increase (0.11% increase) due to increase in regional center caseload and Intermediate Care Facility-Developmental Disabled (ICF-DD) administration fees, slightly offset by a minor adjustment in Federal Compliance resulting in a decrease in consumers eligible for Home and Community Based Services (HCBS).

FY 2017-18 (May Revision) – $6.4 billion (4.1% increase over FY 2016-2017)

1. CASELOAD

The May Revision anticipates an increase of 554 consumers (0.17% increase) over the 317,283 consumers projected for January 31, 2017.

2. PURCHASE OF SERVICE - $39.4 Million Decrease

- Caseload and Utilization
  $ 39.7 million decrease (0.8% decrease) due to the net of adjustments in all budget categories based on updated expenditure trends.

- Assembly Bill (AB) 10, Ch 351, 2013 Statutes, Minimum Wage Increase
  $33.6 million decrease (25.4% decrease) reflecting updated actual expenditures for each POS budget category

- Transition of BHT Services to DHCS
  $29.8 million increase (23.3% increase) resulting from a decrease in savings expected for transitioned consumers based on updated actual expenditures

- BHT Transition – Consumers without an ASD Diagnosis
  $3.3 million decrease (new assumption) in expenditures for consumers without an ASD diagnosis who will transition to Medi-Cal Managed Care beginning January 1, 2018.

- ABX2 1(Assembly Bill 1, 2nd Extraordinary Session, Ch 3, 2016 Statutes)
  $1.8 million increase (0.4% increase) reflecting updated expenditure estimates for direct care staff wages and benefits, increases for POS administrative costs, and other targeted increases for respite, transportation, supported living, and independent living.

- Safety Net Resources
  $5.6 million increase (new assumption) to develop two Stabilization, Training, Assistance and Reintegration (STAR) acute crisis facilities in Northern California and establish intensive transition services to promote successful community transitions for those leaving secured treatment (see more details on page 5).

3. OPERATIONS – $3.7 Million Increase

- Caseload
  $2.4 million increase (0.36% increase) resulting from increases in caseload and ICF-DD Administration Fees, with a minor decrease in Federal Compliance resulting from a decrease in consumers eligible for HCBS.

- Policy Adjustment
  $1.3 million increase (1.5% increase) to fund 0.5 psychologists per regional center to assess children with an Autism Spectrum Disorder (ASD) diagnosis and provide a recommendation by a psychologist for BHT services.

FUTURE FISCAL ISSUES AND REVISED MAJOR ASSUMPTIONS

Future Fiscal Issues

Self-Determination

Senate Bill (SB) 468, Chapter 683, Statutes of 2013, requires the Department to implement a statewide Self-Determination Program (SDP), subject to approval of federal funding. The Department submitted an application for federal funding to the Centers for Medicare & Medicaid Services (CMS) on December 31, 2014. The SDP will allow regional center consumers and their families more freedom, control, and responsibility in choosing services and supports to help meet the objectives in their individual program plans. Participation is limited to 2,500 individuals in the first 3 years of the SDP, including approximately 100 participants in the current State-only funded self-determination pilot project. To ensure the cost neutrality of the SDP, which is required in statute, SB 468 requires the additional federal reimbursements generated by former self-determination pilot participant's savings be used to offset administrative costs to the Department, including the required criminal background checks. Any remaining funds can be used to offset regional center costs to implement the SDP.

In response to changes requested by CMS, the Department formally resubmitted the Home and Community-Based Services (HCBS) Waiver application on September 29, 2015. As is typical when submitting an application for federal funding, CMS responded, requesting additional information regarding the Waiver application. The Department has responded to this and all subsequent requests for information, and has resolved the majority of CMS' questions/issues. The Budget Act of 2016 also includes provisional language to administer the SDP once federal approval has been received.

CMS Final Regulations for Home and Community-Based Services

The Department administers both a 1915(c) Waiver (the HCBS Waiver for Persons with Developmental Disabilities) and a 1915(i) State Plan program. These programs enable the State to receive federal funding for services provided to approximately 130,000 consumers.

In early 2014, CMS published final regulations affecting 1915(c) Waiver programs, 1915(i) State Plan programs, and 1915(k) Community First Choice State Plans for HCBS provided through Medicaid. The purpose of the regulations is to ensure individuals receive HCBS in settings that are integrated in and support full access to the community. Originally, CMS required states to comply with the new federal regulations by March 17, 2019, to maintain HCBS funding (estimated at $1.7 billion for the Department in 2017-18). However, on May 9, 2017, CMS notified states that given the difficult and complex nature of achieving compliance, it extended compliance by three years to March 17, 2022.

On November 23, 2016, DHCS submitted the revised Statewide Transition Plan (STP) for CMS approval. The STP describes at a high level, California's overall commitment

Future Fiscal Issues – Continued

CMS Final Regulations for Home and Community-Based Services – Cont.
to, and plan for, achieving compliance including the potential need for changes in statute and/or regulation to comply with federal regulations. Concurrent with the development of the STP, the Department is engaged in the multi-year process of implementing the federal regulations with the guidance of a comprehensive stakeholder group. To enable the Department to complete some of the required activities, the 2016 enacted budget included funding for regional center staffing to assist with conducting individual provider assessments as well as funding to enable service providers to make modifications to comply with federal regulations. Additionally, the Administration proposed trailer bill language with the 2017 Governor's Budget to provide the Department temporary administrative flexibility and other specific authority to comply with the federal regulations.

Developmental Services Task Force
On July 24, 2014, the California Health and Human Services Secretary convened a task force to strengthen developmental services in the community. The task force includes consumers, consumer advocates, regional centers, community service providers, labor organizations, families of developmental center residents, legislative staff, and staff from the Department. Subsequent meetings were convened to focus on service rates, the rate-setting structure and sustainability, and how regional center operations are funded. The task force will develop recommendations in the context of a growing and aging population, resource constraints, and availability of community housing and employment resources to meet the specialized needs of consumers.

Revised Major Assumptions

General Fund to Cover BHT Services for Fee-for-Service Consumers
The Department requests $7.1 million GF in 2016-17 to backfill unrealized reimbursements for children who transitioned to DHCS and receive BHT services on a fee-for-service basis.

In 2016, approximately 12,000 regional center consumers under the age of 21 with an ASD diagnosis transitioned to DHCS and Medi-Cal Managed Care for BHT services. An additional 1,683 fee-for-service consumers transitioned to DHCS on paper, but continued to receive BHT services through the regional centers with the expectation that DHCS would reimburse the Department for the expenditures. However, DHCS has been unable to reimburse the Department for approximately $7.1 million in BHT expenditures because a recommendation from a physician or psychologist is required for those services to be eligible for FFP under Medi-Cal. This provision was not previously required for the Department to claim FFP under the 1915i SPA or HCS Waiver. For 2017-18, this issue will be addressed by the "Psychological Evaluations for BHT Fee-for-Service Consumers" issue described above.

Revised Major Assumptions – Continued

Reimbursements for BHT Services Provided to Fee-for-Service Consumers
In 2017-18, the Department proposes $7.4 million in reimbursement authority from DHCS to cover the costs of BHT services provided to children on a fee-for-service basis. This includes expenditures for approximately 1,700 children with an ASD diagnosis, as well as 280 children who do not have an ASD diagnosis but for which BHT services are medically necessary

MAY REVISON - OTHER NOTABLE ITEMS

Safety Net Plan

In compliance with Welfare and Institutions Code Section 4474.15(a), the Department has prepared its "Plan for Crisis and Other Safety Net Services in the California Developmental Services System" (Safety Net Plan). The plan provides background information on the developmental disabilities services system, details stakeholder input and guidance received on the need for a safety net of services, and proposes new service options to broaden the continuum of service options to support individuals with the most challenging service needs.
In alignment with the Safety Net Plan, the May Revision proposes $7.5 million General Fund (GF) in 2017-18 to establish the following:
• Two state-operated, 24/7 mobile acute crisis teams,
• Two acute crisis homes to relocate and expand Stabilization, Training, Assistance and Reintegration (STAR) services in Northern California, and
• Intensive wrap-around services for individuals transitioning out of secure treatment.

These funds are in addition to $13.7 million in existing funds the Department proposes to allocate to accomplish the following:
• Develop intensive wrap-around services for persons with co-occurring developmental disabilities and mental health needs,
• Renovate two existing homes at Fairview DC near Harbor Village to relocate and expand Southern STAR services,
• Develop four vendor-operated homes to provide step-down services for individuals with co-occurring developmental disabilities and mental health needs, and
• Develop two vendor-operated homes to provide step-down services for individuals transitioning from the Porterville Secure Treatment Program.

The Safety Net Plan also proposes trailer bill language to amend Government Code Section 14670.35 to authorize an amendment to the existing ground lease for property at Fairview DC, known as Harbor Village, to renovate and maintain the two Southern STAR homes.

DEVELOPMENTAL CENTERS PROGRAM

FY 2016-2017 (Current Year)

The May Revision reflects an ending DC population on June 30, 2017 of 793 residents, an increase of 33 residents (4.3% increase) over that estimated in the Governor's Budget. The additional residents are a result of fewer placements due to delays in resident transitions to the community and the availability of Community Placement Plan (CPP) residential resources. The Department expects to correct these placement delays in 2017-18.

The May Revision updates the Governor's Budget to $539.9 million, an increase of $10.1 million (1.9% increase) reflecting incremental changes approved through the collective bargaining process.

FY 2017-18 (May Revision)

The May Revision proposes a total of $466 million, a net increase of $16.2 million (3.6% increase) from the Governor's Budget. The net increase is comprised of the following adjustments:

Employee Compensation
$10.5 million increase reflecting incremental changes approved through the collective bargaining process.

DC Operations Expenditure Increase
$12.1 million net increase to retain 136.3 positions due to technical corrections to the staffing calculations and adjusted resident population. The adjustment in resident population results in the need to operate one Intermediate Care Facility (ICF) unit at Fairview longer than estimated in the Governor's Budget, which also limits the reduction of staffing and associated Operating Expenses and Equipment (OE&E) costs.

Transfer of Community State Staff Program (CSSP) Reimbursement Authority to the Headquarters Program
$8.3 million decrease in reimbursements to transfer authority for the CSSP to Headquarters.

Safety Net Mobile Acute Crisis
$1.9 million and 14.5 positions to operate two Mobile Acute Crisis Unit teams in California. These teams will be an additional service provided by the Northern and Southern Stabilization, Training, Assistance, and Reintegration (STAR) homes at Sonoma and Fairview.

HEADQUARTERS

FY 2016-2017 (Current Year)

The May Revision reflects an increase to the 2016-17 Headquarters' operations funding of $1.5 million for Employee Compensation adjustments approved through the collective bargaining process and included in Item 9800. The total updated 2016-17 Headquarters budget is $52.7 million.

FY 2017-2018 (May Revision)

The May Revision proposes total Headquarters operations funding for 2017-18 of $61.4 million. This is a net increase of $9.1 million over the Governor's Budget, reflecting the following adjustments:

Employee Compensation

$0.8 million increase reflecting an incremental increase from the Governor's Budget for employee compensation adjustments approved through the collective bargaining process.

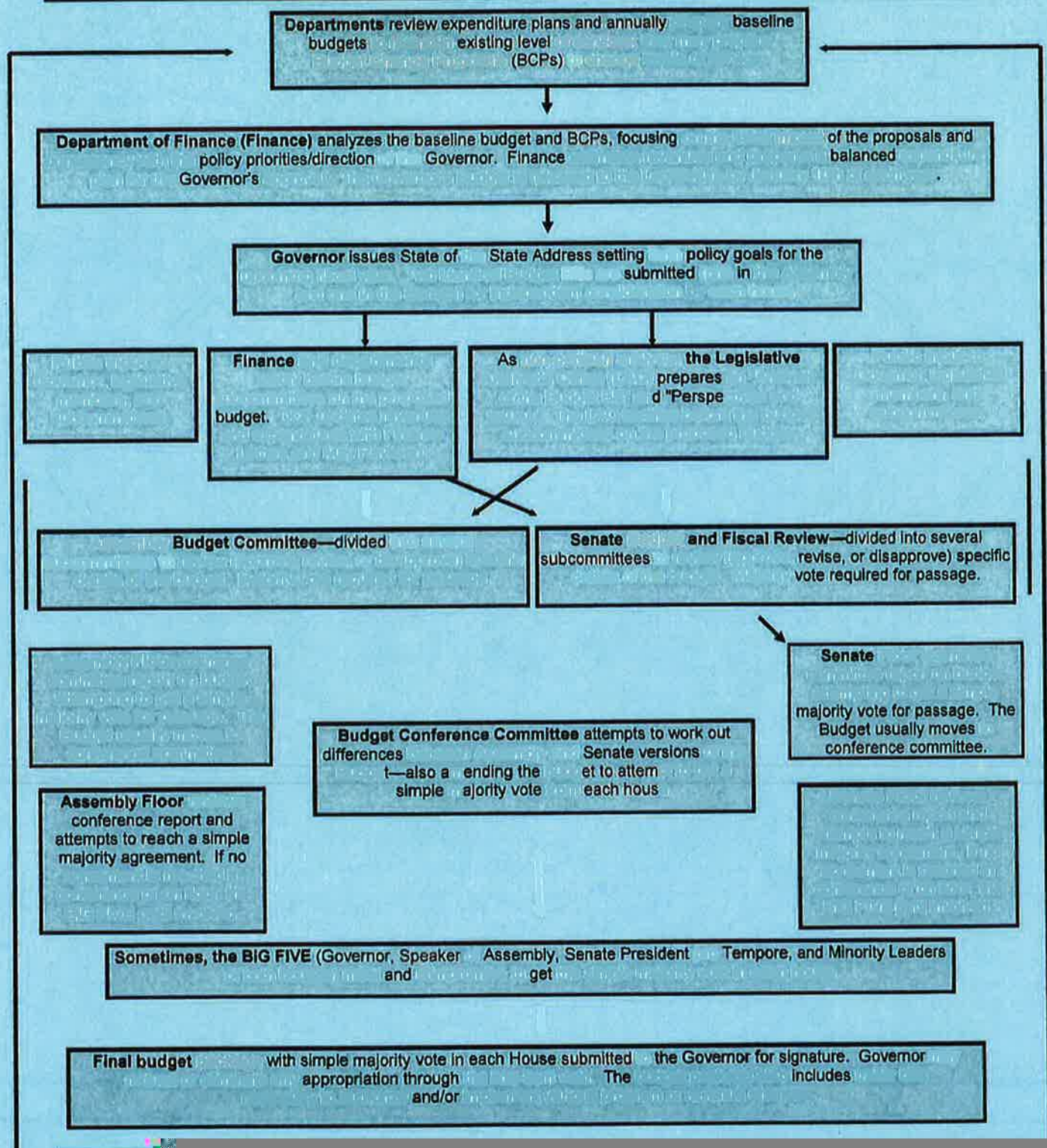
Transfer of CSSP Reimbursement Authority from the DC Program

$8.3 million increase in reimbursement authority from the DC Program.

CAPITAL OUTLAY

The May Revise proposes no changes for 2016-17 or 2017-18.

HE NN A B D ET PRO



For current regional center consumers, the budget will equal 100% of the amount of the total purchase of service expenditures made by the regional center during the past 12 months. This amount can be adjusted by the IPP team, if the team determine an adjustment is needed for one of the following reasons:

---There is a change in your circumstances, needs, or resources that would result in and increase or decrease in your purchase of service expenditures; or

--There are prior needs or resources that were unaddressed in the IPP, which would have resulted in an increase or decrease in your purchase of service expenditures.

For a participant who is new to the regional center system or does not have 12 months of purchase of service expenditures, the IPP team will determine the services and supports needed and available resources. The regional center will use this information to identify the cost of providing the services and supports based on the average cost paid by the regional center unless the regional center determines that you have unique needs that require a higher or lower cost. This amount will be your individual budget unless it is adjusted as described below.

The regional center must certify that regional center expenditures for the individual budget, including any adjustment for current consumers, would have occurred regardless of your participation in the Self-Determination Program.

The budget will not be adjusted to include additional funds for either the independent facilitator or the financial management services.

7. Who can assist me during the person-centered planning process?

You can use an independent facilitator that they select to assist in the person-centered planning and IPP processes. An independent facilitator must be a person who does not provide services to you and is not employed by a person who provides services to you. You may also use a regional center service coordinator to assist with these functions. An

independent facilitator can advocate for you during a person centered planning meeting, assist you in making informed choices about your budget, and help you identify and secure services. The cost of the independent facilitator is paid from your individual budget.

8. Who assists me with managing my budget so that my funds will last throughout the year?

Participants are required to use a fiscal manager, vendored through the regional center, to help manage and direct the distribution of funds contained in your individual budget and ensure you have enough funds to implement your IPP throughout the year. These services can include bill paying, facilitating the employment of service and support workers, accounting, and compliance with applicable laws. The cost of the fiscal manager is paid from your individual budget, except for the costs of any criminal background check. You and your regional center service coordinator will receive a monthly statement from the fiscal manager which shows the budget amount in each category, the amount you have spent and the amount remaining.

9. Can I move money around in my budget?

The bill allows you to annually transfer up to 10% of the funds originally distributed to any budget category to another budget category or categories, and allows transfers of more than 10% provided the transfer is approved by your IPP team or the regional center. DDS will determine the budget categories with input from stakeholders.

10. What services and supports can I get with self-determination?

The Self-Determination Program will fund only those services and supports that are eligible for federal matching funds and only when generic services (for example, other governmental services such as special education, IHSS, Medi-Cal or insurance) are not available. It will also allow the purchase of some services which were suspended

services such as social recreation, camping, non-medical therapies, and respite[7].

11. What happens if I move from one regional center to another? Can I still participate in the Self-Determination Program?

You will continue to receive self-determination services and supports if you transfer to another regional center catchment area, provided that you remain eligible for the program. The bill requires the balance of your individual budget to be reallocated to the receiving regional center.

12. What happens if I no longer want to participate in self-determination or am no longer eligible for the program?

The bill requires regional centers to provide for your transition from the Self-Determination Program to traditional regional center services and supports if you are no longer eligible for or voluntarily choose to leave the program..

13. If I leave the Self-Determination Program, can I return?

If the regional center finds you ineligible for the Self-Determination Program you can return to the program upon meeting all applicable eligibility requirements, and upon approval of your planning team. If you, leave the program voluntarily you cannot return to the program for at least twelve months. During the first three years of the program, your right to return is also conditioned on your regional center not having reached its limit on the number of participants.

14. Can my regional center require me to participate in self-determination if I don't want to?

The Self-Determination Program is fully voluntary. A regional center cannot require participation in the program.

15. What if I am in a licensed long-term care facility and I want to participate in the In Self-Determination?

---

[7] Welfare and Institutions Code Section 4648.5(a) and 4686.5

If you currently live in a licensed long-term care facility you are not eligible for the Self-Determination Program. However, you may request that the regional center provide person-centered planning services in order to make arrangements for transition to the Self-Determination Program, provided that you are reasonably expected to transition to the community within 90 days. In that case, the regional center shall initiate person-centered planning services within 60 days of the request. If you are not ready to transition to the community, you may ask that your interest in self-determination be reflected in your IPP and request the regional center help you participation in self-determination as part of the transition process.

16. What if I do not receive Medi-Cal? Can I still participate in self-determination?

The bill authorizes participation in the Self-Determination Program for consumers who are not eligible for Medi-Cal, provided that they meet all other program eligibility requirements and the services and supports they receive are otherwise eligible for federal matching.

17. How does the Self-Determination Program ensure the safety of consumers?

The bill establishes criminal background check requirements for providers of services and supports under the Self-Determination Program. It requires DDS to issue a program directive identifying the non-vendored providers that must submit to a criminal background check, which shall include but not be limited to, individuals who provide direct personal care services to a participant and other non-vendored providers for whom a criminal background check is requested by a participant or his/her financial management service. The criminal background check includes a fingerprint requirement for all prospective providers. The cost of the background check is paid by the provider of services.

18. What happens to the individuals who are participating in the self- determination pilot programs?

Individuals receiving services and supports under the self-determination pilot projects can either continue to receive services and supports under the Self-Determination Program, or transition to the traditional model of providing services and supports within the regional center system.

19. What steps can I take if I disagree with a regional center's decision?

The Lanterman Act due process rights apply to self-determination participants. This means, for example, you will receive notice of the regional center finds you ineligible for self-determination or proposes to changes your budget. It also means that you can request a hearing if you disagree with a regional center decision such as your right to participate in self-determination or the amount of your budget.

20. How does the Self-Determination Program ensure transparency and accountability?

Each regional center is required to have a volunteer advisory committee; the majority of whose members are consumers and family members appointed by the regional center and the local Area Board. The clients' rights advocates are also part of the committee. The state Developmental Disability Council will also convene a statewide advisory committee to identify best practices, design effective training materials, and make recommendations for improvements in the Self-Determination Program. DDS is also required to collect and report outcome data to the Legislature as a means of ensuring transparency and accountability.

21. What can consumers and family members do now to learn more or help implement the statewide Self-Determination Program created by SB 468?

-- The Autism Society of Los Angeles plans to hold trainings and conferences as well as distribute materials so consumers and families can learn more. Check the Autism Society's website at www.autismla.org to learn more.

--If you are part of a self-advocacy group or family member groups, you ask your Clients' Rights Advocate or Area Board to do a training about self-determination for your group.

--Share information about self-determination with other consumers and families.

--At your next IPP meeting, ask your regional center to note on your IPP that you are interested in participating in self-determination.

--Volunteer to be on your regional center's advisory committee when it is formed, probably in 2015.

--DDS will obtain input from stakeholders in several areas including, informational materials, possible other budget methodologies and uniform budget categories, and may adopt regulations. You may want to look at DDS website, www.dds.ca.gov, to learn about opportunities to provide input.

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html.

Similarities and Differences between Traditional Regional Center Service Provision and the New Self-Determination Program

	Traditional Regional Center Service Provision	Self-Determination Program
Eligibility - Age	All ages	Over age of 3
Eligibility – Living Arrangement	All settings	Must live in community, Can use SDP in licensed long-term health facility if you are expected to move to the community within 90 days
Planning Process	Individual Program Plan (IPP) - Meeting where goals are established and services and supports are decided	Person Centered Plan (PCP) – A group of people focus on an individual and that person's vision of what they would like to do in the future. The IPP team shall use the Person Centered Planning process to develop the IPP
Frequency of planning process	IPP at least every three years, annually at most regional centers, or within 30 days of a request	PCP at least annually but as often as needed
Who decides what services I get?	Regional Center, but you can reject services	You, to meet the objectives in the IPP
Who pays the bills?	Regional Center	Financial Management Service
Do services have to be provided by vendors of the regional center?	Yes, except in very limited circumstances.	No

	Traditional Regional Center Service Provision	Self-Determination Program
Who finds the service providers?	Regional Center	You, Independent Facilitator, Financial Management Services, Friends, and Family
Does regional center monitor the quality of a service provider?	Yes	No
Are services that are available through generic agencies like school or Medi-Cal paid by regional center or thru my budget?	No	No
Can you change service providers?	Yes, if regional center agrees	Yes
Do I have appeal rights?	Yes	Yes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 11, 2015

Mari Cantwell, Chief Deputy Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

The state of California has requested a new Section 1915(c) home and community-based services (HCBS) waiver entitled *California Self Determination Program Waiver for Individuals with Developmental Disabilities*, CMS control number 1166.00. The proposed waiver seeks to provide home and community-based services to individuals who would otherwise require care at an intermediate care facility (ICF), and to allow participants the opportunity to accept greater control and responsibility regarding the delivery of needed services through enhanced self-direction.

Based on our review of the application and substantive correspondence over the past year between CMS and the state, we have concluded that we need the following additional information and edits made to the proposed waiver before the request can be approved.

CRITICAL RESOLUTION ISSUES

Appendix B: Participant Access and Eligibility

1. **B-3-f. Selection of Entrants to the waiver** - Please clarify if all eligible individuals are granted entrance into the waiver or indicate the process for the selection of entrants that is based on objective criteria and applied consistently in all geographic areas served by the waiver.

Appendix B: Evaluation/Reevaluation of Level of Care

2. **B-QIS, Sub-assurance (a)** - The proposed performance measure (PM) addresses only the percentage of enrollees who had a level of care determination before enrolling in the program; whereas the sub-assurance requires that all "applicants" be evaluated who have a reasonable indication that waiver services may be needed. Please revise or add a second PM to fully address the sub-assurance's requirement.

3. **B-QIS, Sub-assurance (c)** - The second proposed measure states "Number and percent of level of care determinations that were completed accurately" Please define "completed accurately" and revise the performance measure to reflect this.

4. **B-QIS, Remediation** - Are there any escalating consequences if issues occur repeatedly?

Appendix C-3: Waiver Services

5. For the following services, please add a statement to the service definition specifying that children under age 21 who need these services will receive them through the state plan per EPSDT requirements: home health aide services, Dental Services, Prescription Lens/Frames, Optometric/Optician Services, Psychology Services, Skilled Nursing, Speech, hearing and language, Integrative therapies.

6. **Waiver service qualifications** - For all provider types please clearly define the qualification. If a specific regulation or code applies, please include pertinent information regarding that particular citation or the areas the citation covers. If there is a license required please be more specific regarding the type of license needed.

7. **Verification entity** - FMS is not described in Appendix A as a contracted entity. Please explain why the state has specified the FMS as the verifying entity since this appears to be inconsistent with what is in Appendix A for this Medicaid administrative function.

8. **Frequency of Verification** - Please verify how each entity responsible for verification will do so "ongoing thereafter through the IPP process." Please define "ongoing" under frequency of verification. Please also spell out IPP in this instance.

9. **Behavioral Intervention Services - Habilitation Services** - This service should be categorized as an "other" service as it provides services outside the scope of Habilitation services.

10. **Home Health Aide Services** - Specify the additional services that are provided when the state plan benefit is exhausted. Please also specify the state plan service limit.

11. **Respite** - The state's service definition includes "regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver(s) are out of the home." Please clarify as to how this service will include activities that are beyond the scope of child care, and how this service is necessary to avoid institutionalization. Additionally, the state needs to specify the limits on these services since respite is a temporary service.

12. **Advocacy Services** - Is generic legal counsel provided in the state and if so by which entities? If the services are specific to legal counsel please indicate how this does not overlap with independent advocacy listed in Appendix E-1-k of the waiver application. If it is not specific to legal counsel please explain how this service is different than case management/service coordination or the Independent Facilitator services and how duplicate billing will not occur.

13. **Communication Support** - Please indicate how this is service is different than technology services and specialized medical equipment and supplies and how duplicate billing will not occur.

14. **Community Integration and Employment Supports**

a. Please separate these services into two separate waiver services. Please indicate how the community integration is different than community living supports services and how duplicate billing will not occur.
b. Please remove "College, including financial assistance with tuition, books, and other related fees" as the state cannot claim FFP for these services, and also subtract any estimated costs associated with this expense from the Factor D cost estimates in Appendix J.

15. **Community Living Supports** - Please describe how this service is different than other similar services such as homemaker services and community integration services, and what mechanisms the state will put in place to prevent duplicate billing.

16. **Crisis intervention and Support**
    a. Please describe how these services are different and not duplicative of the behavioral intervention services.
    b. Crisis Facility, Other standard- Please include in this section all types of 24 hour care services and not a reference to another service section.

17. **Dental Services** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

18. **Family Assistance and Supports** - Please further define the types of services and supports that would be provided under this service and how this service is different than Training and Counseling Services for Unpaid Caregivers and how duplicate billing will not occur.

19. **Financial Management Services**
    a. Please indicate why this service is listed as "other" instead of Supports for Participant Direction.
    b. Please define "as appropriate" under the provider qualification, license, business license.
    c. Are individuals who provide FMS allowed to provide any other (additional) waiver services to an individual participant?
    d. How many providers do you expect to enroll for this service and please explain how the state will oversee the performance of the FMS providers?

20. **Housing Access Supports** - Please indicate how this service will not duplicate case management, community integration, and advocacy services.

21. **Independent Facilitator**
    a. Please more clearly define this service. Please further explain how this service does not duplicate services provided by the service coordinator, advocacy services, or financial management services.
    b. How will these individuals be trained? How is the training different from that of service providers and/or financial management service coordinators?

c. 700 participants are estimated to use the service starting WY1, is there a workforce of already trained Independent Facilitators to provide services starting WY1?

22. **Individual Training and Education** - How will the state ensure this service is not duplicative of other waiver services? For example, employment related training appears duplicative of the employment supports waiver service. In addition, community integration, advocacy, and community living supports all have similar components.

23. **Integrative Therapies**
    a. Each service will need to be a separate service within the waiver.
    b. Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit. For massage therapy, please specify when this service would be needed and necessary for a waiver participant to live in the community.

24. **Prescription Lens/Frames** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

25. **Optometric/Optician Services** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

26. **Psychology Services** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

27. **Skilled Nursing** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

28. **Specialized Therapeutic Services** - Please remove this service from the waiver. This service is not available through a 1915(c) waiver.

29. **Speech, hearing and language** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

30. **Technology Services** - This service appears to overlap with PERS, communication support, specialized medical equipment and supplies. Please clarify how they are different and how duplicate billing will not occur. The state needs to also remove "but not limited to" from this waiver service definition and specify what can be covered since it is not permissible for the waiver service definition to be open-ended.

31. **Training and Counseling Services for Unpaid Caregivers** - Please explain how this service is not duplicative of family assistance and supports services.

32. **C-2-c-i: Types of facilities subject to 1616(e)** - Per the instructions in the Technical Guide please remove the information from this section.

33. **C-2-f: Open Enrollment of Providers** - Please describe the enrollment process that assures all willing and qualified providers have the opportunity to enroll.

34. **Qualified Providers, Sub-assurance (a)**
    a. Please explain why bi-annual reviews by DSS are of sufficient frequency to ensure licensed providers initially meet all required standards prior to furnishing waiver services.
    b. Regarding the second proposed PM, Please clarify what the review consists of. How will it help the state to ensure that providers are meeting required licensure and/or certification standards and adhering to other applicable standards?

35. **Qualified Providers-Sub-assurance (a) and Sub-assurance (b)** - Please clarify what is meant by "Representative Sample – 5."

36. **Qualified Providers-Sub-assurance (b)**
    a. The proposed PM only addresses providers who initially meet all required standards; however, the sub-assurance is not limited to initial adherence. Please either revise the proposed PM to indicate how providers continually meet all required standards, or add an additional PM that measures continuous monitoring of providers who do not require licensing or certification.
    b. Please explain why bi-annual reviews by DDS are of sufficient frequency to ensure non-licensed providers initially meet all required standards prior to furnishing waiver.

37. **Qualified Providers-Sub-assurance (c)**
    a. How does the State monitor the successful completion of 70 hours of competency based training?
    b. Are direct support professionals (DSPs) the only providers that must meet a training requirement? If not, please either revise the proposed PM to measure all provider training requirements or add an additional PM.
    c. A provider could potentially provide services for an extended period of time without having met training requirements. Please explain why 70 hours of competency based training within two years of hire is sufficient to assure that the provider training is conducted in accordance with state requirements and the approved waiver. How did the state arrive at 70 hours given training can vary for each participant?

38. **C-5: Home and Community-Based Settings**
    a. Please include a list of the specific settings where individuals will reside.
    b. Please include a list of specific settings where individuals will receive services.
    c. Please include a detailed description of the process the state Medicaid agency used to assess and determine that all waiver settings meet the HCB settings requirements.

d. Please include the process that the state Medicaid agency will use to ensure all settings will continue to meet the HCB settings requirements in the future.

Appendix D: Participant-Centered Planning and Service Delivery

39. D-1-d: Service Plan Development Process

a. Please describe as part of the planning process how participants are informed of services available under the waiver.
b. Please describe how responsibilities are assigned for implementing the plan.
c. Please describe how waiver and other services such as state plan services are coordinated.
d. Please identify who is assigned the responsibility to monitor and oversee the implementation of the service plan.

40. D-1-g: Process for Making Service Plan Subject to the Approval of the Medicaid Agency

a. Please provide the basis for the sample size of plans reviewed, how it is representative of the total population, and the review methodology.
b. Please include the frequency with which DHCS or DDS completes reviews of the plans.

41. D-2-a: Service Plan Implementation and Monitoring

a. Please clarify how monitoring methods address services furnished in accordance with the service plan, participant access to waiver services is identified in the plan, participants exercise free choice of provider, services meet the participants need, effectiveness of back up plans, participants health and welfare, and participants access to non-wavier services in service plan including health services.
b. Please clarify the method for prompt follow-up and remediation of identified problems.
c. Please clarify the methods used to compile systemic collection of information about monitoring results, and how problems identified during monitoring are reported to the state.

42. D-QIS, Service Plan

a. Please explain why bi-annual reviews by DDS are of sufficient frequency to ensure the service plans address all the participants' assessed needs and personal goals in sub-assurance a,c,d, and e.
b. Please clarify what is meant by "Representative Sample – 5 for sub-assurance a, c, d, and e.

43. D-QIS, Sub-assurance (a)

a. For each PM, please add the words "all of" after the word "addressed" in all instances.
b. How is it determined that the consumers' assessed needs are "adequately" addressed? Who makes this determination?

44. **D-QIS, Sub-assurance (c)** - Please clarify that the term "required intervals" means that service plans were updated/revised when warranted by changes in the waiver participant's needs.

45. **D-QIS, Sub-assurance (d)**
    a. How will the state determine whether participants have received the appropriate type, scope, amount, duration and frequency of services specified in the IPP?
    b. How does the state monitor/ensure that participants with similar needs (similar service plans) do not have drastically different budgets? How will the state monitor whether individual budgets are equitable?

46. **D-QIS, Sub-assurance (e)** - The proposed PM does not specifically measure whether participants are afforded a choice among services and providers. Please revise this PM to specifically address these issues.

Appendix E: Participant Direction of Services

47. **E-1-c: Availability of Participant Direction by Type of Living Arrangement** - Please specify/define "community living arrangement" where the state indicated participant direction is supported, including the size of the living arrangement.

48. **E-1-f: Participant Direction by a Representative** - Please describe the safeguards that ensure a non-legal representative functions in the best interest of the participant.

49. **E-1-i-i: Payment for FMS** - Please specify how the state will compensate the entities that provide FMS services. Per the HCBS Waiver Technical Guide examples could be a per transaction fee, a monthly fee per participant, a combination of both types of fees, or another method. The state indicates in response to this item in the waiver that FMS costs will be paid from the individual budget but that the individual budget will not be increased to include these costs. This is not permissible. The state may include the FMS waiver service costs in an individual budget but then must reflect and account for this is the individual budget methodology as described in Appendix E-2-b-ii.

50. **E-2-b-ii: Participant, Budget Authority** - Please specify and define "budget categories." Are there limits to and/or within budget categories? Per the previous comment, if the state intends to pay for waiver FMS costs from the individual budget, then the state needs to revise the budget methodology.

51. **E-2-b-ii: Participant Directed Budget** - Please describe how the budget methodology is made available to the public.

52. **E-2-a: Participant Employer Status** - What mechanism does the state have in place to ensure that individuals maintain authority and control over employees when co-employment is occurring.

53. **E-2-b-v: Expenditure Safeguards**
    a. Please describe the safeguards to address potential service delivery problems that may be associated with budget underutilization or premature depletion of the participant budget.

b. What is the state Medicaid agency's role in ensuring that potential budget problems are identified on a timely basis, including over-expenditures or underutilization?

Appendix F: Participant Rights

54. F-1-a: Opportunity to Request a Fair Hearing

a. Please specify who provides Fair Hearing information to the participant?
b. Please specify this information is also given to a participant at the time of their entrance into the waiver.
c. Please specify how notice is made and who is responsible for issuing the notice.
d. Please clarify what assistance, if any, is provided to the individual pursuing a fair hearing.
e. Please indicate where notices of adverse action and the opportunity to request fair hearings are kept.

Appendix G: Participant Safeguards

55. G-1-c: Participant Training and Education

a. What is the frequency of providing training and information?
b. Do the trainings provided by the regional centers to participants and informal caregivers include how to notify the appropriate authorities when the participant may have experienced abuse, neglect, or exploitation?

56. G-1-d: Responsibility for Review of and Response to Critical Events or Incidents

a. How do regional centers monitor special incident reporting for non-vendored providers?
b. Please specify who is responsible for an investigation, how investigations are conducted, and the timeframe for conducting and completing the investigation.
c. Please also indicate the timeframes for informing the participant, applicable representative, and other relevant parties, such as providers, of the investigation results.
d. What is the timeframe for reporting for non- vendored providers?
e. How are non vendored providers notified of SIR requirements?

57. G-2-a: Safeguards Concerning Restraints: Applicability: Restraints - The state selected that they will not permit the use of restraints but then indicated in the response that there are certain circumstances in which restraints may be used. Therefore, the state needs to revise the selected response that currently indicates that they do not permit the use of restraints, to "the use of restraints is permitted" and complete the required information for this section.

58. G-2-c: Seclusion - The state selected that they will not permit the use of seclusion but then indicated in the response that there are certain circumstances in which seclusion may be used. Therefore, the state needs to revise the selected response that currently indicates that they do not permit the use of seclusion, to "the use of seclusion is permitted" and complete the required information for this section. CMS notes that the use of seclusion must comport with the home and community-based setting requirements at Section 42 CFR 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR 44.301(c)(1) and (c)(2).

59. **G-3-b: Medication Management and Follow-up** - Please indicate the methods for conducting monitoring, how monitoring has been designed to detect potentially harmful practices, and follow-up to address such practices?

60. **G-3-b-ii: State Oversight and Follow-up** - What is the process to communicate information and findings from monitoring to the Medicaid Agency and operating agency regularly? What is the frequency state monitoring is performed?

61. **G-3-c-iii: Medication Error Reporting** - Please specify the types of medications errors that must be recorded and also those which must be reported.

62. **G-3-c-iv: State Oversight Responsibility** - Please specify the requested information in this section.

63. **QIS-G: Health and Welfare, Sub-assurance (a)** - This PM measures the timeliness of special incident reports and does not measure that the state, on an ongoing basis, addresses and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death. The state needs to develop additional PMs to measure all aspects of this sub-assurance. Also, special incident reports are not the only means of determining whether instances of abuse, neglect, etc. have occurred, as it is possible that some of these instances could go unreported. The state must develop other metrics by which to measure that all instances of abuse, neglect, exploitation and unexplained death are being identified, even if a special incident report has not been filed.

64. **QIS-G, Sub-assurance (b)** - What is the timeframe for appropriate actions to be taken? Please either modify or add PMs to measure that an incident management system is in place that effectively prevents further similar incidents to the extent possible.

65. **QIS-G, Sub-assurance (d)** - How is it determined that a consumer's special health care requirements or safety needs are met? One or more PMs should be added to measure compliance with the state's overall health care standards. The sub-assurance ties the monitoring of health care standards to the responsibilities of the service provider. Please add one or more PMs to measure provider adherence to the health care standards.

66. **Appendix H: Quality Improvement Strategy** - Please include how the QIS stratifies information for each respective waiver, include the control numbers of the other waivers, and provide the other long term care services addressed in the QIS.

Appendix I: Financial Accountability

67. **I-1: Financial Integrity and Accountability**
    a. What are the differences, if any, between the DDS fiscal audits every two years and their follow-up audits in alternate years or more frequently as needed?
    b. What determines if a follow-up audit is needed more frequently than in alternate years?
    c. Are all providers subject to annual onsite audits? If not, what percentage of individual and agency providers are audited on an annual basis and are they chosen by random sample?

d. Are some providers audited more frequently than others? If yes, why and how often are they audited?
e. How does the state recognize whether a provider is a certified biller or not?

68. I-2-a: Rate Methodology - Please describe how information about payment rates is made available to waiver participants.

69. I-2-a: Rate Methodology - Regarding the negotiation of rates between the waiver participant and the selected provider:

a. Please confirm that all waiver service rates are negotiated by participants. If any services are not negotiated by participants, please explain how rates for those services were developed.
    i. Would rates for expanded state plan services also be negotiated?
b. Are participants and providers given any guidance as to what an appropriate rate may be?
c. Is there any limit for what a participant can spend per unit of service?
d. Please describe state's oversight process of rate determination.
e. How does the state ensure that the negotiated rates are consistent with economy, efficiency and quality of care?
f. What role, if any, would the regional center play in setting the rate?
g. Please describe the parameters that would prevent a participant from varying from a reasonable rate.

70. I-2-d: Billing Validation Process

a. Does the state use patient surveys to validate post payment billings? If yes, please describe those methods. If not, describe what processes are in place to assure only proper payments are being made and that any payments for inappropriate billings are recouped.
b. How does DDS ensure that the services were provided?
c. How does DDS ensure that payments are not made for services when a participant is in a nursing facility?

71. QIS – I: Financial Accountability, Sub-assurance (a)

a. How does the State ensure that claims are paid only for services rendered?
b. How does the State ensure that claims are coded correctly?
c. How does the State ensure that services have been actually rendered before they are paid?
d. Please explain why bi-annual reviews are of sufficient frequency to assure the service plans address all the participants' assessed needs and personal goals. Please clarify what the sampling approach is, since the state indicated that less than 100% of the claims will be reviewed.

72. QIS-I, Sub-assurance (b)

a. Please clarify how the approved service rate is assured to be developed consistent with the approved rate methodology.
b. Please clarify what the sampling approach is, since the state indicated that less than 100% of the claims will be reviewed.

Appendix J: Cost Neutrality Demonstration

73. J-2-c: Development of Factor D

a. Please describe how the per capita cost, by service, was trended forward to the number of persons who will be served during years 1 through 3.
b. What is the basis for the estimates of 1,000 and 2,500 for the number of eligible recipients?
c. Please clarify whether the Average Length of Stay units noted in each waiver year represent months or days. If the units are months, please update the waiver to have the Average Length of Stay measured in days.
d. Please confirm the source of the data used to create the Factor D estimates.
e. What analysis was done to ensure that this data was appropriate to use for the projections of this waiver?
f. Were any adjustments made to the data before developing projections for this waiver?
g. Please clarify why Therapeutic/Activity-Based Day Services (Hour) rate is $40 while Therapeutic/Activity-Based Day Services (Month) rate is $50.
h. What history led to the estimate for Technology services?

74. J-2-c: Development of Factors D', G and G'

a. Please confirm that the state has accounted for and removed the costs of prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.
b. Please confirm the source of the data used to create the estimates for each of these factors.
c. What analysis was done to ensure that this data was appropriate to use for the projections of this waiver?
d. Were any adjustments made to the data before developing projections for this waiver?

ISSUES THAT NEED FURTHER CLARIFICATION OR CORRECTION

1. **Overall Questions about the Waiver**
   a. What is the anticipated impact of this new waiver on DD waiver enrollment?
   b. A number of services are not available in the current DD waiver; will the DD waiver be updated at renewal or through amendment to mirror services under the SDP?
   c. How will the Waiver Monitoring Process for the SDP waiver be integrated into the existing HCBS Biennial Collaborative Review Process?

2. **Main 6-I: Public Input** - We note that individuals and organizations made comment during the public input period. Please include in this section all the methods and details of how people were able to make public comment.

3. **Appendix A-2-b** - When was the Interagency Agreement (IA) between the State Medicaid Agency and DDS last updated? How frequently is the IA updated? Please provide CMS with the link or a copy of the IA.

4. **B-1-b: Additional Criteria** - When selecting the first option in E-1-d: Election of Participant Direction, this section must specify that the waiver is limited to individuals who want to direct some or all of their services.

5. **B-3-f: Selection of Entrants to the waiver**
    a. How are informational meetings about the SDP being publicized?
    b. How often will the SDP orientation be offered?
    c. How does an individual let their regional center know that they are interested in enrollment?
    d. How is this documented at the regional center?
    e. If there is going to be an interest list or wait list please describe this process?

6. **B-4-b: Medicaid Eligibility Groups Served in the Waiver** - Since the 1931 group has been separated into three distinct eligibility groups; other caretaker relative specified at 435.110, pregnant women specified at 435.116 and children specified at 435.118, the state should remove the check mark from the 1931 group in Appendix B-4-b. No other changes are necessary, since the state has included all other mandatory and optional groups covered under its state pan under the waiver request.

7. **B-6-i: Procedures to Ensure Timely Re-Evaluations** - Please include all pertinent information regarding the procedures used to ensure that re-evaluation will be performed on a timely basis.

C-1- Waiver services

8. **Taxonomy code**- CMS would encourage the state to use the taxonomy codes for the services section.

9. **Participant- Directed Goods and Services** - Please indicate in the definition that the participant directed goods and services must be documented in the service plan and are purchased from the participant directed budget. Also please include that experimental or prohibited treatments are excluded.

10. **Transition/ Set up Expenses** - Please indicate the amount in the amount section if there is a limit for these services.

11. **Transportation** - How will the state determine when the use of natural supports, such as family, neighbors, friends, have been exhausted and services begin?

12. **Vehicle Modifications** - Please add the assurance in the waiver service definition that the vehicle may be owned by the individual or family member with whom the individual lives or has consistent and ongoing contact, who provides primary long term support to the individual and is not a paid provider of such services.
    Please also include any cost limits in the limits sections associated with this service.

13. **C-2-a: Criminal History/Background Investigations**
    a. Please define "other services and supports" in reference to providers who may need to obtain a criminal background check.

b. What is the state's process to ensure that mandatory background investigations have been conducted?
c. Please describe the scope of the investigation.
d. How will the state ensure that they have been conducted in accordance with the state's policies?

14. **C-2-c-ii: Larger Facilities** - Please remove N/A and insert "required information is contained in response to C-5."

15. **I-2-a: Rate Methodology** - Please describe the process used for public input in this section.

Under Section 1915(f)(2) of the Social Security Act, a waiver request must be approved, denied, or additional information requested within 90 days of receipt, or the request will be deemed granted. The 90-day period for this waiver request ends on December 28, 2015. These questions constitute a formal RAI, after which a new 90-day period will begin upon the State's re-submission of a revised waiver application, via the web-based Waiver Management System (https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp). Please refer to CMS control number CA 1166.00 in all future correspondence regarding this waiver.

In addition to re-submitting the waiver application, the state should also send a formal written response to these questions to Amanda Hill in Central Office with a copy to Adrienne Hall in the San Francisco Regional Office (Amanda.Hill@cms.hhs.gov; Adrienne.Hall@cms.hhs.gov). For assistance or information regarding this RAI, please contact Amanda Hill at (410) 786-2457 or Adrienne Hall at (415) 744-3674. Thank you for your prompt attention. We look forward to continuing to work with the state officials to move towards implementation of this new waiver.

Sincerely,

/s/

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Rebecca Schupp, Chief, Long-Term Care Division, DHCS
Jalal Haddad, Long-Term Care Division, DHCS
Amanda Hill, CMS, CMCS

Self-Determination Program Enrollment

During the first three years of the Self-Determination Program, enrollment is limited to 2,500 people. To help ensure the selection of the 2,500 participants is equitable, the following process was developed by the Self-Determination advisory group.

What does someone need to do to be considered for enrollment?

1. ***Participate in an informational meeting at your regional center.*** It's important to hear, in greater detail, information about the Self-Determination Program. At this meeting, people will learn not only about the opportunities but also the increased responsibilities involved in accepting more control over coordinating their services. Understanding this information will help people decide if the Self-Determination Program might be a good option for them.

2. ***After participating in the informational meeting, let the regional center know you're interested in enrolling in the Self-Determination Program.*** After you have participated in the informational meeting and you think that Self-Determination is a good option for you or your family member, you must let the regional center know you're interested in enrolling in the Self-Determination Program. As discussed below, this does not guarantee you will be selected as part of the first 2,500 participants.

What happens after someone participates in the informational meeting and lets the regional center know they're interested?

1. ***Regional centers send names of those interested to the Department of Developmental Services (DDS).*** Only those consumers/ family members who have participated in an informational meeting will be eligible for enrollment in the Self-Determination program.

2. ***DDS will send confirmation to those whose names were forwarded by the regional centers.***

3. ***DDS will randomly select the first 2,500 enrollees from among those who have attended an informational meeting.*** This selection will be done from the names of those received by DDS from the regional centers. The selection takes into consideration the following factors to ensure those selected are representative of the statewide regional center population:
   - Regional Center
   - Ethnicity
   - Age
   - Gender
   - Disability diagnosis

4. ***Those selected can enroll in the Self-Determination Program.*** The enrollment will be done through the regional centers who will work with each participant to enroll in orientation, establish an individual budget, etc.

5. ***If not selected initially, consumers will remain on the interest list for future enrollment opportunities.***

Tri-Counties Regional Center

WHAT'S HAPPENING WITH SELF-DETERMINATION AT TCRC?

The Five Principles of Self Determination

- **Freedom** to exercise the same rights as all citizens; to establish, with freely chosen supports, family and friends, where they want to live, with whom they want to live, how their time will be occupied, and who supports them;
- **Authority** to control a budget in order to purchase services and supports of their choosing;
- **Support**, including the ability to arrange resources and personnel, which will allow flexibility to live in the community of their choice;
- **Responsibility**, which includes the opportunity to take responsibility for making decisions in their own lives and accept a valued role in their community;
- **Confirmation** in making decisions in their own lives by designing and operating the service that they rely on.

From the Law

Section 4685.8, SB 496

"The Self-Determination Program (SDP) is a voluntary delivery system consisting of a mix of services and supports, selected and directed by a participant through person-centered planning, in order to meet the objectives in his or her Individual Program Plan (IPP). Self-determination services and supports are designed to assist the participant to achieve personally defined outcomes in community settings that promote inclusion, and allow participants to have more control in developing service plans and selecting service providers."

What is Self-Determination? The Self-Determination Program (SDP) is a voluntary alternative to the traditional way of providing regional center services, including greater control of individualized budget.

Who is Eligible?

People served by TCRC

- Over age 3
- Who live at home or in the community
- Who are in the process of moving into the community

Must be willing to get training and follow the program's rules

When Will Self-Determination Start?

This program starts when it's approved for Federal Funding.

- 2,500 people across the state can join during the first 3 years.
- Then the program will be available to all those served by the regional center.
- TCRC has been approved to enroll 114 participants during the first three years.

How do I Enroll?

1. Participate in the Pre-Enrollment Informational Meeting
2. Confirm you're still interested
3. TCRC will send your name to the Department of Developmental Services (DDS) to be put through the selection process. DDS will select the initial 114 participants (16 current and 98 new) for TCRC.

Interested?

A **Self-Determination Pre-Enrollment Informational Meeting** will be held. Get added to our "Interest List". Email **self-determination@tricounties.org**, call (805) 288-2500 or contact your Service Coordinator. Visit www.tri-counties.org, click on "newsletter" to the right, join our list, check the box next to Self-Determination.

DDS's "Interest List"

To self-identify as an interested party with DDS and receive updates on Self-Determination, email DDS at sdp@dds.ca.gov. Give DDS:

1. Your name
2. Name of the person interested
3. Your regional center

Join our Meeting!

Tri-Counties Self-Determination Advisory Committee meetings are held quarterly. Our next meeting will be on July 26, 2016 in the Santa Barbara Annex at 5:30. If attending the meeting in SB, please RSVP. Telephone conferencing is also available. Visit our website for details. **www.tri-counties.org**

TCRC SELF DETERMINATION ADVISORY COMMITTEE

2017 CALENDAR

JUNE 27, 2017

Santa Barbara Office Annex Room

5:30 p.m. Light Dinner

6:00 p.m. Self Determination Committee Meeting

JULY 25, 2017

Santa Barbara Office Annex Room

5:30 p.m. Light Dinner

6:00 p.m. Self Determination Committee Meeting

OCTOBER 24, 2017

Santa Barbara Office Annex Room

5:30 p.m. Light Dinner

6:00 p.m. Self Determination Committee Meeting