EXECUTIVE DIRECTOR REPORT

March 8, 2014

I. FY 2014-2015 BUDGET UPDATE

- **Attachment #1:** FY 2014-2015 Governor's Budget Highlights for Department of Developmental Services
- **Attachment #2:** ARCA Analysis of FY 2014-2015 Governor's Budget Proposal
- **Attachment #3:** Annual Budget Process Flow Chart
- **Attachment #4:** ARCA Early Start Advocacy Day
- **Attachment #5:** ARCA Report on the Regional Center POS Budget: Inadequate Rates for Service Provision in California
- **Attachment #6:** ARCA Report on the Regional Center OPS Budget: Funding the Work of California's Regional Centers

Governor Brown issued his official annual State Budget Proposal on January 9, 2014. After almost a decade of ongoing reductions, the Governor's FY 2014-2015 State Budget Proposal for a second consecutive year, does not call for any new reductions to the Developmental Services budget. While the Governor's proposed budget is a status quo budget compared to current FY 2013-2014, it provides a $110.1 million increase in funding for the minimum wage increase per AB 10 that affects community care facilities, day program services, habilitation services, respite services, supported living services and transportation. The Governor's Budget also provides an additional $7.5 million increase to fund the changes in the Fair Labor Standards Act regulations regarding the payment of overtime by service providers who were previously not required to pay overtime. Given the number of persons served by the regional center system is expected to grow to 273,643 persons, an increase of 7,934 persons over current FY 2013-2014, the Governor's budget provides $121.1 million increase for caseload and utilization growth. In total, the regional center Purchase of Service (POS) budget is provided with a $235.6 million increase (6.2% increase) over current FY 2013-2014 budget and the regional

center Operations budget (OPS) is provided with a $15.4 million increase over current FY 2013-2014 budget (2.7% increase). **(Attachments #1-#2).**

Budget hearings in Sacramento by the Legislature are scheduled to take place on March 19 for the Assembly Budget Subcommittee No. 1 on Health and Human Services and on March 27 for the Senate Budget and Fiscal Review Subcommittee No. 3 **(Attachment #3).** ARCA will be representing the regional centers at these hearings and will be advocating for restoration of some regional center services for which funding has been significantly reduced or eliminated during the past several years. There will be a particular focus on advocacy to restore Early Start services in FY 2014-2015 **(Attachment #4).** ARCA will also be advocating for restoring some of the numerous reductions that have occurred over the past several years to the regional center OPS budget. ARCA has developed two reports, one on the regional center POS budget entitled "Inadequate Rates for Service Provision in California" and the other on the regional center OPS budget entitled " Funding the Work of California's Regional Centers" that will be used in budget discussions this legislative session **(Attachment #5-#6).**

Tri-Counties Regional Center (TCRC) has also developed a "Budget Watch" page on the TCRC website (www.tri-counties.org). Current information and resources related to the budget is posted on this page.

II. LEGISLATION

- **Attachment #7:** SB 367 (Block): Regional Center Board of Directors Cultural and Linguistic Competency

- **Attachment #8:** AB 1595 (Chesbro): State Council on Developmental Disabilities

SB 367 (Block) has amended Section 4622 of the Lanterman Act pertaining to regional center governing boards to require training for board members on issues relating to linguistic and cultural competency, post these trainings on the regional center website and require regional center board of directors to annually review the performance of the regional center in providing services that are linguistically and culturally appropriate. The ARCA Training Coordinators Group will be working with the regional centers to determine how these new requirements may be implemented in a uniform manner across the twenty-one regional centers **(Attachment #7).**

AB 1595 (Chesbro) is a bill that would address statutory concerns raised by the Federal Administration on Intellectual and Developmental Disabilities (AIDD) regarding the structure and function of the California State Council on Developmental Disabilities (SCDD) and its 13 Area Boards. In November 2013 the

AIDD sent a letter to the SCDD indicating that its 2014 grant award was classified as "high risk" for a number of reasons. SCDD will be accepting public comment at their meeting on March 20 on the Proposed Legislative Concepts document which outlines the significant changes that are anticipated to be incorporated into the bill's language in the near future **(Attachment #8)**. The changes include:

- Area Boards are State Council Regional Offices whose governing boards will be changed to State Council Regional Advisory Committees
- The State Council has full authority to decide how to spend its money, including on regional offices or deputy director positions
- The Governor will have full authority to appoint members of the State Council and they no longer have to be recommended by an Area Board
- State Council members can stay until their replacement is appointed and the Council is to communicate with the Governor's office more effectively about vacancies
- The State Council must have at least one individual representing each Regional Office area
- The State Council Executive Director can hire all staff independent of the Governor's office or board recommendations including Executive Directors of the State Council's Regional Offices.

III. THE WAY FORWARD UPDATE

The Southern California Conference of Regional Center Directors (SCCRCD) have initiated a dialogue among member Regional Center Executive Directors, Board Presidents and Association of Regional Center Agencies (ARCA) Board delegates on the future direction of the community based developmental disabilities service system. Several Northern California regional centers have also joined the SCCRCD with this effort.

Numerous external forces including chronic and recurring budget reductions have imposed dozens of new changes through Trailer Bills since 2009 impacting every provision of service offered by regional centers. As the gap between expectations and financial support widens accompanied with continued "tinkering" with the system, it appears that the community based services system may be on the wrong path not only unable to effectively address budgetary challenges, but may also result in a system that is unable to carry out its mission of meeting the needs of persons with developmental disabilities and their families as outlined in the Lanterman Act. Regional centers must be willing to take risks, hear the critics, and be open to change

and innovation while all stakeholders must recognize the limitations on public funds and the implications of these limitations on provision of services.

In an attempt to respond proactively and more strategically to these pressures, the SCCRCD has used surveys, numerous focus groups with persons with developmental disabilities, interviews with experts nationwide and will be using an upcoming invite only conference to gather input and develop a set of recommendations in the form of a "white paper" to guide the system into the future. The conference is scheduled to take place on April 3-4, 2014 in Southern California and will have six representatives from each of the twenty-one regional centers comprised of the regional center Executive Director, one senior staff, a Board of Directors member, a parent of a person with developmental disabilities , a person served by the regional center and a regional center service provider. Numerous state and nationally recognized speakers have been invited to participate and help the Way Forward Group develop a set of recommendations for the future of the developmental services system in California. TCRC is in the process of identifying the delegation from TCRC that will be participating in this event.

IV. Q&A

Attachment #1

Department of Developmental Services

Governor's Budget Highlights

Edmund G. Brown Jr.
Governor
State of California

Diana S. Dooley
Secretary
California Health and Human Services Agency

Mark Hutchinson
Chief Deputy Director
Department of Developmental Services

January 2014

DEPARTMENT OF DEVELOPMENTAL SERVICES
GOVERNOR'S BUDGET HIGHLIGHTS

PROGRAM HIGHLIGHTS

The Department of Developmental Services (the Department) is currently responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring that approximately 267,042 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 in two ways: the vast majority of people live in their families' homes or other community settings and receive state-funded services that are coordinated by one of 21 non-profit corporations known as regional centers. A small number of individuals live in four state-operated developmental centers and one state-operated community facility. The number of consumers with developmental disabilities in the community served by regional centers is expected to increase from 265,709 in the current year to 273,643 in Fiscal Year (FY) 2014-15. The number of individuals living in state-operated residential facilities will is expected to be 1,049.

The January 2014 Governor's Budget includes $5.2 billion total funds ($2.9 billion GF) for the Department in 2014-15; a net increase of $221.8 million above the updated 2013-14 budget, a 4.5 percent increase.

COMMUNITY SERVICES PROGRAM

2013-14

To provide services and support to 265,709 persons with developmental disabilities in the community, the Governor's Budget updates FY 2013-14 funding to $4.4 billion total funds ($2.5 billion GF). The Governor's Budget includes an increase of $4.5 million total funds (-$6.3 million GF decrease) for regional center operations (OPS) and purchase of services (POS). This is composed of:

Caseload and Utilization

$2.4 million increase (-$8.4 million GF decrease) in regional center OPS and POS costs to reflect caseload and utilization due to updated popoulation and expenditure data including Home and Community Based Services (HCBS) waiver enrollment above budgeted levels.

Regional Center Operations Adjustment

$2.1 million increase GF in OPS to reflect an adjustment to correct the double counting of savings related to the 2009-10 Early Start Eligibility savings proposal.

2014-15

The Governor's Budget projects the total community caseload at 273,643, as of January 31, 2015, and assumes an increase of 7,934 consumers over the updated 2013-14 caseload. The estimate proposes 2014-15 funding for services and support to persons with developmental disabilities in the community at $4.6 billion total funds ($2.6 billion GF), an increase of $255.3 million ($155.3 million GF) over the enacted 2013-14 budget. The regional center budget changes include:

Caseload and Utilization

$138.6 million increase ($82.9 million GF) in regional center OPS and POS to reflect caseload and utilization due to updated population and expenditure data including HCBS Waiver enrollment above budgeted levels.

Regional Center Operations Adjustment

$2.1 million increase GF in OPS to reflect an adjustment to correct the double counting of savings related to the 2009-10 Early Start Eligibility savings proposal.

Impacts from Other Departments

-$3.1 million GF decrease in POS to reflect the Department of Health Care Services restoration of Enteral Nutrition and partial restoration of Adult Dental Services as a Medi-Cal Optional Benefit.

Minimum Wage Increase

Assembly Bill (AB) 10, Chapter 351, Statutes of 2013 which increases the minimum wage from $8.00 to $9.00 effective July 1, 2014:

- $0.1 million ($0.1 million GF) increase in OPS due to the minimum wage increase will impact positions in regional center Core Staffing that are budgeted at salary levels that are below $9.00; and

- $110.1 million ($69.3 million GF) increase in POS applies to services which rely on employees that are paid minimum wage.

Federal Overtime Change

$7.5 million ($4.0 million GF) increase in POS to reflect the impact of regulatory changes in the United States Department of Labor Fair Labor Standards to include overtime compensation for service providers that previously were not required to pay overtime effective, January 1, 2015.

DEVELOPMENTAL CENTERS PROGRAM

2013-14

To provide services and support for 1,333 residents in developmental centers (average in-center population) the Governor's Budget updates FY 2013-14 funding to $556.0 million ($305.2 million GF), an increase of $13.0 million ($7.5 million GF) over the FY 2013-14 enacted budget. Authorized positions net increase is 106.5. The developmental center budget changes include:

Employee Compensation Changes and Statewide Fleet Reduction

Net increase of $6.4 million ($4.0 million GF) due to employee compensation increases approved through the collective bargaining process, changes in retirement contribution rates, and savings from Executive Order B-2-11 Fleet Reduction.

Sonoma DC Program Improvement Plan

$7.2 million ($3.9 million GF) and 118.5 position increase for partial year cost for additional staff, training, overtime for training, vehicles and opening an additional Intermediate Care Facility Unit at Sonoma DC to support implementation of the facility's Program Improvement Plan (PIP) with the California Department of Public Health and Federal Centers for Medicare and Medicaid Services.

Lanterman DC Reduction for Decline in Land Use

-$0.5 million (-$0.3 million GF) and -12 position reduction primarily from the decline in land use and square footage at Lanterman DC in preparation for closure December 31, 2014.

Reduction in the Lottery Education Funds

-$62,000 decrease due to a reduction in the Lottery Education Funds.

2014-15

For FY 2014-15, the Governor's Budget provides services and support for 1,110 residents (average in-center population) in developmental centers, a decrease of 223 residents (including all residents from Lanterman DC with a closure date of December 31, 2014) from the 2013-14 enacted budget. Funding decreased to $526.0 million ($275.0 million GF); a decrease of -$16.9 million (-$23.1 million GF). Authorized positions decreased to 4,464.5; a decrease of 339.5 positions below the enacted budget. By the end of the budget year, there is expected to be 1,049 individuals residing in the state operated facilities. DC costs are also adjusted for Lanterman DC closure activities that will continue after closure. Adjustments to the enacted budget for the developmental centers include:

Employee Compensation Changes and Statewide Fleet Reduction

Net increase of $6.9 million ($4.3 million GF) due to employee compensation increases approved through the collective bargaining process, changes in retirement contribution rates, and savings from Executive Order B-2-11 Fleet Reduction.

Sonoma DC Program Improvement Plan

$9.2 million ($5.1 GF) and 118.5 position increase for continuing costs into 2014-15 at Sonoma DC for the PIP to ensure the facility is in compliance with federal and state licensing and certification requirements.

DC Population Decrease Staffing Adjustments (Excluding Lanterman)

-$12.8 million (-$7.2 GF) decrease for population staffing adjustments at the DCs for Level of Care (LOC) 114.0 and Non-Level of Care (NLOC) 55.0 (excluding Lanterman DC).

Lease Revenue Debt Service Adjustment

$2.8 million ($2.8 GF) increase due to Control Section 4.30 for an adjustment to the Lease Revenue Debt Service.

Restoration of Federal Reimbursements at Sonoma DC

$15.7 million funding shift from general fund to reimbursement to eliminate the GF backfill in 2013-14 for the four Sonoma ICF units withdrawn from the Medicaid Provider Agreement to ensure continued federal funding for the remaining six ICF units.

Reduction in the Lottery Education Funds

-$62,000 decrease due to a reduction in the Lottery Education Funds.

Foster Grandparents Program Funding Transfer

-$0.3 million (-$0.2 GF) decrease to transfer funding from Foster Grandparents Program to Community Services.

Lanterman Closure Activities

Net decrease of -$22.7 million (-$12.0 GF) for Lanterman closure activities as detailed below.

LANTERMAN DEVELOPMENTAL CENTER CLOSURE UPDATE

The Governor's Budget continues to support Developmental Center and Community efforts towards closure of the Lanterman facility on December 31, 2014. The Department, working with regional centers, anticipates the transition of approximately 120 Lanterman DC residents in FY 2013-14. The Governor's Budget anticipates the transition of another 22 residents to community living arrangements in FY 2014-15 with the anticipated resident population being zero on December 31, 2014, with the closure of the facility.

The Governor's Budget reflects a net decrease in 2014-15 of -$22.7 million (-$12.0 million GF) for position reductions due to the Lanterman DC closure, staff separation costs, enhanced staffing adjustments, and post-closure activities. The reduced funding is the net of the following adjustments:

- -$33.7 million (-$18.5 GF) decrease and -317.0 position reduction with the anticipated residential population being zero on December 31, 2014;
- $11.8 million ($6.4 GF) increase to support numerous activities with the closure of the facility and separation of staff;
- -$2.3 million (-$1.2 GF) and -40.0 positions reduction of Enhanced Staff that are no longer needed for closure related activities beginning July 1, 2014;
- -$2.0 million (-$1.1 GF) reduction of half year funding for the remaining 48.0 Enhanced Staff Positions to support costs during the closure period of July 1, 2014 through December 31, 2014; and
- $3.5 ($2.4 GF) and 68.0 position increase for post-closure related activities. This funding is for the period from January 1, 2014 through June 30, 2014.

The Lanterman Closure Update Report and closure milestones will be released separately.

SPECIAL REPAIRS

The Budget provides $100 million in a statewide item to various state agencies to address critical infrastructure deferred maintenance needs. Of this amount $10 million will be allocated to the Department for critical deferred maintenance projects at the DCs.

CAPITAL OUTLAY

The 2014-15 Governor's Budget does not include any new Capital Outlay requests.

HEADQUARTERS

2013-14

The Governor's Budget for FY 2013-14 updates funding for Headquarters' operations to $40.0 million ($25.3 million GF), an increase of $0.48 million ($0.33 million GF) compared to the FY 2013-14 enacted budget. The Headquarters budget increase is due to employee compensation increases approved through the collective bargaining process and changes in retirement contribution rates.

2014-15

The Governor's Budget proposes Headquarters operations funding for FY 2014-15 of $40.7 million ($25.9 million GF), an increase of $1.4 million ($.9 million GF) compared to the FY 2013-14 enacted budget. The Headquarters budget increase is composed of the following:

- $.5 million ($.3 GF) increase due to employee compensation increases approved through the collective bargaining process and changes in retirement contribution rates.

- $0.9 million ($0.6 GF) increase due to the *Vendor Audit Positions* Budget Change Proposal (BCP) that requests 7.0 limited-term auditor positions to assist with the increased demand for vendor audits and the associated recovery of funds from reduced vendor fraud, waste, and abuse.

- Conversion of 1.0 limited-term Career Executive Assignment, Assistant Deputy Director position to 1.0 permanent full-time in the Office of Federal Programs and Fiscal Support, Community Services Division, at no additional costs.

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ASSOCIATION OF REGIONAL CENTER AGENCIES
ANALYSIS OF THE FY 2014-15 NOVEMBER ESTIMATE
(GOVERNOR'S BUDGET)
JANUARY 10, 2014

FY 2013-14 (Current Year)

1. CASELOAD

The FY 2013-14 May Revision estimated the regional center Community Caseload to be 265,097 consumers for January 31, 2014. The November Estimate increases the January 31, 2014 caseload to 265,709, an increase of 612 consumers (a 0.2% increase).

2. PURCHASE OF SERVICE - $ 2.6 million Increase (0.07% Increase)

$ 2.6 million increase to Purchase of Services due to updated caseload and expenditure data.

3. OPERATIONS - $1.7 Million Increase (0.6% Increase)

- $1.0 million decrease to reflect updated caseload data and correct calculation of Account Clerks:
  - $1.2 million increase in the Core Staffing schedule due increase caseload.
  - $2.2 million decrease in the Core Staffing schedule to correct the number of Account Clerks originally budgeted. Due to electronic billing the ratio of Account Clerks to total consumers in the Core Staffing Formula dropped from 1:600 to 1:800. However, in the May Revision for FY 2013-14 the Accounts Clerks were erroneously calculated at the old 1:600 ratio.

- $2.1 million increase to correct the double counting of savings related to the 2009-10 Early Start Eligibility savings proposal.

- $508,000 increase in case managers to meet HCBS waiver requirements to reflect updated caseload data.

- $140,000 increase to reflect updated costs for various projects.

FY 2014-15 (Budget Year)

1. CASELOAD

The budget anticipates an increase of 7,934 consumers (a 3.0% increase) over the 265,709 consumers projected for January 31, 2014.

2. PURCHASE OF SERVICE - $235.6 Million Increase (6.2% Increase)

- $121.1 million increase over current fiscal year for caseload and utilization growth.
- $3.1 million decrease due to the restoration of Medi-Cal benefits for Enteral Nutrition and some Adult Dental services.
- $110.1 million increase for the minimum wage increase per AB 10. The affected services are community care facilities, day program services, habilitation services, respite services, supported living services, and transportation.
- $7.5 million increase to fund the changes in the Fair Labor Standards Act regulations regarding the payment of overtime by service providers that previously were not required to pay overtime.

3. OPERATIONS – $15.4 Million Increase Over Current Year (2.7% Increase)

- $14.7 million increase in Staffing due to the projected increase in caseload.
- $17,000 increase in case managers to meet HCBS waiver requirements to reflect updated caseload data.
- $343,000 increase in the Foster Grandparent Program.
- $160,000 increase in Special Projects for the Client's Rights Advocacy contract due to increased caseload numbers.
- $136,000 increase for the minimum wage increase per AB 10.

Future Fiscal Issues

DDS listed two future fiscal issues which could have an impact on regional center costs. These are:

1. Change of Rates for Some ICFs

On February 27, 2013, the Centers for Medicare and Medicaid Services (CMS) approved a state plan amendment submitted by the Department of Health Care Services (DHCS), changing the rate setting methodology for Intermediate Care Facilities (ICFs). Applying this new methodology, DHCS estimates that 36% of ICFs may be subject to a rate reduction of up to 10%, retroactive to August 1, 2012. Stakeholders have expressed concern, both prior to and after CMS' approval that enacting this change would result in some ICFs closing because the providers could not absorb a reduction in rates that have been frozen since 2008. Other residential options (e.g. a different ICF or a regional center funded setting) would be necessary for the individuals residing in any ICFs that decide to no longer offer ICF services. Since ICFs are funded by Medi-Cal, any movement of individuals from an ICF to a regional center funded residential setting will result in increased costs to the Department of Developmental Services (DDS). The number of ICFs that may cease operation and the resulting fiscal impact has not been determined. DDS, in conjunction with DHCS, will continue to monitor the outcome of the application of the new rate setting methodology.

2. Patient Protection and Affordable Care Act (PPACA) – Employer Mandate

A key reform of the healthcare system included in the PPACA is the requirement that many businesses that do not currently offer insurance to employees make healthcare coverage available or pay a fine to cover the cost of the coverage through the new health exchange. In addition, the health insurance must meet the requirements for a qualified health plan.

Effective January 1, 2015, service providers with 50 or more full time employees will need to provide health insurance that meets the requirements of a qualified healthcare plan or pay a fine. While some service providers already provide health insurance for their employees that meet these requirements, provision of this type of coverage is not a DDS mandated cost. Therefore, for those service providers affected by this requirement that do not provide health insurance for their employees, it is likely DDS will receive requests for rate increases if the new requirements result in an increase in costs. These requests could include a rate adjustment for unanticipated costs (permissible for some cost statement based rates such as day programs) or health and safety requests.

ASSOCIATION OF REGIONAL CENTER AGENCIES
ANALYSIS OF NOVEMBER ESTIMATE FOR FISCAL YEAR 2014-15
JANUARY 12, 2014

PURCHASE OF SERVICE BUDGET

	Purchase of Service	Quality Assurance Fees	Total POS
FY 2013-14 Enacted Budget	**$3,790,330,000**	**$9,424,000**	**$3,799,754,000**
Update of Caseload, Utilization, and Expenditure Data	$2,553,000		$2,553,000
Updated FY 2013-14 Budget	**$3,792,883,000**	**$9,424,000**	**$3,802,307,000**
Update of Caseload, Utilization, and Expenditure Data	$121,146,000	$0	$121,146,000
Restoration of Medi-Cal Benefits for Enteral Nutrition and Some Adult Dental Services	($3,133,000)		($3,133,000)
AB 10 Minimum Wage Increase	$110,054,000		$110,054,000
Federal Labor regulations Change	$7,500,000		$7,500,000
Proposed FY 2014-15 Budget	**$4,028,450,000**	**$9,424,000**	**$4,037,874,000**

REGIONAL CENTER OPERATIONS BUDGET

	Operations	ICF-DD Administrative Fees	Total Operations
FY 2013-14 Enacted Budget	**$560,314,000**	**$1,745,000**	**$562,059,000**
Caseload and Expenditure Update	($403,000)		($403,000)
Adjustment to FY 2009-10 Savings from Early Start Eligibility Savings Proposal to Eliminate Double Counting of Certain Savings	$2,145,000		$2,145,000
Updated FY 2013-14 Budget	**$562,056,000**	**$1,745,000**	**$563,801,000**
Caseload and Expenditure Update	$15,246,000		$15,246,000
AB 10 Minimum Wage Increase	$136,000		$136,000
Proposed FY 2014-15 Budget	**$577,438,000**	**$1,745,000**	**$579,183,000**

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THE ANNUAL BUDGET PROCESS

Departments review expenditure plans and annually prepare baseline budgets to maintain existing level of services; they may prepare Budget Change Proposals (BCPs) to change levels of service.

Department of Finance (Finance) analyzes the baseline budget and BCPs, focusing on the fiscal impact of the proposals and consistency with the policy priorities/direction of the Governor. Finance estimates revenues and prepares a balanced expenditure plan for the Governor's approval. The Governor's Budget is released to the Legislature by January 10th of each year.

Governor issues State of the State Address setting forth policy goals for the upcoming fiscal year. Two identical Budget Bills are submitted (one in the Assembly and one in the Senate) for independent consideration by each house.

Public input to Governor, legislative members and subcommittees.

Finance and departments testify before budget subcommittees on the proposed budget. DOF updates revenues and expenditures with Finance Letters and May Revision.

As non-partisan analysts, **the Legislative Analyst's Office (LAO)** prepares an "Analysis of the Budget Bill" and "Perspectives and Issues". Testifies before the budget subcommittees on the proposed budget.

Public input to Governor, legislative members and subcommittees.

Assembly Budget Committee - divided into several subcommittees to review (approve, revise, or disapprove) specific details of the budget. Majority vote required for passage.

Senate Budget and Fiscal Review - divided into several subcommittees to review (approve, revise, or disapprove) specific details of the budget. Majority vote required for passage.

Assembly Floor examines committee report on budget attempting to get 2/3 vote for passage. The Budget usually moves to conference committee.

Budget Conference Committee attempts to work out differences between Assembly & Senate versions of the Budget - also amending the budget to attempt to get a 2/3 vote from each house.

Senate Floor examines committee report on budget attempting to get 2/3 vote for passage. The Budget usually moves to conference committee.

Assembly Floor reviews conference report and attempts to reach 2/3 agreement. If no agreement is reached in conference or on floor, the BIG 5 gets involved.

Senate Floor reviews conference report and attempts to reach 2/3 agreement. If no agreement is reached in conference or on floor, the BIG 5 gets involved.

Sometimes, the BIG 5 (Governor, Speaker of Assembly, Speaker pro Tempore, and Minority Leaders of both houses) meet and compromise to get the 2/3 vote required in each house.

Final budget package with 2/3 vote in each House submitted to the Governor for signature. Governor may reduce or eliminate any appropriation through the line-item veto. The budget package also includes trailer bills necessary to authorize and/or implement various program or revenue changes.

Individual departments and the **Finance** administer, manage change, and exercise oversight of the Budget on an ongoing basis. **The Joint Legislative Budget Committee (JLBC)** provides some coordination between the two houses and oversees the LAO. The JLBC is involved in the ongoing administration of the Budget and reviews various requests for changes to the Budget, after enactment.

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Omar Noorzad - Early Start Advocacy Day - Friday, March 14, 2014 -9:00 a.m.

From: Eileen Richey <Erichey@arcanet.org>
To: "Bonnie Sebright (bsebright@sdrc.org)" <bsebright@sdrc.org>, "John Hunt(...
Date: 3/4/2014 8:36 AM
Subject: Early Start Advocacy Day - Friday, March 14, 2014 -9:00 a.m.
CC: "Rick Rollens (rollensconsult@aol.com)" <rollensconsult@aol.com>, "AmyWe...

Early Start Advocacy Day

Friday, March 14, 2014
9 am to 12 noon

Space is limited click here to register!

Free Event

When and Where

Friday, March 14, 2014
9 am to 12 noon

Magnolia Place Family Center
1910 Magnolia Avenue
Los Angeles, CA 90007

Featured Speakers

State Senator Holly Mitchell

James Lau
First 5 LA Policy Director

Invited Guests

Dear Advocate for Children,

If you are reading this you are a key partner in renewing the spirit of Early Start. Beginning in 2009 shortfalls in the state budget led to changes in the Early Start program, which provides services to young children (birth to three) with a heightened risk for a developmental disability. Most notably, therapeutic services were eliminated for children who are:

* Infants and toddlers at-risk due to factors such as extremely premature births or prenatal drug exposure;

* Infants and toddlers at-risk because they have a parent with a developmental disability; and,

* Toddlers referred for services at two years of age with considerable delays not significant enough to meet the new, stringent criteria, many of whom are later diagnosed with Autism Spectrum Disorder.

These children have missed out on the services they needed and did not receive the early intervention they deserved. As the state economy recovers, now is the time to Renew Early Start. We need help telling lawmakers your stories of why early intervention matters and should be a priority.

Now is the time to make sure that all children get the Early Start they deserve.

Featured speakers include Senator Holly Mitchell,
James Lau, First 5 LA Policy Director, and other elected officials and community leaders. Hear stories from parents/caregivers, early care and education providers, pediatricians, early intervention providers, foster care providers, homeless service providers, advocacy organizations and other key community members that have seen firsthand the impact of the cuts to Early Start.

For more information:
Contact Patricia Herrera, M.S. at 211 LA County at (626)350-1841 x2200.

For additional information on Early Start, please visit **www.renewearlystart.net**.

State Senator
Ed Hernandez

Quick Links

Register Now

Renew Early
Start Fact Sheet

Join Our Mailing List!

Organizations Supporting the Event:

211 LA COUNTY Help Starts Here

FIRST 5 LA

ZERO TO THREE

children's bureau

IDA CALIFORNIA

CHILD DEVELOPMENT INSTITUTE

CH1LDREN NOW

CALIFORNIA CONSULTING

San Gabriel Valley Civic Alliance

ARCA ASSOCIATION OF REGIONAL CENTER AGENCIES

L.A. Care HEALTH PLAN

Health Net Community Solutions

ALLIANCE for CHILDREN'S RIGHTS

Forward this email

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Constant Contact

This email was sent to Erichey@arcanet.org by pherrera@211la.org |
Update Profile/Email Address | Instant removal with SafeUnsubscribe™ | Privacy Policy.
| P.O. Box 726 | San Gabriel | CA | 91778

INADEQUATE RATES FOR SERVICE PROVISION IN CALIFORNIA

Prepared by the

Association of Regional Center Agencies

January 2014

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INADEQUATE RATES FOR
SERVICE PROVISION IN CALIFORNIA
EXECUTIVE SUMMARY

The Association of Regional Center Agencies (ARCA) represents the 21 regional centers in supporting and advancing the intent and mandate of the Lanterman Developmental Disabilities Services Act (the Lanterman Act). ARCA advocates on behalf of the 265,000 individuals served by the regional centers statewide, and works in cooperation with other entities to promote services for persons with developmental disabilities.

Regional center budgets are divided into two parts: Purchase of Service (POS) which provides funding to pay more than 45,000 direct service providers in the community, and Operations (OPS), which provides funding to support the regional center's role in service coordination, resource development, and quality assurance.

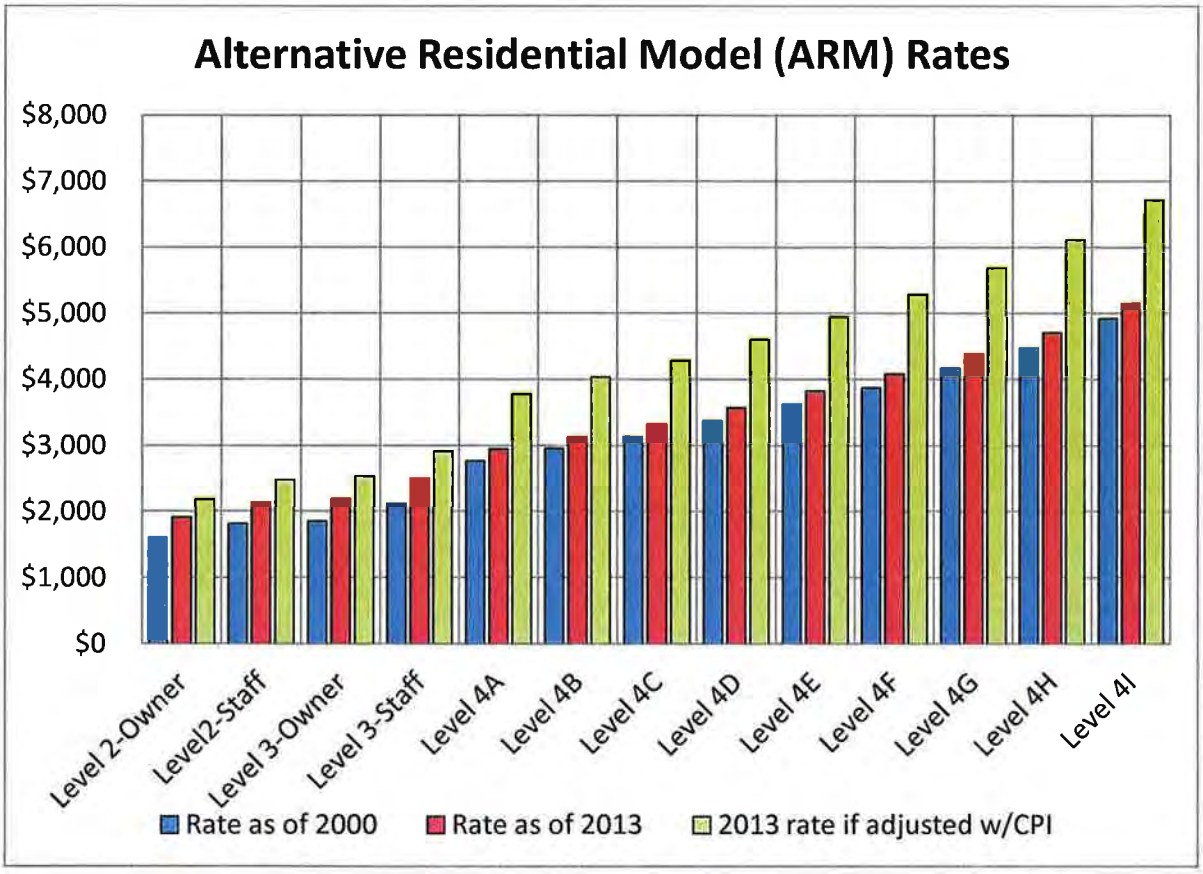
Issues impacting the OPS budget are addressed in ARCA's publication *Funding the Work of California's Regional Centers.* This paper focuses on the POS budget and the problems caused by stagnant rates for the provision of services, which in turn impacts the clients regional centers are charged to serve. There are five major areas covered in this paper in order to illustrate the issue of underfunding for services.

1. Overview of Rate-Setting Processes in California

There are six primary mechanisms to establish rates for service providers: Alternative Residential Model (ARM), Non-Negotiated Rate Community Based Programs, Supported Employment, Negotiated Rates, Usual and Customary, and Schedule of Maximum Allowances (SMA). As the regional centers are not involved in the rate-setting for SMA or Usual and Customary, this paper addresses the first four rate types.

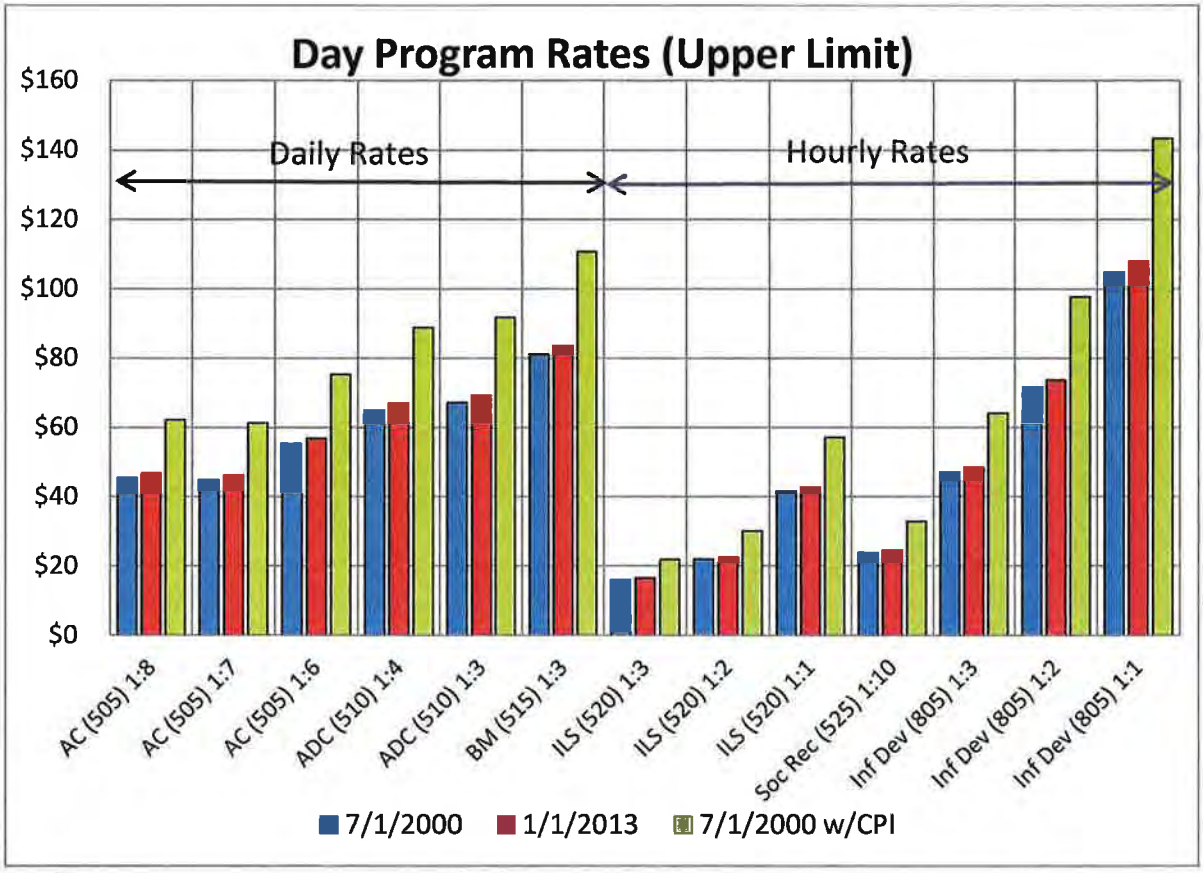
2. Rate-Setting Processes

The ARM rates and the community-based day program rates are set by DDS. The chart below illustrates the ARM rates as of July 1, 2000, the current ARM rates, and what the ARM rates would be if they had kept pace with inflation.



Source: DDS Rates Lists.

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The chart below compares the day program upper limit rates as of July 1, 2000, the current upper limit rates, and what the upper limit rates would be if the day program rates had kept pace with inflation.



Source: DDS Rates Lists.

Negotiated rates became subject to legislation that imposed a freeze and a maximum allowable rate (the median), regardless of the provider's actual costs. These two measures have created extreme difficulties for regional centers in their attempts to develop new and specialized services. Supported employment is the only service with rates that are set statutorily. They have been unchanged since 2008. In order for individuals with developmental disabilities to achieve full participation in the community, they must have integrated living and employment options, as well as the necessary supports to achieve those. This has become increasingly difficult to provide.

3. California Budget Crises And Their Effects

Since 2000, the budget crises in California have caused rate increases to be infrequent and minimal. There has been legislation that resulted in payment reductions, as well as

freezes that have kept the reimbursement rate stationary. For over a decade service rates have been subjected to this holding pattern, while actual costs have continued to increase. All new service providers were subject to the median rate, which was frozen once it was established. Finally, there was additional legislation which established: 1) a uniform holiday schedule with 14 non-service and non-paid days per year; 2) requirements for provider reviews and audits at a cost of $4000-15,000; 3) a cap on administrative costs impacts providers when costs increase to absorb changes in health care and workers' compensation; and 4) restriction on the use of POS funds to start up new programs, which can impact the development of needed services. These actions have impacted services in many different ways, but ultimately they put at risk the fiscal viability of the services for individuals with developmental disabilities.

4. Changing Needs For A Changing Population

Over the years the services necessary to support individuals with developmental disabilities have evolved. Most individuals live in the community as intended by the Lanterman Act, but this integration requires new and different services to assist in the achievement of independence, self-sufficiency, and quality of life. The demographics of the individuals served by Regional Centers has changed. There are more individuals with autism. There is a significant number of children who will be exiting the public education system and entering adult services provided through regional centers. Over the next twelve years there will be over 70,000 young adults exiting the school system, and of these, 24,000 will need services in the next three years. Advanced medical interventions let people served by regional centers live longer. Parents who have supported their adult children in their homes are aging as well. Statistics indicate there are over 5,400 persons between the ages of 52 and 62 and older with disabilities still living with their parents. Regional centers will need to develop community services for these individuals. Over the next ten to twelve years all of these variables will add significant stress to the system via a need for services that are difficult to develop and sustain at current inadequate funding levels.

5. Reports And Studies

The serious concerns about the effect of low reimbursement rates on services have been long-standing. A number of studies and reports have drawn the same conclusion; the rate system is inadequate and does not effectively support services as they were intended. Although some changes to the system have been attempted, there needs to be a long-term solution through overall rate adjustment to reflect the realities of the costs. The client population has changed over time and the service delivery system has evolved, but the rate system has not kept pace with those changes.

SUMMARY

From a policy perspective, California's developmental services system is poised to promote better service outcomes for the over 265,000 individuals with developmental disabilities. Services can be more individualized and lead to greater levels of community participation, employment, and independence. Unfortunately, long-standing underfunding of the service system not only undermines this potential forward progress, but also the adequacy of the community-based provider network.

The concepts in this paper are not new. Studies dating back many years all draw the same conclusion; quality services and achievement of outcomes is directly related to staff qualifications, retention and continuity of care. But this goal is unachievable within the limitations of the current rates. Acknowledging the problem with a passive response does not help the over 265,000 individuals served to move forward. The task before us seems insurmountable because it has been ignored for so long.

Forty-five years ago, California made a promise to the state's most vulnerable residents. The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge...." Without a definitive response to the

problem presented, the state risks the health and well-being of clients and their families for whom the state has accepted responsibility.

PREFACE

The Association of Regional Center Agencies (ARCA) represents the 21 regional centers in supporting and advancing the intent and mandate of the Lanterman Developmental Disabilities Services Act. ARCA advocates on behalf of the over 265,000 individuals served by the regional centers statewide, and works in cooperation with other entities to promote services for persons with developmental disabilities.

Since the 1990s, the regional center system has experienced extensive budget reductions. The state budget crises have resulted in provider rate freezes, inadequate median rates, and limited start-up funding. The quality and effectiveness of purchased services and supports for individuals with developmental disabilities has suffered, and many individuals and families are facing barriers to receiving the services and supports they need.

ARCA considers the preservation of services for individuals with developmental disabilities as one of its highest priorities. Towards that end, ARCA has made a commitment to pursue rate reform in order to maintain needed services for persons with developmental disabilities. ARCA's Strategic Plan includes rate reform for the developmental services system as a primary area of focus.

INTRODUCTION

Californians with developmental disabilities receive direct services from approximately 45,000 service provider agencies throughout the state. Those service providers deliver needed community-based supports and services as an alternative to institutional care. These services include residential care, day programs, independent and supported living services, respite services, transportation, behavioral services, and many others. Regional centers assist individuals with developmental disabilities in understanding the services that are available to them in order to live in the community. These services are designed to meet the unique needs and choices of the individuals. The developmental services system is focused on ensuring minor children can remain in their family homes, and seeing adults achieve the greatest level of independence possible. There are more than 150 service category types (service codes) that define each specific service available. Eighty-seven and one-half percent of the regional center budget, called "Purchase of Services" (POS) funding, funds those service providers. For fiscal year 2014-15, it is estimated that approximately $3.9 billion will be spent on these services.

> "...Regional centers are mandated to access generic and other services for consumers and families before expending regional center funds. There are both fiscal and philosophical reasons for this mandate. The backdrop precipitating the Lanterman Act was the devaluation of people with developmental disabilities, with the attending discrimination and segregation, which limited their access to services commonly available to others... Despite heavy reliance on accessing alternative resources, the special service and support needs of people with developmental disabilities are such that the needs cannot always be met through generic resources. In such cases, the regional centers are required to develop and fund needed services and supports. Thus, regional center consumers receive services from a broad array of public and private providers or vendors..."[i]

Although the expenditures for developmental services are significant, it is important to look at California's expenditures from a national perspective. Data in the publication *The State of the States in Developmental Disabilities* illustrates California's spending compared to other states. Calculation of a state's fiscal effort is the measure used in this report to compare and rank states. Based on the most recent data, California's fiscal effort for community and institutional services is ranked 34th among all states, or 16% below the national average. California

has consistently fallen in the bottom half in fiscal effort for many years. For example, California ranked 37th in 1997, then ranked 39th in 2002, and is currently ranked at 34th.

The funding the state invests in services is linked to the quality of the services. In order to provide quality services, it is important for providers to be able to hire, train, and retain qualified staff for consistency and continuity of care. Lack of adequate revenue affects the ability of providers to:

- Compete with other types of employers in the recruitment of experienced and educated staff due to lower staff wages
- Retain staff due to lower wages and the inability to offer benefits comparable to other employers

These constraints, as a result of an inadequate rate system and outdated rates, are a serious impediment to the provision of the specialized services necessary to meet the needs of persons served. Individuals with autism, challenging behaviors, or complex medical needs require providers to hire more experienced and educated staff to provide services that produce the intended outcomes. Over the past 20 years, laws, regulations, and best practices have changed, placing increased expectations on providers.

> *"Although little data is available on direct-support workers, the last available survey of community-care facilities documented average wages of $10.24 per hour in 2001 after wage pass-through legislation—a rate augmentation earmarked to increase compensation by almost 20% in order to retain direct-support workers. In the five years since then, reimbursement rates have been frozen. This wage is lower than a single worker with no dependents would have needed for basic self-sufficiency in California in 2005. Data on access to health insurance is even more limited.*
>
> *Low wages are the main cause of very high turnover rates in community settings. In Wyoming, for example, when total compensation rose from $9.08 in 2001 to*

$13.19 by 2004, turnover dropped from 52% per year to 32%. California does not collect data on turnover, but small surveys reported turnover rates ranging from 24% to over 50%. High turnover forces providers to struggle to find qualified workers, undermines training, continually disturbs relationships between workers and clients, and ultimately undermines quality of care." [ii]

The serious concerns about the effect of low reimbursement rates on the quality of services have been long-standing. A number of studies and reports show the rate system is inadequate. Some changes to the system have been attempted, but there needs to be a long-term solution through overall rate improvement. The needs of people served have changed over time, and the service delivery system has evolved, but the rate system has not kept pace with those changes. It no longer supports the services to meet the needs of the individuals regional centers serve. Years of underfunding, paired with increased statutory and regulatory requirements, have pushed the system to its breaking point, causing shortages in services and supports needed now and in the future.

OVERVIEW OF RATE SETTING PROCESSES IN CALIFORNIA

In order to understand the costs for the provision of services, and thus see their underfunding, it is important to know how rates are established. There are six primary mechanisms to establish rates for service providers. None of those rates, once set, can be adjusted without (funded) legislative action.

1. *Alternative Rate Model (ARM)* – Community Care Facilities (CCFs), which make up the bulk of residential care providers, are paid a rate according to the ARM. The rate depends on the program design for the facility. The program design shows services and level of care, which is the basis for the number of direct care hours (staff-to-client interaction) provided to the clients in the facility.

2. *Non-Negotiated Rate Community-Based Programs* – Day programs, independent living services, in-home respite agencies, and some other services had their rates set by the Department of Developmental Services (DDS) based on a cost statement the provider completed and submitted to the regional center. The cost statement reflected the anticipated costs of operating the business. Initially, a temporary rate was set, based on aggregate projections. After six months, a permanent rate was set based upon actual costs.

3. Statutorily Set – Supported employment rates are the only statutorily established rates in the developmental services system. The rate for all providers is the same, regardless of actual service costs. Neither DDS nor the regional centers have the authority to modify the rate.

4. *Negotiated Rates* – Some service providers are paid a rate negotiated with the regional center, based on cost data submitted to the regional center. The ability of regional centers to negotiate rates has been almost completely eliminated by the establishment of the median rate, which sets an upper limit that cannot be exceeded, regardless of the provider's cost of operation.

5. *Usual and Customary* – Some categories of service providers are paid their "usual and customary" rate, which is what they charge the general public for their services, such as counseling. This option is available only when at least 30% of their customers are not regional center clients.

6. *Schedule of Maximum Allowances (SMA)* – Service providers who provide services that are reimbursable under the Medi-Cal program, such as nurses, are paid the SMA rates. These rates are established by the Department of Health Services (DHS).

Since usual and customary rates are the current market rates, and DHS sets the SMA rates, these rates will not be addressed in this paper. This paper will address the first four types of rates, various changes that have affected them, the implications for

individuals with developmental disabilities and service providers, and providers' ability to provide ongoing quality services.

RATE SETTING PROCESSES

Alternative Rate Model (ARM)

History and Foundation of Rate-Setting Procedure

Community Care Facilities (CCFs) are defined in Title 17 regulations. They serve children, adults, and the elderly. Payment rates are set by DDS in accordance with the ARM, which was developed in the late 1980s. The ARM rates were introduced in a pilot program conducted from 1985 to 1987. By January 1, 1991, all CCFs were converted to the ARM rates.

The ARM system set rates based on the level of support provided by the CCF. Those levels range from 1 to 4, with level 4 being subdivided from 4a through 4i. Level 1 CCF residents require the least intensive supports, while Level 4i CCFs serve clients with the most complex needs. The current ARM rates range from $993 (Level 1) to $5,159 per month per resident (Level 4i) (see Appendix B: Community Care Facility Rates for more information). As the facility levels (and resident needs) increase, so do the mandated levels of staffing hours, staff training, and outside consultation in areas such as medical and behavioral supports. Generally, regional center clients do not live in Level 1 facilities, as they require more support to meet their needs. Some individuals' needs can be met with basic supervision, while others require staff who have specialized training in medical or behavioral management, and lower staff-to-client ratios. The ultimate aim of the ARM model was to base reimbursement for service providers on the intensity of the support needs of the individuals within the facility.

Rate Adjustments, Reductions, and Freezes

Since July 1, 2000, the ARM rates have been increased three times:

1. In FY 2001-02 the ARM rates were increased for the Supplemental Security Income-State Supplementary Payment (SSI/SSP) pass-through of 1.5%.

2. In FY 2002-03 the ARM rates were again adjusted for the SSI/SSP pass-through of 1%.

3. In FY 2006-07 all service providers whose rates are set by DDS were granted a 3% rate increase. Some CCFs (Levels 2 and 3) also received a 3.7% increase due to the minimum wage increase. Other CCFs, which provide increased levels of service, did not receive the 3.7% increase, even though many of them had employees qualifying for the minimum wage increase. Those levels of service are classified as 4a through 4i.

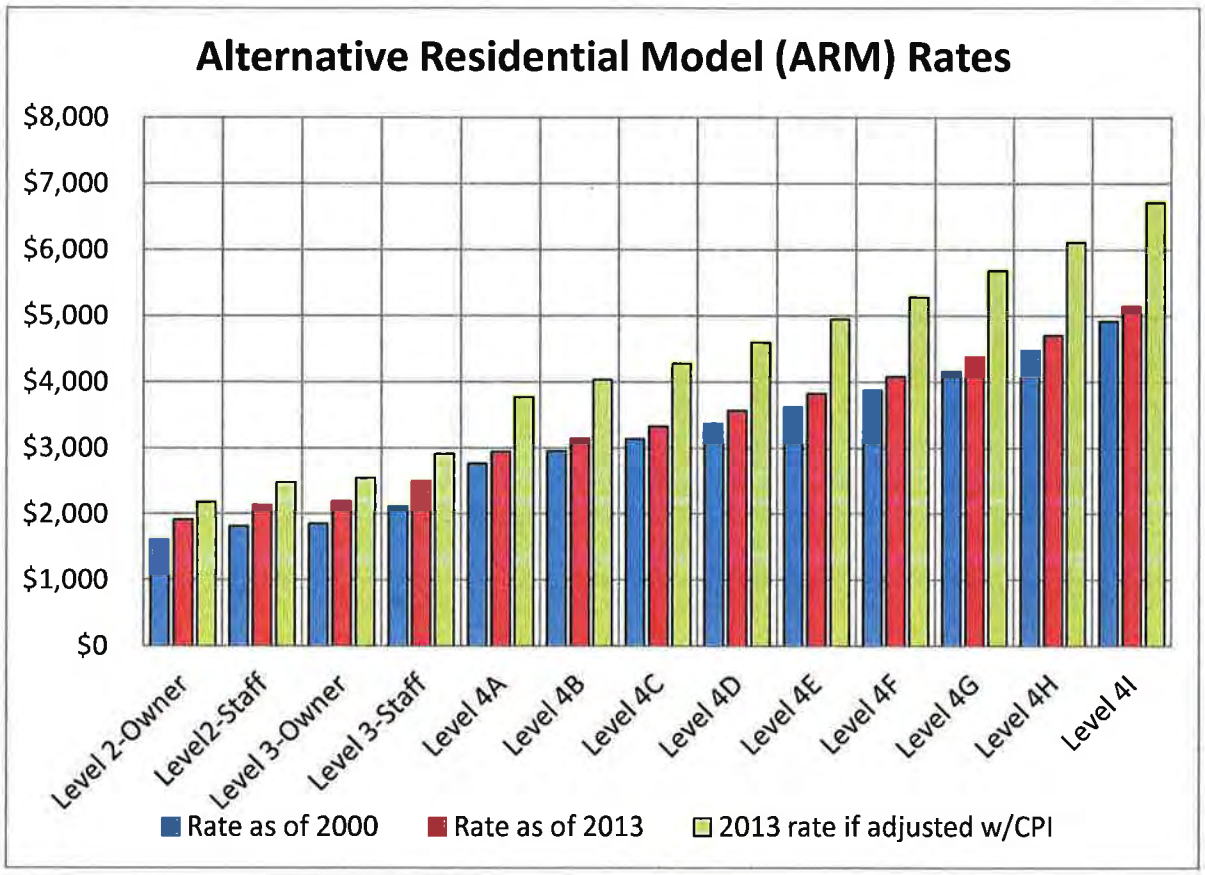
From February 1, 2009 to June 30, 2010, CCFs were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total of 4.25% reduction. On July 1, 2012, the 3% payment reduction ended but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

Although the ARM rates were initially established to reflect residents' level of need, statute froze CCF rates on June 30, 2008. That statute states "...no regional center may approve any service level for a residential service provider, as defined in Section 56005 of Title 17 of the California Code of Regulations, if the approval would result in an increase in rate to be paid to the provider...."[viii] Many individuals become long-term (and, often, life-long) residents in these facilities. As residents age, their needs increase, requiring more support. Regional centers are forbidden, with a few exceptions, from increasing a facility's reimbursement to match the changing needs of the residents. Therefore, as residents' needs increase, either the facility can try to provide more services for the same rate to maintain these individuals in a facility that they consider home, or the resident will have to move.

Rates and Inflationary Growth

In comparing the current ARM rates to those in effect on July 1, 2000, the rates for Level 2 homes have increased by 19.3%, whereas the rates for Level 4i homes (meeting the most complex needs), have increased by only 4.9%. Since July 2000, the Consumer Price Index (CPI) for California has increased 36.6%. Although the CPI is an important indicator in the stagnation of rates, it still does not reflect all of the additional costs of doing business that have occurred.

The chart below illustrates the ARM rates as of July 1, 2000, the current ARM rates, and what the ARM rates would be if they had kept pace with inflation.



Source: DDS Rates Lists.

New Philosophy, Old Rates

In recent years, regional centers have moved towards providing clients with more home-like living arrangements. To achieve this type of living environment, regional centers have requested providers to develop homes with four beds or fewer. This philosophy is driven by the guidelines issued by the Centers for Medicaid and Medicare Services (CMS) for establishing home-like environments that qualify for the home and community-based waiver. The ARM rates were established using a six-bed model that spread the fixed costs over the first five residents, with the sixth resident providing a profit margin. Consequently, care providers find it difficult to develop these smaller homes with the current ARM rates, as fixed costs make it more expensive to operate a facility with fewer residents. This is beginning to result in an inadequate supply of this resource.

Non-Negotiated Rate Community-Based Programs

Day Service Categories, Service Codes, and Client-Staff Ratios

Ratios are defined in Regulations and/or within the program design

Source: Title 17 Regulations.

History and Foundation of Rate-Setting Procedure

Five types of day programs are defined in Title 17 regulations, with a sixth, for infants and their families, defined in Welfare and Institutions Code § 4693. In 1984, per Welfare

and Institutions Code § 4691, DDS established program standards, and developed a rate-setting procedure delineated in the 'Rate Procedure Manual.' But in 1987, the California Association of Rehabilitation Facilities (CALARF) and others took legal action seeking to compel DDS to make regulations establishing a new set of standards and rate-setting procedures. A settlement of the case, along with additional legislation (AB 877, Chapter 1396, Statutes of 1989), eventually resulted in the adoption of rate-setting regulations for community-based day programs that are in use today. [ix]

DDS set day program providers' rates based on their cost statements. The cost statement calculated a rate of reimbursement for the program, and DDS set the rate depending on where that rate fell within the schedule of "Allowable Range of Rates." That schedule was established by averaging the costs for all the types of like programs throughout the State. Based upon the prescribed calculations in regulations, a lower and upper limit was set, and the average became the temporary rate. New programs received the temporary rate for six months, and then they submitted a cost statement documenting their actual costs for assignment of a permanent rate. If a program's calculated rate was between the upper and lower limits of the "Allowable Range of Rates", then DDS set the provider's rate at their calculated rate. But even if the program's calculated rate was above the upper limit of the "Allowable Range of Rates", DDS would only set the rate at the upper limit. Providers whose calculated rate fell below the lower limit were compensated at the lower limit of the range. In the past, programs would submit cost statements every two years to DDS, which would update the "Allowable Range of Rates" based on the new data. The biannual cost statements would be the driving force for adjustment to the range of rates, which ensured the rate range realistically reflected contemporary costs.

Closely related to day programs are work activity programs, which are defined in Welfare and Institutions Code § 4850.2 (g). Work activity programs assist individuals with increasing their time in paid work, productivity rate, attendance level, and work-appropriate behavior, with the aim of developing the skills necessary for competitive

employment. Similar to day programs, temporary rates are assigned by DDS, but in the case of work activity programs, the permanent rate is set after there are at least three months of cost data.

Rate Adjustments, Reductions, and Freezes

A California Bureau of State Audits report, released in October 1999, stated "if the State had increased funding, providers would have received a rate adjustment every two years; however, there were no rate increases between fiscal years 1992-93 and 1997-98. [In] September 1998 the State granted $33 million in additional funding. Although the increase allowed these providers to receive adjustments, it was only enough to fund rates based on their fiscal year 1995-96 costs... Furthermore, their rates will remain at this level until the department revises its current rate-setting process or receives additional state funding." [x]

The "Allowable Range of Rates" was last updated in FY 1998-99, when that report was written, which means the rates were already substantially outdated and stagnant even prior to the 2003 rate freeze, under AB 1762.

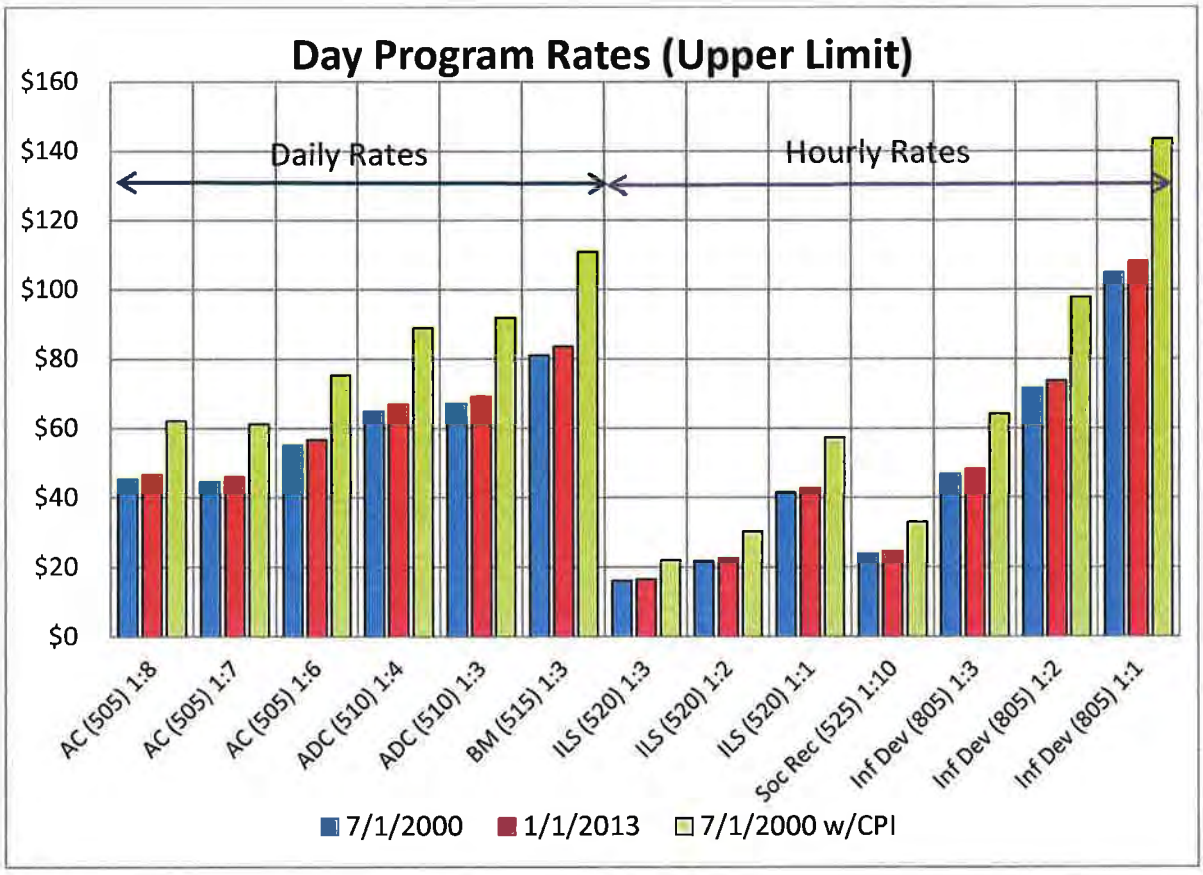
It is important to note that regional centers and providers report that DDS currently sets the rate at the temporary rate, and they remain frozen at this rate indefinitely. Cost statements are not being required and rates are not being considered based upon actual provider costs, which is resulting in underfunding of these programs.

Since FY 2000-01, day program rates were increased in FY 2006-07 by 3%, and then again via an adjustment for the raise of the minimum wage in that same year.

From February 1, 2009 to June 30, 2010, day programs were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total reduction of 4.25%. On July 1, 2012, the 3% payment reduction ended, but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

Rates and Inflationary Growth

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The chart below compares the upper limit rates as of July 1, 2000, the current upper limit rates, and what the upper limit rates would be if the rates had kept pace with inflation.



Source: DDS Rates Lists.

New Philosophy, Old Rates

Day programs have evolved and expanded the scope of their services. Day programs now include behavioral skills training. People moving out of the developmental centers, as well as those in the community with challenging needs, create demands that day programs have to address. Day programs are also being limited to 30 to 45 participants, rather than the larger traditional model, in order to provide more innovative,

individualized, and outcome-driven services. The new smaller model, while preferred, does not work financially for providers given the current rates.

Many programs now place a strong emphasis on pre-vocational skills - helping an individual prepare for the workplace. Some of the needed skills include dexterity, attention span, time management, compliance, and attention to detail. To assist in their success, regional centers work with providers to supply individual or group supports in their place of employment through supported employment.

Supported Employment

History and Foundation of Rate-Setting Procedure

Supported employment provides individuals with the opportunity to work in the community in integrated settings, either in individual or group job placements. Support services are provided to enable individuals to learn job skills needed in order to maintain employment. The services were originally vendorized and authorized by regional centers, but the program later became the responsibility of the Department of Rehabilitation. During this period, the rates were statutorily established, with an aim of balancing overall costs with program outcomes and demand. In 2004, responsibility for the program transitioned back to the regional centers, but the statutory determination of rates continued. This is the only service category which has statutorily-defined rates.

Rate Adjustments, Reductions, and Freezes

Rates for supported employment have risen and fallen with more volatility than rates that are established by DDS. In 1998, the rate for both group and individual supported employment job coaching hours was set at $27.50 per hour (AB 2779). In 2000 it was increased to $28.33 (AB 2876) and reduced in 2003 to $27.62 (AB 1752). In 2004 the rate was again increased to $28.33 when the program was returned to the purview of the regional centers (SBX1 24). In 2006, as a result of too few individuals securing employment, the rate was increased to $34.24 (AB 1807), only to be reduced two years later to $30.82 (AB 1781), a rate that remains in effect today.

Supported Employment Reductions				
Hourly rate for individual Reduced from $34.24 to $30.82	Hourly rate for group services Reduced from $34.42 to $30.82	Intake fees Reduced from $400 to $360	Job Placement Reduced from $800 to $720	90-dayRetention fee Reduced from $800 to $720

Source: AB 1183 (2008)

Rates and Inflationary Growth

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The rate for supported employment services has increased only 8.8% in that same timeframe.

New Philosophy, Old Rates

Supported employment provides the most integrated work option for individuals served by regional centers. In spite of the increased focus on this outcome, the service has not expanded to meet the needs of a population increasingly interested in it. Consistent with national trends and the passage of recent legislation (AB 1041), the movement of individuals from day programs or directly from school into employment settings is expected to increase. Regional centers work with providers to supply individual or group supports in the person's place of employment through supported employment.

Negotiated Rates

History and Foundation of Negotiated Rates

Negotiated rates, per Section 57300 of Title 17 of the California Code of Regulations, were paid for many services, based on negotiations between a service provider and the regional center (see Appendix D: Service Codes for more information). Regional centers can negotiate rates for services that meet individuals' unique needs.

Title 17 regulations prescribe the service categories that allow for negotiation in order to meet these needs. But "...there [was] little regulatory guidance on how these negotiations [were] to be conducted and few parameters governing how the rates [were] set and adjusted. In an effort to better understand and control costs in areas where

rates are negotiated, DDS embarked on a multi-year project. The first step in this project involved developing and distributing three rate surveys to the regional centers." [xi] The surveys, conducted during FY 2007-08, reviewed the negotiated rates paid by regional centers and the vendors who qualify for negotiated rates.

Rate Adjustments, Reductions, and Freezes

As a result of the review, negotiated rate services were changed to a median rate system – which had the effect of simultaneously being an adjustment, a reduction, and a rate freeze.

A median is determined by arranging data set in numeric order. The middle of the array has an equal number of points above and below it – even if some points are the same. This middle value is called a median. The "median rate" is determined by finding the median among all the rates paid to providers of a particular service code.

Examples:

$2,400	$2,500	$2,800	$3,000	$4,900	$5,000	$5,600

The median rate in the example above is $3,000

$10.75	$10.75	$11.38	$11.38	$12.99	$18.78	$33.95

The median rate is $11.38 (although the mathematical average, or "mean," is $15.71, and there are several duplicate rates. The middle remains the middle.)

After the study was completed, DDS set the median rates based on the 2007 data in the regional centers' rate tables. Those rates included the median rates at both the regional center and state level. The former reflected the median paid for each service within each regional center's catchment area. The latter was the median of each service's rates across the state. 77 service code categories were impacted by the introduction of the median rates. Commencing July 1, 2008, with few exceptions, existing negotiated rates were frozen at the rate in effect as of June 30, 2008.

Median rates for all new negotiated rate services/providers, inclusive of specialized residential facilities and supported living services, were established. Once the rates were set, they were frozen (AB 5, Welfare and Institutions Code § 4691.9). Median rates require the vendoring regional center to use either their median rate or the statewide median rate, whichever is lower (AB 5 and AB 1183, Welfare and Institutions Code § 4681.6 and § 4689.8). In many cases, the statewide median is much lower than the regional center's median and is inconsistent with other similar programs vendored by that regional center. This creates a wide disparity in rates between existing and new providers, and creates difficulty in obtaining new providers. Service providers in regions with particularly high costs of doing business are immediately short-changed by this methodology. Some statewide median rates are lower than the current minimum wage. In 2011, median rates were reviewed and recalculated based on updated data from regional centers, resulting in some median rates being decreased.

From February 1, 2009 to June 30, 2010, negotiated rate services were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total reduction of 4.25%. On July 1, 2012, the 3% payment reduction ended, but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

When median rates were established by DDS, regional centers and service providers raised a number of concerns. Two of them, explained below, illuminate the severe constraints the median rate places on the service system.

Some service codes, called "miscellaneous service codes," can be used by a regional center for multiple types of services. For example, socialization training is used for social skills training provided by a licensed therapist, which requires a higher rate based on a therapist's expertise and training. This rate was also used for various after-school socialization opportunities or activities receiving much lower rates. Therefore, this particular service code could have varying hourly rates of $10.00, $12.50, $28.75, $70.00, or $95.00, resulting in a median rate set at $28.75. Individuals with the

diagnosis of autism frequently require this type of service. Yet with this low rate, the opportunity to expand the availability of new, licensed and skill-intensive providers has been extremely difficult, if not impossible.

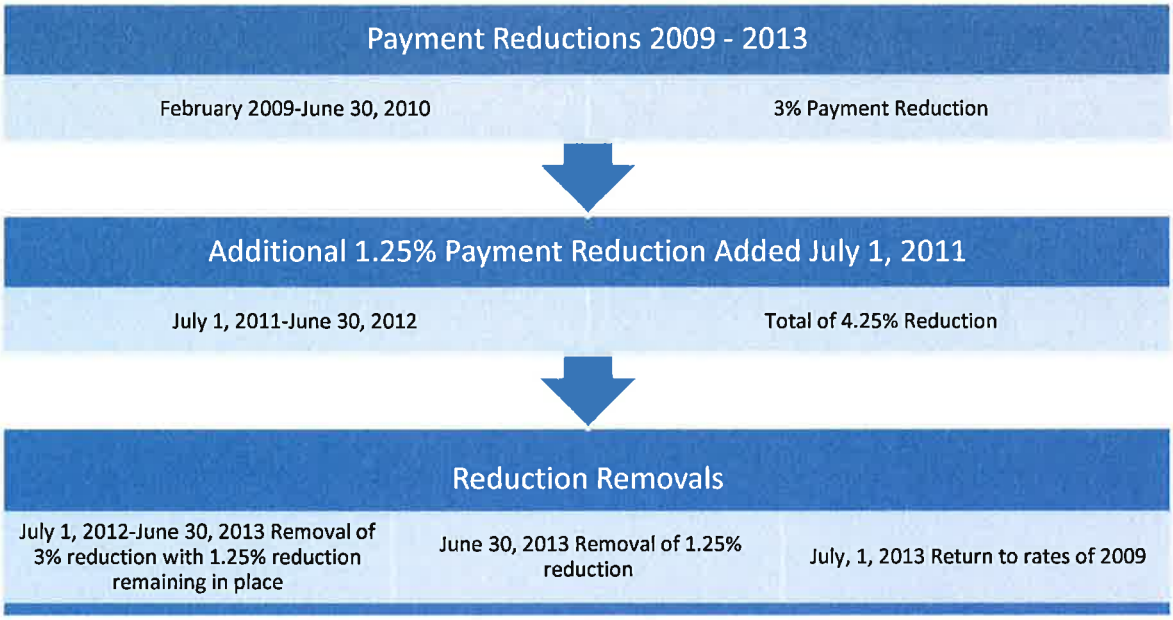
Another important issue is the start-up of new facilities. A vendor with a long track record of excellent work may wish to expand their services to meet regional needs. If they provide those services at a facility (a "site-based" program) and decide to open a new site, they would be subject to the median rate at the new site. They would not be paid their existing rate for the **same service.** Regardless of the service – and vendor – being identical, since it is being provided at a new site, it is considered a new service. If a vendor does not have a site, because their services are offered within the community (*e.g.*, services helping an individual actively participate in the community), then they can expand their services to more individuals through their existing vendorized business. Without a new vendorization, they retain their current rate, and are not subject to the median rate. This creates an inequity between vendors. It also makes it difficult for those providers who are subject to the median rate to expand services to other geographic locations where their services may be needed.

CALIFORNIA BUDGET CRISES AND THEIR EFFECTS ON SERVICE PROVIDERS

Since 2000, there have been recurring budget crises impacting the rates of services for persons with developmental disabilities. In response to these crises, and in attempts to contain costs, over several years various legislation was passed that eroded services. In 2003, many service rates were frozen at their already inadequate rates, and these rates remain frozen. Also in 2003, there was a restriction placed on regional centers preventing the use of POS funds to start up new programs. Service providers were subject to payment reductions from 1.25% to 4.25% from 2009 to 2013. Other factors affecting services were the implementation of an ongoing uniform holiday schedule (FY 2009-2010), a requirement for independent reviews and audits, and an administrative cap of 15% for providers (2011).

Payment Reductions and Freezes

From 2009 through 2013, regional centers were required to implement payment reductions for most services (Sec. 10 of Chapter 13 of the third Extraordinary Session of the Statutes of 2009, as amended by Section 16 of Chapter 9 of the Statutes of 2011). Two separate reductions, of 3% and 1.25%, were put in place.



Although on July 1, 2013, those reductions were ended, rates still remain low and far behind where they should be, due to lack of adjustments and rate freezes. The additional effect of this payment reduction, although time-limited, took its toll on many of the providers.

Aside from small rate increases and an adjustment for the minimum wage to three of the service categories (residential levels 2 and 3, day programs, and in-home respite) in FY 2006-07, rates have remained stagnant, while inflationary pressures have increased (*i.e.*, fuel costs and worker's compensation).

In 2003, many service rates were frozen, and continue to remain so by virtue of an annual renewal of this freeze (initially set forth by AB 1762, Chapter 230, Statutes of 2003. Welfare and Institutions Code §§ 4648.4, 4691.6, and 4681.5). The services in the table below were initially subject to the rate freeze, but additional services' rates were frozen by subsequent legislation, to be discussed later in this paper (see Appendix A: Glossary for more information).

Supported Living Services	Transportation, including travel reimbursement
Socialization Programs	Community Integration Programs
Mobile Day Programs	Behavior Intervention Programs
Creative Arts Programs	Supplemental Day Service Program Supports
Adaptive Skills Trainers	Independent Living Specialists
Community Care Facilities	Day Programs
Respite Agencies	

Source: AB 1762, Chapter 230, Statutes of 2003.

Decrease in Available Service Days

During FY 2009-2010, Trailer Bill language (ABX4 9, Chapter 9, Statutes of 2009) added § 4692 to the Welfare and Institutions Code. Called the "uniform holiday schedule," it imposed fourteen total unpaid/non-service (furlough) days each year on work activity programs, activity centers, behavior management programs, social recreation programs, and infant development programs. In addition to day and work programs, it also impacted a number of other services: adaptive skills trainers; socialization training programs; client/parent support behavior intervention programs; community integration training programs; community activities support services; program support groups (day service); and creative arts programs. It was effectively a 1.6% reduction in funding for these programs. It also placed burdens on family members and residential providers who had to provide care on these additional

holidays. The uniform holiday schedule was implemented August 1, 2009 and remains in place today.

Independent Reviews and Audits

On March 24, 2011, Welfare and Institutions Code § 4652.5 required an independent review of vendors who receive regional center funding in excess of $250,000, and an independent audit of vendors who receive regional center funding in excess of $500,000. Vendors are reporting that the cost of these reviews and audits can run between $4,000-$15,000. The threshold for these reviews and audits is low; many small providers meet this threshold. For example, the owner of a single Level 4i home with five of their six beds filled could be funded at over $300,000 annually, requiring an independent review. As previously indicated, the ARM rate was based on the fixed costs spread over five beds, with the sixth bed as a profit margin. Given this scenario, the residential provider may barely cover their fixed costs, yet is responsible for the additional expense of an independent review. These reviews/audits do not yield useful information for the regional centers from a quality assurance (QA) perspective. The focus is fiscal, not programmatic, and does not examine utilization of funds as intended within their program design. The audits do not provide the regional centers with information relevant to determining if the provider is using the money appropriately for direct services to the individuals served. This requirement places an additional financial burden on many providers, and negatively impacts the ability to provide direct services to the individuals they serve.

Administrative Cap of 15%

Trailer Bill Language (SB 74, effective March 24, 2011) added § 4629.7 to the Welfare and Institutions Code, requiring all regional center contracts or agreements with service providers to expressly require that not more than 15% of regional center funds be spent on administrative costs. Direct service expenditures are those costs immediately associated with the services provided to clients. Administrative costs include, but are not limited to, any of the following:

- Salaries, wages, and employee benefits for managerial personnel whose primary purpose is the administrative management of the entity, including, but not limited to, directors and chief executive officers
- Salaries, wages, and benefits of employees who perform administrative functions, including, but not limited to, payroll management, personnel functions, accounting, budgeting, and facility management
- Facility and occupancy costs, directly associated with administrative functions
- Maintenance and repair
- Data processing and computer support services
- Contract and procurement activities, except those provided by a direct service employee
- Training directly associated with administrative functions
- Travel directly associated with administrative functions
- Licenses directly associated with administrative functions
- Taxes
- Interest
- Property insurance [xiii]

Some providers report that California has a tremendous amount of employment and tax regulations that require expertise that they do not have as a clinician, for example. The providers must hire or contract for payroll, human resource department or staff (HR), data and computer services, and office staff for scheduling. These employed/contracted individuals stay apprised of employment laws, workers' comp issues, taxes, disciplinary issues, quality assurance, and finance.

Providers now must also participate in E-billing requiring data entry to submit billings to regional centers. They have to have the expertise and manpower for billing insurance companies and regional centers for services and co-pays. In an attempt for providers to become more productive and responsive in case reporting to regional centers, they are becoming more automated, allowing staff to do electronic scheduling and online report

writing, etc. Automation results in requiring Information Technology (IT) assistance for protection of information as related to the Health Insurance Portability and Accountability Act (HIPAA).

The cost of insurance and workers' compensation is increasing dramatically. Providers who work with the more challenging individuals state that their workers compensation increases with injuries occurring during the course of doing business.

Providers are also reporting that they will be affected by the Affordable Care Act (ACA), but the state currently does not allow for adjustments to rates in response to legislative changes/mandates.

Restriction on Start-up Funding

Initially set forth by AB 1762 (Stats. 2003, Ch. 230), Welfare and Institutions Code §§ 4781.5 & 4781.6 restricted regional centers from using POS funds to start new programs. Before this, regional centers could use POS funds to help start programs to serve unmet needs. But AB 1762 limited start-up funding to just two circumstances – the protection of client health and safety, or "extraordinary circumstances." The regional center must receive prior written approval from DDS in either case.

There are a number of different reasons start-up funding is helpful in establishing services within a given geographic area (as indicated by a needs assessment). The ability to establish services closer to where individuals live improves access to services in their own communities, and can be more cost-effective by decreasing the need for an extensive transportation network and its related costs.

Separately, regional centers have the ability to utilize Community Placement Plan (CPP) budgets to offer start-up funds for specialized services for individuals moving from the developmental centers, and for those at risk of placement in a developmental center. These factors limit the ability of regional centers to offer specialized services and maintain long-term viability within the community.

Changing Needs For a Changing Population

The Center for Health Policy Studies reports that *"today's complex, community-based service delivery is comprised of thousands of different providers… Requirements for providers have also grown in sophistication as federal and state laws have changed. Expectations of the community service delivery system have also become more rigorous as knowledge and information about best practices are more readily shared through conferences, resource libraries, internet webpages and listservs…*

To a large extent, our sense of successful service provision has been focused on the quantity of services provided….The reports of workgroups recognize the importance of requiring and gathering information on the quantity of services provided and compliance with law and needed regulations. However, they recommend an additional focus that asks: Is anyone better off? ...In the past ten years, there has been a nationwide movement toward outcome-based service delivery that links quality assurance processes for providers to the achievement of consumer and family outcomes." [xiv]

Changing Demographics' Effect on Service Needs

A 2004 study by Braddock and Hemp found a quartet of factors driving demand for services. Youth aging out of special education programs, increased longevity (coupled with aging caregivers), and a general trend out of institutional, and into community, settings. [xv]

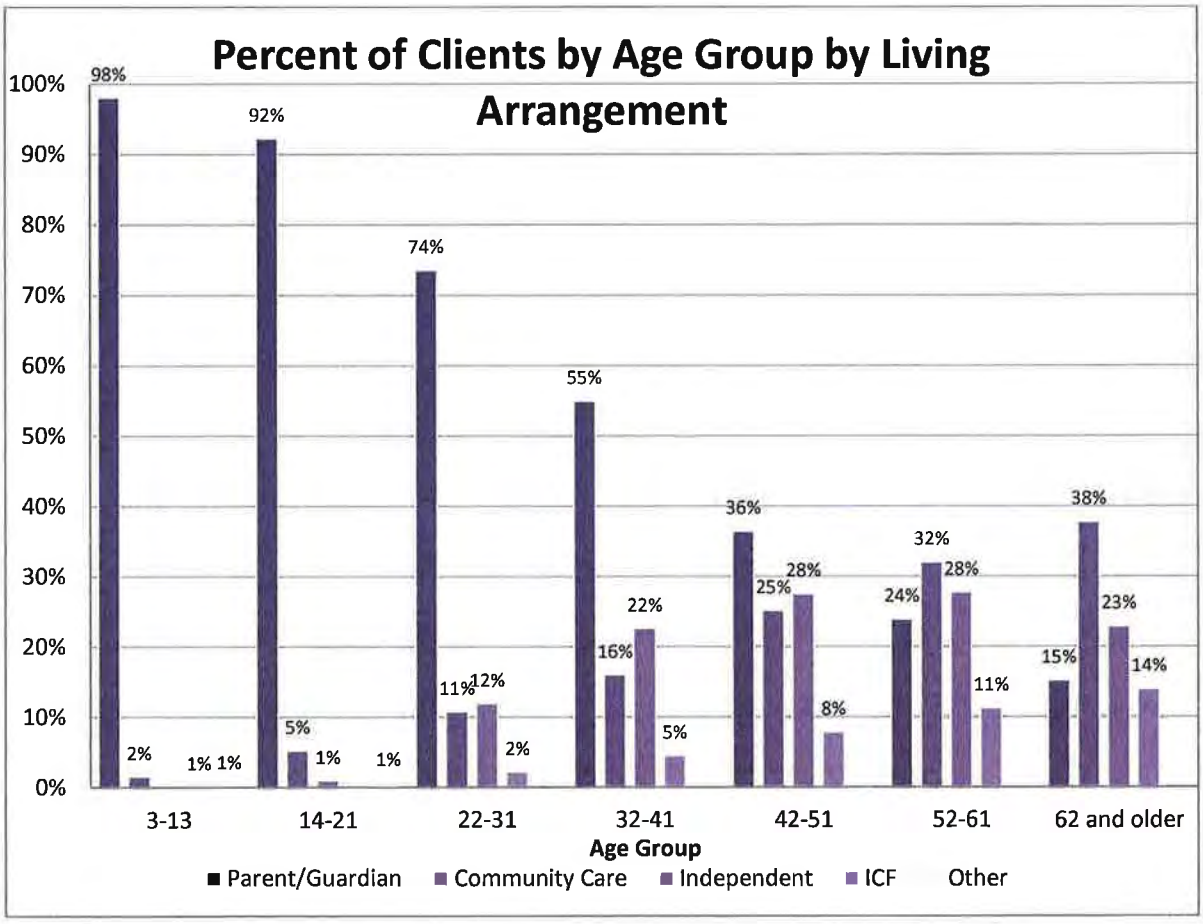
In 2011, a report from University of California, Los Angeles (UCLA) reiterated those concerns and found that improvements in modern medicine have increased the life expectancy of persons with developmental disabilities. In a lifetime-service system, this translates to more years of service needs and needs that grow more intense as individuals age. As they age, the caregiving provided by aging parents must often be

supplemented or replaced by more formal services. And "when a caregiver dies, a DDS consumer likely requires an alternative residential setting at a high cost." [xvi]

Current data bears out the timeless truth and growing relevance of the core findings of those two studies.

Living Arrangements

As indicated in the chart below, individuals 21 years and younger primarily live with their parent or guardian, but this begins to shift significantly from the age of 22 on.



Source: DDS Quarterly Report – September 30, 2013.

It is projected that individuals served by the regional center system, ages 42-62 and older, who are currently living with their parent(s) or guardian(s) will require residential and day/work services in the coming years to support them in the community.

Aging Caregivers

"An aging caregiver may require an increased level of services and supports to maintain their family member in the home. When these caregivers die, or are no longer able to support their loved ones, alternative living arrangements must be developed or located. Almost all forms of out-of-home care are more costly than supporting a person in their own home. The Department's data clearly shows that the percentage of consumers living out-of-home increases as they age." [xvii]

Individual choice and needs change over time

The data indicate that almost 90% of 18-21 year-olds still live with their parent(s) or guardian(s). Among 22 to 31-year-olds, roughly 74% have such living arrangements. In short, as with the population as a whole, as the adult child ages, they move from the parent/guardian's home to another living arrangement. There are different reasons for this movement, such as the choice to live in another setting as an assertion of independence or an aging parent being unable to continue to care for them. The new living arrangement is not always a community care facility, but there will still be a need for services and supports, such as independent living skills, to help them to maintain that new situation.

With increasing age, individuals' needs expand to require community care facilities, supported living, personal assistance, transportation, medical services, or medical equipment. With individuals' increased needs, it can be projected that those in independent living may require personal assistance, medical assistance, community care, or ICF or SNF placement, dependent upon their age and/or health-related variables.

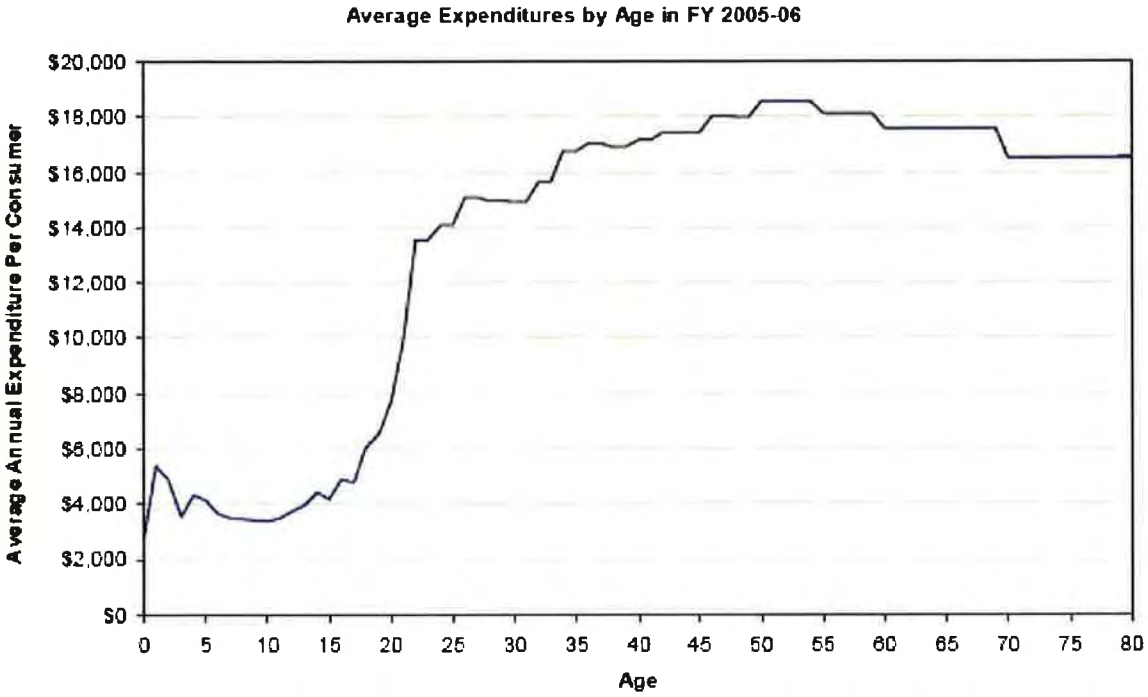
Given the need for these additional services and supports, the system needs to be prepared to have an array of alternative living arrangements and other support services available. This requires an assessment of need and the proactive development of resources. To facilitate this, an adequate rate structure needs to be in place to encourage providers to expand their services to address the growing need.

As of September 2013, there are 5,427 individuals 52-62 years and older still living with their parents, 2,096 who are 62 years and older living independently, and 1,422 individuals still residing in the developmental centers. Regional centers will have to develop community services for up to 8,945 individuals in the next five to ten years.

Individuals Aging Out of the Public School System

The number of young adults who will be transitioning out of the public education system in the next decade is significant. There is an increase in regional center costs when this happens because those individuals require day or work programs, independent living skills training, residential services, or other supports to assist them to work and live as independently as possible. Additionally, young adults with autism typically need a higher intensity and number of services. This issue has been compounded in recent years by the sharp decrease in funding for adult education programs which once funded services to many adults without cost to the regional centers. This shift in funding from a generic resource to the regional centers creates additional pressures for development and sustainability.

Per-client expenditures by age



Source: "Controlling Regional Center Costs." [xix]

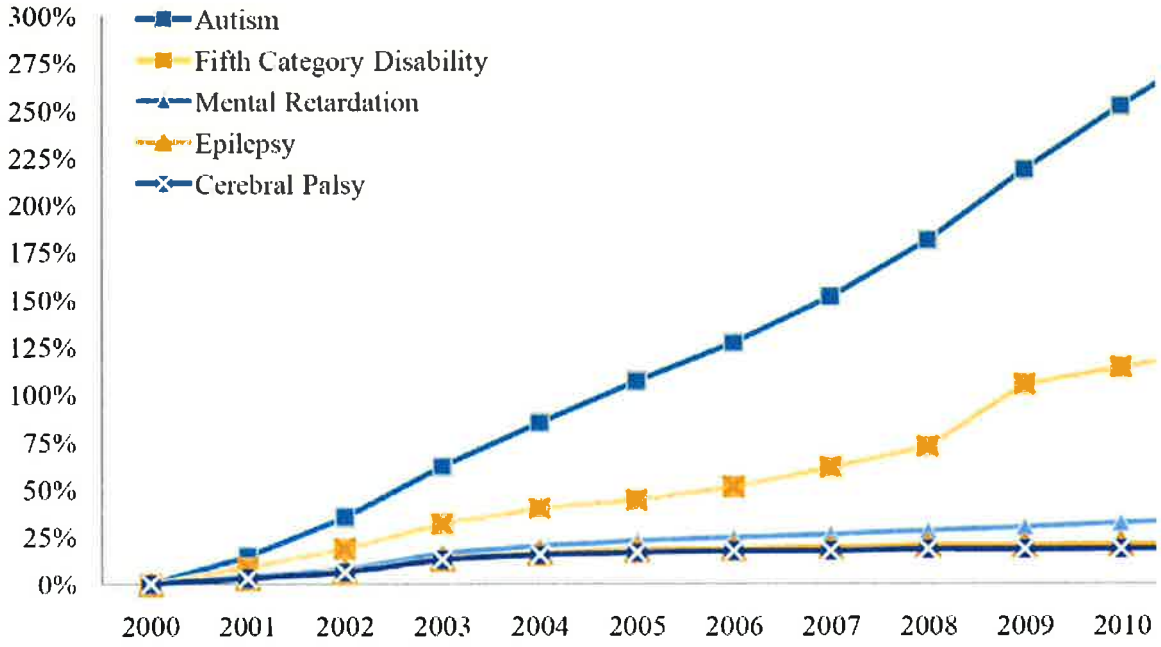
The DDS quarterly report of September 2013 indicates that the number of children with an eligible developmental disability between the ages of 10-21 years (regardless of diagnosis) are:

- 10-13 years - 24,758
- 14-17 years - 22,452
- 18-21 years - 23,924

From the statistics in the report, it can be projected that community-based services will need to be developed to meet the needs of 71,134 young adults in the next twelve years, and of them, almost 24,000 will need services in the next three years alone.

The majority of children with developmental disabilities aging out of the school system have autism. As indicated in the chart below, the growth has exceeded the number of persons with other developmental disabilities.

Growth in California population with autism versus three other major developmental disabilities and the "fifth category," 2000–2010



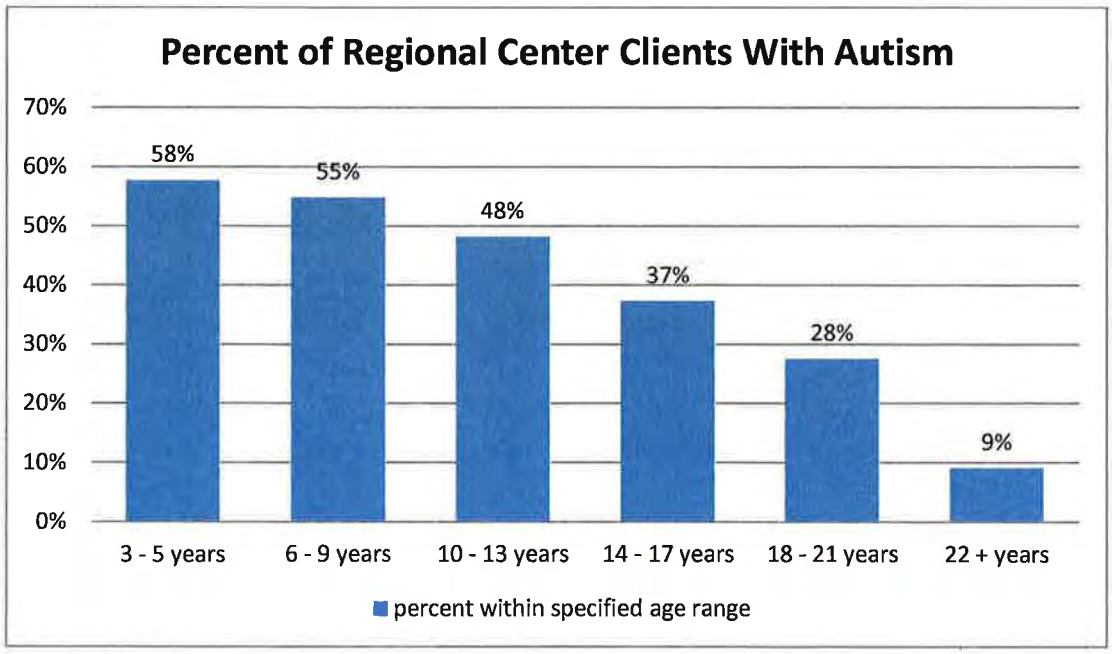
Notes: Developmental disability groups are not mutually exclusive, due to potential duplication of individuals across diagnostic categories. The "fifth category" refers to disability conditions found to be closely related to mental retardation or to require similar treatment (Welf. & Inst. Code §4512).

Source: Authors' analysis of data provided by Department of Developmental Services Data Extraction Unit; 2011.

Source: "Challenges to Sustaining California's Developmental Disability Services System." [xviii]

Most persons with autism are in the younger age ranges. There are many services offered to younger children with autism, but the cost of services is usually shared with schools and private insurance. Also illustrated in the chart below, only 9% of adults older than the age of 22 served by regional centers have a diagnosis of autism. In spite

of this low percentage, the development of services to meet their needs associated with aging is a significant challenge as well.



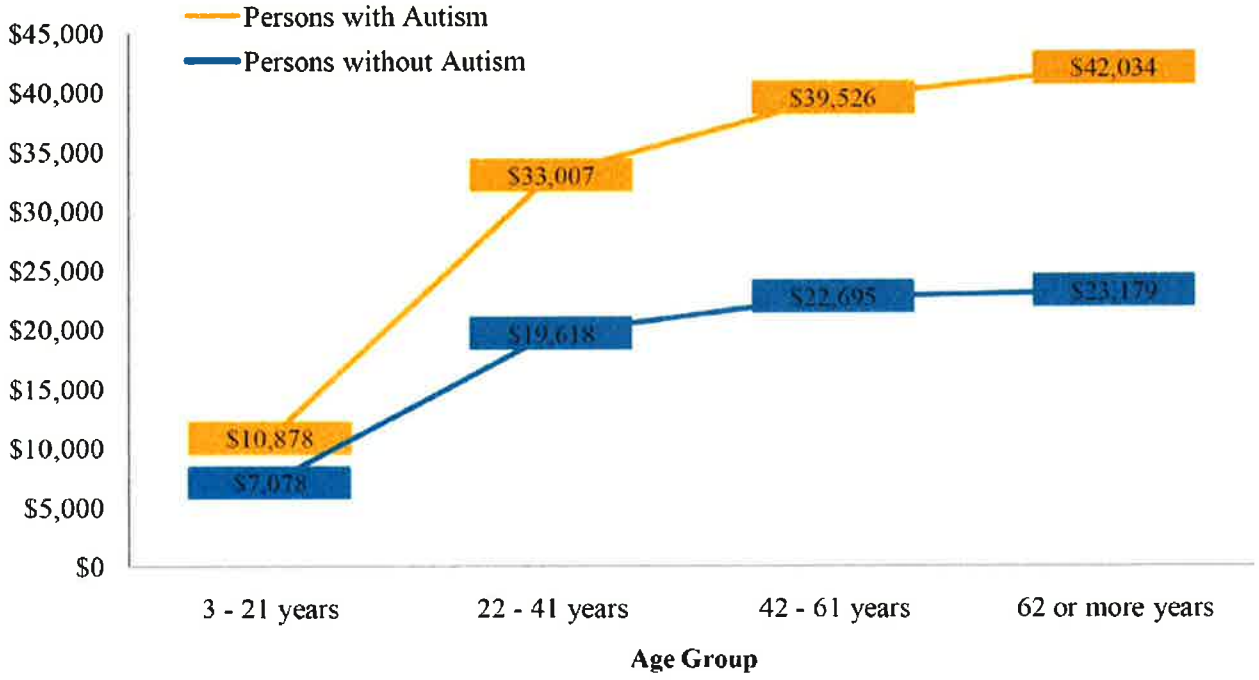
Source: DDS Quarterly Report – September 30, 2013.

The DDS quarterly report as of September 2013, indicates:

- Individuals ages 10-13 years (11,926) have a diagnosis of autism
- Individuals ages 14-17 years (8,382) have a diagnosis of autism
- Individuals ages 18-21 years (6,599) have a diagnosis of autism

Community-based services and supports to meet the specialized needs of almost 27,000 young adults with autism will need to be developed over the next 12 years. Those services and supports are generally more expensive than for persons with other diagnoses. The challenge the median rate creates for regional centers is an inability to negotiate adequate rates, not only for the establishment and expansion of the needed services, but also to sustain these services.

Average annual expenditure per Regional Center client by age group for those with autism and those without (FY 2006-07)



Source: Department of Developmental Services, *Factbook, 11th Edition*, 2008, State of California, Department of Developmental Services.

Source: "Challenges to Sustaining California's Developmental Disability Services System." [xx]

Individuals with Challenging Needs

Many negotiated rate services address severely challenging needs, whether medical, psychiatric, forensic, or a combination thereof. Supporting individuals with complex needs requires staff with extensive training and experience in the individual's particular area of need. Staff-to-client ratios, as well as staff skills, are the primary drivers of service cost for this population. The table below illustrates the number of individuals served in forensic or psychiatric facilities and out-of-state placements.

In 2012, Trailer Bill language (AB 1472), created Welfare and Institutions Code § 4648(a)(9)(B) and (C), which prohibits regional centers from purchasing residential services from facilities that are not eligible for federal funding. The law went into effect

July 1, 2012. All residents are to be moved out of those facilities by June 30, 2014. To develop appropriate community settings to meet those individuals' unique and intensive needs it is commonly acknowledged as taking up to three years. Only two years were provided in law and regional centers were expected to begin transition almost immediately without sufficient resources. More fundamentally, the services required are subject to the median rate, making it extraordinarily difficult to find service providers to meet those needs.

Type of Facility	Number of Individuals (Statewide)
Criminal Justice System	208
Facilities Ineligible for FFP	149
Out-Of-State	24
Total: 381	

Source: Department of Developmental Services, Individuals with Challenging Needs, November 2013.

There are hundreds of individuals who need specialized services to meet their medical, psychiatric, and forensic needs who are not currently in these facilities. These individuals remain in the community accessing a patchwork of available services. This patchwork frequently costs more than if a specialized, holistic service with an adequate rate structure was able to be developed.

The Health and Human Services Agency convened a Task Force on the Future of the State's Developmental Centers. Its report, released at the end of 2013, identified 445 individuals with complex medical needs, 315 of whom will require specialized medical homes in the community. The Task Force also identified 227 residents with complex and challenging behaviors and approximately 200 other residents with involvement in the criminal justice system. All of these individuals will most likely require more

specialized negotiated-rate living arrangements and day programs to meet their needs in the community.

REPORTS AND STUDIES

1997: Department of Developmental Services (DDS) Report to the Legislature

As part of the 1996 Budget Act, DDS was required to review existing methodologies in use, survey other possibilities, and gather stakeholder input. In November 1996, DDS met with stakeholders to review current, and recommend new, rate-setting practices. In summary, DDS said "retaining the existing system would involve no disruptions of current practices and trends, and allows continued use and evaluation of the several alternatives, and particularly the AB 637 proposal process discussed…that are designed to increase the flexibility and creativity of regional centers in meeting local needs. It is undesirable to alter the system before the efficacy of present and anticipated practices can be assessed." [iii]

Reports and Studies

1997
Department of Developmental Services Report to the Legislature

1999
Bureau of State Audits Report

2000
DDS May Revise

2001
Center for Health Study Policies report in response to SB 1038

2007
DDS Report to the Legislature on Controlling Costs

2011
UCLA Study on Challenges to the System

1998: Senate Bill 1038

Welfare and Institutions Code § 4681.1, enacted by SB 1038, states that the department shall adopt regulations that specify rates for community care facilities. As a result, DDS contracted with the Center for Health Policy Studies to examine the rate system and identify a methodology for payment to providers that would support the achievement of the desired outcomes for clients and family.

1999: Bureau of State Audit Report

The BSA found "the State's system was designed to provide optimal service to adult consumers, yet insufficient funding hampers providers' and regional centers' ability to appropriately supply services and retain staff. Inadequate state funding often forces centers to pay providers rates that do not reflect current economic conditions, which increases the chance that consumers will receive fewer or inferior services and increases the difficulty providers have in retaining staff." [iv]

2000: May Revise to the Governor's Budget:

In comments submitted with its request for rate increases for several services, DDS stressed the importance of adequate funding. "Without funding sufficient to recruit, train, and retain a skilled labor force, the Department puts at significant risk the health, safety, and well-being of consumers. Specialized knowledge results from a long-term relationship with consumers, families, and the surrounding community. Turnover issues are amplified in the lives of consumers and families when the knowledge, skills, and abilities of the experienced direct support professional gains over time is lost. The transfer of knowledge to newly hired workers is incomplete, and results in a reduction in service quality. Without sufficient funding, we jeopardize the long-term investment value of a skilled workforce." [v]

2001: Center for Health Policy Studies

As a result of 1998 legislation, DDS contracted with the Center for Health Policy Studies (CHPS) to develop a cost-modeled rate system. The two-phase contract ran from February 1, 2000, through July 31, 2001. The first phase was to develop a residential rates model. The second phase was to apply the model to other services. The model developed was built around client outcomes. From that baseline, it allowed for the incorporation of different variables, such as current economic trends, changes in law (*i.e.*, minimum wage), and other elements to be accounted for, thereby making rate adjustments fair and equitable among providers. The conclusion was that cost-modeled systems, if funded adequately, and if developed for all service types, would promote consistency and fairness among providers. [xiv]

2007: DDS Report to the Legislature

DDS completed a report in response to "legislation chaptered on August 24, 2007, [that] required the Department of Developmental services to 'develop a plan of options for consideration by the Administration and the Legislature to better control regional center costs of operating and providing state-supported services." This report contains an extensive review of the developmental services system. The report concludes by stating "there are no simple solutions for reducing regional center expenditures. However, it is critical that discussions about cost containment are informed by an understanding of the existing system so that fiscally responsible decisions can be made while ensuring quality services for [clients] and their families." [vi]

2011: UCLA Study

A UCLA report, published almost ten years after the 2001 CHPS study, reiterated CHPS' conclusion: *"Establishing a fee schedule that is informed by thorough cost-based analysis and that incorporates adjustments for the increasing cost of service provision would allow vendors to sustainably maintain operations by limiting undue fiscal strain. A cost-based analysis recognizes the inherent variability in consumer needs -- where more severe conditions require more intense and expensive services -- and it also engages stakeholders in the rate-setting process.*

Furthermore, the cost statements required for rate setting should reflect the true costs of providing efficient and high-quality services, as required by the California Welfare and Institutions Code § 4690. This would allow for the consideration of any mechanisms that have been employed by vendors to reduce costs in a rate-restricted environment in order to maintain solvency. The inclusion of an explicit adjustment for input price inflation, such as the Consumer Price Index (CPI), would mitigate threats to access by recognizing the ongoing cost increases faced by vendors." [vii]

SUMMARY

From a policy perspective, California's developmental services system is poised to promote better service outcomes for more than 265,000 individuals with developmental disabilities. Services will be more individualized and will lead to greater levels of community participation, employment, and independence. Unfortunately, long-standing underfunding of the service system undermines this potential forward progress and the adequacy of the community-based provider network.

The concepts in this paper are not new. Studies dating back many years speak to the same point, but it bears repeating now. Even though client outcomes are directly tied to the quality and availability of services, the rate structure inhibits their quality – or makes it impossible to provide them. Acknowledging the problem with a passive response does not help the people we serve to progress. The challenge before us looms large only because it has been ignored for so long.

The provision of services has changed dramatically in recent years, owing to the shift in client population and advances in knowledge and methods of intervention. Accompanying these changes has been an evolution of services and service categories, as existing models were not flexible enough to meet emerging needs. The ability to negotiate rates for more innovative or individualized service models makes them viable. It is critical that all service codes be considered for rate-setting review. As the philosophy of the developmental services system evolves, and better outcomes are expected, there needs to be a renewed commitment to develop and sustain service models to meet the needs of individuals both today and in the future.

Over fifty years ago, California made a promise to the state's most vulnerable residents. The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to the people with developmental disabilities as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an

obligation to them which it must discharge..." Absent effective intervention, the health and well-being of clients and their families, for whom the state has accepted responsibility, are at risk. [xxi]

ENDNOTES

[i] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 14.

[ii] "Supporting Californians with Developmental Disabilities," CPRC/CPAC Briefing Paper, California Policy Research Center, University of California, Berkley, 2006, p. 4-5.

[iii] "Rate Setting Alternatives for Community-Based Day and Residential Services," Report to the Legislature, Department of Developmental Services, Community Services Division, February 27, 1997, p. 19.

[iv] "Department of Developmental Services: Without Sufficient Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults," Bureau of State Audits, California State Auditor, October 1999, p. 14.

[v] "Rate Increase for Day, Infant, and Respite Programs," State of California May Revision Proposal, Fiscal Year 2000-2001, Department of Developmental Services, April 2000, p. 4.

[vi] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 98.

[vii] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 7.

[viii] Welfare and Institutions Code § 4681.5 (*Amended by Stats. 2008, 3rd Ex. Sess., Ch. 3, Sec. 6. Effective February 16, 2008.*)

[ix] "Department of Developmental Services Detail of Proposed Changes," 2001 May Revise to the Governor's Budget.

[x] "Department of Developmental Services: Without Sufficient Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults," Bureau of State Audits, California State Auditor, October 1999, p. 15.

[xi] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 52.

[xii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 12.

[xiii] "Additional Clarification on Implementation of Statutory Requirements in SB 74, Chapter 9, Statutes of 2011," Department of Developmental Services, Letter of Regional Center Executive Directors, September 16, 2011, p.4.

[xiv] Draft Report to the Service Delivery Reform Committee, Center for Health Policy Studies, May 15, 2001.

[xv] "Analysis of California's Commitment to Developmental Disabilities Services," David Braddock, Ph.D. and Richard Hemp, M.A., January 23, 2004, p. 8.

[xvi] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 4.

[xvii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 23.

[xviii] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 3.

[xix] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 26.

[xx] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 4.

[xxi] WIC § 4501

FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

Prepared by the Association of Regional Center Agencies

September 2013

CONTENTS

FUNDING THE WORK OF
CALIFORNIA'S REGIONAL CENTERS
EXECUTIVE SUMMARY

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

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

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

These problems can be categorized into four groups: (1) actions leading to a direct reduction in the OPS budget without a corresponding decrease in operations workload, (2) actions imposing additional workload for which no additional, or inadequate, funding

was added to the OPS budget, (3) inaction with respect to updating the OPS budgeting formula, and (4) design flaws inherent in the OPS budgeting formula.

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

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

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

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

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

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

The Lanterman Act specifies that regional centers must adhere to certain caseload ratios (ratios of Consumer Program Coordinators [CPCs] to consumers served).

However, since salaries have been frozen at 1991 levels, regional centers are unable to hire sufficient CPCs to meet the required caseload ratios and, consequently, puts over $1 billion in federal funds at risk.

4. Design Flaws in the OPS Formula

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

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

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

CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[iii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the

primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has "accepted a responsibility" is directly threatened.

I. INTRODUCTION

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

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

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

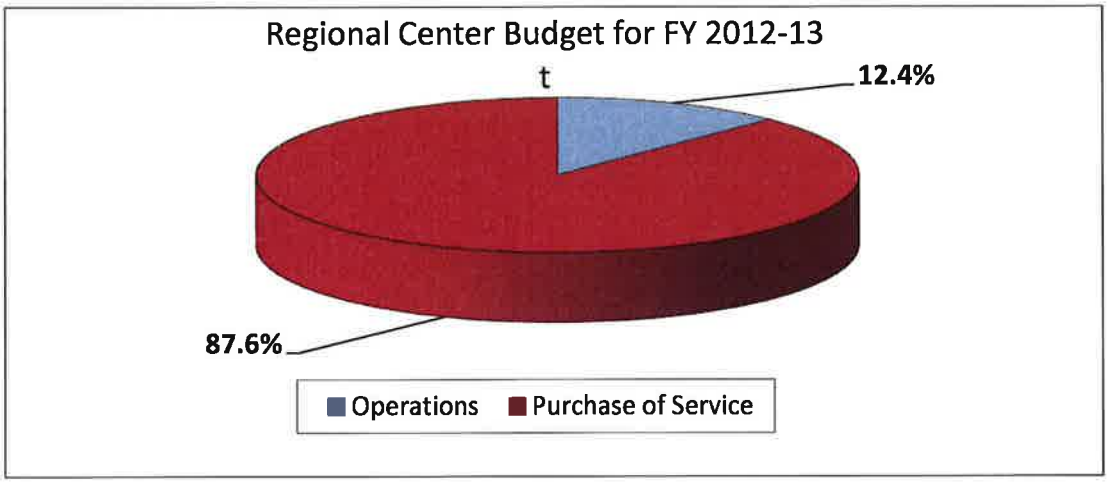
II. BACKGROUND

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

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

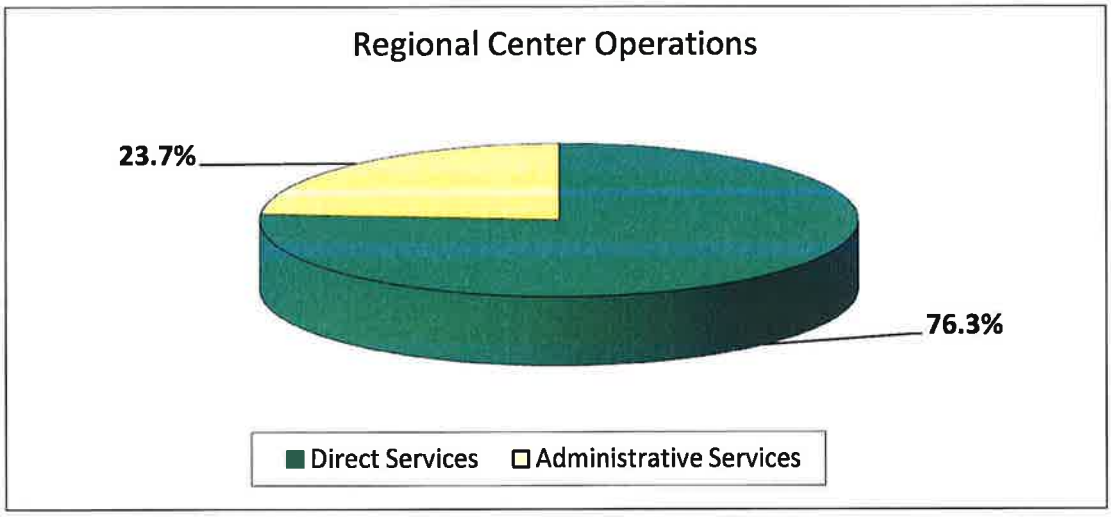
The OPS budget funds a regional center's costs related to personnel and benefits, insurance, leases, equipment, information technology, accounting/payment functions, personnel management, consultant services, independent financial audits, consulting/legal services, board support, travel, office facilities,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

Chart 1



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

Chart 2

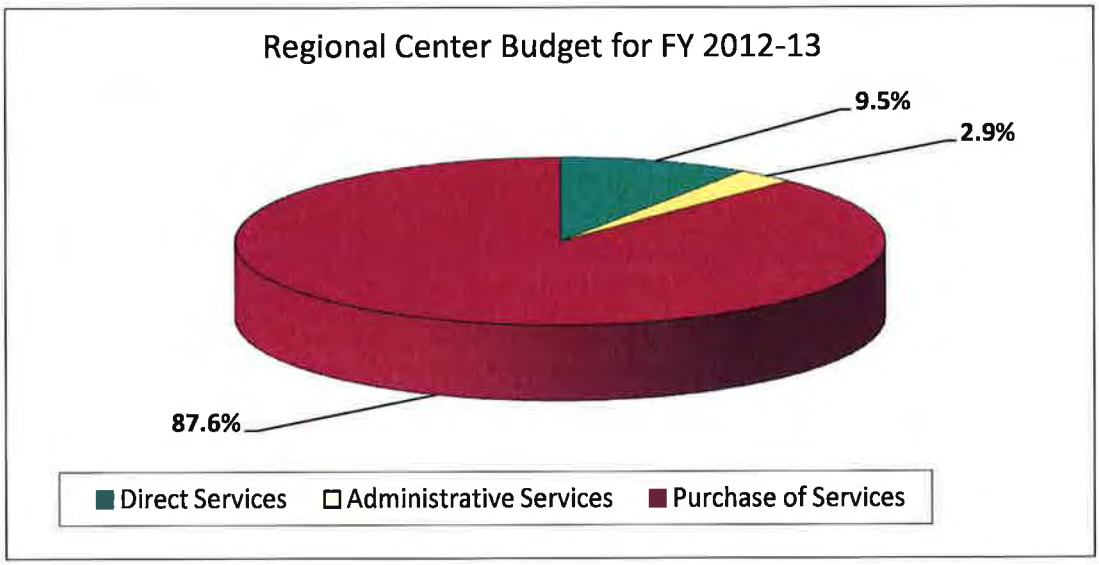


Direct services funded through the OPS budget include service coordination, assessment/diagnosis, individual program planning, consumer money/benefits management, clinical services, 24-hour emergency response, quality assurance,

advocacy, intake/assessment/referral, family support, training, special incident reporting/investigation, etc. Therefore, reductions in the regional-center OPS budget impact the provision of direct services to consumers. An attached publication prepared by Frank D. Lanterman Regional Center describes, in greater detail, the range of important direct services provided by regional centers.[iii]

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

Chart 3



B. Budgeting and Allocation Methodology - Prior to 1979-80, each regional center developed its own staffing pattern and budget through negotiations with the Department of Developmental Services (DDS). Each staffing pattern was based on a program-budget methodology, and the budget-allocation methodology for compensation was based on projected actual salaries and benefits. While this approach addressed local variation and provided for flexibility and innovation, there was also argument for a less

subjective and more equitable method for allocating staffing resources to regional centers taking into account the size of the regional center (based on caseload) and the resources necessary to accomplish the regional centers' statutory and contractual mandates. This led to the development of the current methodology for funding the regional centers' personnel and related operational costs, which is commonly referred to as the "core staffing formula." This formula, developed in 1978, was crafted by DDS personnel based on their knowledge of existing regional center staffing patterns that had previously been approved by DDS, and other standards that were available at the time. For example, the case management ratio of one service coordinator to 62 consumers was based on what county welfare offices used for the Absent Parent Program to receive federal funding. This 1978 formula was arguably an improvement over the initial approach to budgeting and allocating OPS funding, but the formula was still an *ad hoc* creation developed without the benefit of the specialized study that such an important and complex statewide publicly-funded service system needed. There is no written analysis, justification, or documentation supporting the 1978 base formula, which is the same formula used today, except for some "add-ons" and minor changes.

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

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

CHART 4

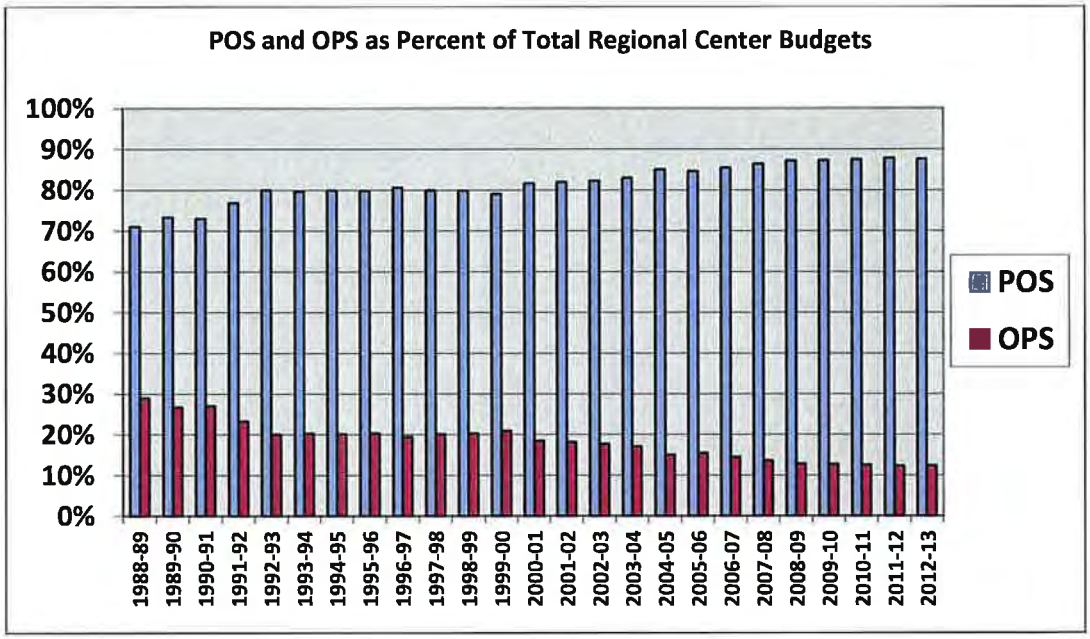
CATEGORY	FY 2013-14 MAY REVISION FY 2012-13 BUDGET *(Dollars in thousands)*	% OF TOTAL BUDGET
Operations	$537,415	12.8
Purchase of Services	3,647,976	86.7
Early Intervention and Prevention Programs	22,384	0.5
TOTAL	**$4,207,775**	**100.0**

CHART 5

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

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	TOTAL BUDGET *(Dollars in thousands)*	% POS	% OPS
2005-06	2,784,773	84.6	15.4
2006-07	3,167,170	85.5	14.5
2007-08	3,512,929	86.4	13.6
2008-09	3,861,302	87.2	12.8
2009-10	3,886,591	87.3	12.7
2010-11	3,909,604	87.5	12.5
2011-12	3,958,227	87.8	12.2
2012-13	4,162,793	87.6	12.4

CHART 6



C. Factors Leading to OPS Underfunding – The factors that have led to the diminution of regional centers' operating capacity and to the current regional center OPS funding crisis fall within four primary categories: (1) actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in

operational workload, (2) actions imposing additional workload for which the regional centers received no additional - or inadequate - funding, (3) inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business, and (4) design flaws in the OPS formula. While not an exhaustive list, these factors, broken out by category, are as follows:

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

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

- Extending Regional Center Assessment Timelines: Regional centers have mandated timelines for completing their assessment of prospective consumers and for developing an individual program plan or individualized family service plan for those found eligible for services.[vi] The timeline for completing the assessment phase

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

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

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

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

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

Another round of reductions to regional center budgets began again in 2009 with the passage of ABX4 9 and continued through 2012. Though many of these budget

reductions used euphemisms such as "cost containment," "operational efficiencies," and "General Fund savings," they were, in effect, unallocated reductions.

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

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

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

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

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

- Managing/Implementing the New Uniform Fiscal System: During 1984, DDS implemented the statewide Uniform Fiscal System to provide for uniform accounting procedures and centralized collection of client and fiscal data. There were numerous

implementation issues and unfunded workload related to maintaining this new system.

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

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

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

- Administering Vouchers: In 1991, the Department adopted new regulations establishing a voucher mechanism for paying for specified services. This new approach gave families and adult consumers a direct role in procuring nursing, day care, respite, transportation, diapers and nutritional supplements. While beneficial for many who choose to obtain their services through this purchasing mechanism,

the processing of billings and payments for individual families is very staff-intensive, which includes training family members on record keeping and payroll tax requirements, and for which regional centers received no additional resources to perform the increased workload.

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

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

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

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

5. Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.
6. Quality assurance expertise to assist the regional center in providing the necessary coordination and cooperation with the Area Board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

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

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

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

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

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

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

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

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

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

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

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

- Every two years screening all vendored service providers against federal and state databases to ensure vendors have not been disqualified from participating

in the Home and Community Based Services (HCBS) Waiver program [Wel. & Insti. Code §4648.12].

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

- Completing transition plans for all regional center consumers residing out-of-state and conduct statewide search for in-state services and development of appropriate services as needed [Wel. & Insti. Code § 4519(e)].

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

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

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

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

- Failure to Update Salaries in the Core Staffing Formula

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

state ceased providing regional centers cost-of-living adjustments for their personnel costs. **This policy change, which has continued through the current fiscal year, is the action that has impacted the OPS budget most significantly**.

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

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

- Failure to Fully Fund Mandated Caseload Ratios

According to Wel. & Insti. Code § 4640.6, regional centers are required to maintain certain caseload ratios. For consumers on the HCBS Waiver or in Early

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. 1983 – *Personnel Task Force Report.* ARCA establishes a Personnel Task Force to (1) pursue a core staffing study, and (2) coordinate a study comparing the state's classification and pay plan with that of the regional center core staffing formula. Cooperative Personnel Services (at that time an entity within the State Personnel Board) conducts the comparison classification study and issues its report in February of 1984. The report finds that the regional center position salaries lag the state equivalent positions by 12.4%. The Task Force develops a recommended staffing allocation formula reflecting the resources needed for regional centers to comply with their contractual and statutory obligations. The Personnel Task Force releases its report in February 1984, including a copy of the CPS study as an

appendix. DDS, while sympathetic, is not able to gain support within the Administration to implement the report's recommendations.

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

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

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

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

DDS uses the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal is supported within the

Administration, but is not included in the Governor's budget because of a severe economic downturn.

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

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

CHANGES IN THE OPERATIONS BUDGETING FORMULA

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

YEAR	CHANGE	FUNDING (Millions)	REASON
	sufficient staffing for performing quarterly monitoring visits.		
98-99	Establishing 14 additional regional center clinical teams.	4.5	Same as above
98-99	Increasing monitoring frequency of consumers with health conditions living in CCFs. Regional center are provided addition staff for new activities.	5.3	New DSS Title 22 regulatory requirements.
98-99	Reducing CPC caseloads to 1:62 (included reduction of CPC salary savings requirement; updating CPC salaries; restoration of unallocated reduction for CPCs; and funding other essential positions). (Half-year funding)	27.9	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
99-00	Additional funds to fully implement the above reduction of CPC caseloads to 1:62.	27.9	Same as above
98-99	Establishing a consumer complaint process in statute. Regional centers each provided ½ position for new workload.	0.7	Legislation (SB 1039) establishing a consumer complaint process, i.e., Wel. & Insti. Code 4731.
98-99	Fund Essential Regional Center Positions – Information Systems manager, Personal Computer Systems Manager, Training Officer, Special Incident Coordinator, Vendor Fiscal Monitor, Human Resources Manager, and Information Systems Assistant (half-year funding)	6.7	Fund essential positions previously not included in the core staffing formula
99-00	Additional funds to fully implement the above new positions.	6.7	Same as above
99-00	Performing health status reviews of consumers during a part of the IPP process.	3.2	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
00-01	Establishing 1:45 maximum caseload ratios for service coordinators for consumers placed out of state developmental centers.	0.6	Same as above
01-02	Implementing a statewide risk management system, including regional center risk management committees.	6.7	Same as above
02-03	Establishing Federal Program Coordinators and providing unfunded rent relief.	15.2	State initiative to increase and maintain federal financial participation.
03-04	Establishing Federal Compliance Specialists and fiscal/contract documentation staff.	4.4	Same as above
03-04	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	1.4	State initiative to increase federal financial participation.
03-04	Complying with requirements of the federal	1.4	Congressional enactment

YEAR	CHANGE	FUNDING (Millions)	REASON
	Health Insurance Portability and Accountability Act (HIPPA)		of HIPPA legislation.
04-05	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	2.8	State initiative to increase federal financial participation.
04-05	Funding for regional center administrative activities associated with implementing the Family Cost Participation Program.	.6	Enactment of legislation establishing the Family Cost Participation Program.
05-06	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.8	State initiative to increase federal financial participation.
06-07	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.3	Same as above
07-08	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.1	Same as above
06-07	Funding for expansion of Autism Spectrum Disorder Initiative	1.7	State initiative to better serve consumers with autism spectrum disorder
07-08	Additional funds to implement the expansion of the Autism Spectrum Disorder Initiative.	1.8	Same as above
08-09	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	.9	State initiative to increase federal financial participation.
09-10	Fund additional case managers to participate in IPP meetings of consumers residing in state developmental centers	3.1	Pursuant to the Capitol People First lawsuit settlement

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

III. THREAT TO FEDERAL FUNDING

In a 1992 oversight hearing before a Senate Budget Subcommittee, the DDS Director testified that *"the Department believes that regional centers have sustained the most serious and damaging budget reductions of all entities in the developmental services system. The Department is concerned that two years of unallocated reductions to*

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

One of the key issues identified by CMS during its review were the inordinately high caseloads of regional center service coordinators, which is a situation directly related to insufficient resources, since service coordinators, and their associated costs, comprise about 60% of the entire regional center OPS budget.[xiv] The CMS review noted that

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

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

IV. CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[xviii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to

severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has "accepted a responsibility" is directly threatened.

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1. Annual California State Budget Acts, from Chapter 359, Statutes of 1978 through Chapter 118, Statutes of 1991, Witkin State Law Library of California.

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3. "Fiscal and Program Compliance Review of Department of Developmental Services Regional Center Operations," State of California, Department of Finance, Fiscal Management Audits, April 1979.

4. "Regional Center and CCSB Differential Caseload Staffing," State of California, Department of Finance, Program Evaluation Unit, April 1980.

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9. "Report on Regional Center Administrative and Service Activities," California Department of Developmental Services, April 1, 1992.

10. Dennis Amundson, Testimony for the Oversight Hearing of the Senate Budget Subcommittee #3 on Health, Human Services and Labor, Department of Developmental Services, November 5, 1992.

11. "Regional Center Core Staffing Study – Final Report," prepared by Citygate Associates for the California Department of Developmental Services, September 1999.

12. "What Is This Thing Called Regional Center 'Operations'," Published in *Viewpoint*, the Frank D. Lanterman Regional Center newsletter, Summer 2003.

13. "Medicaid and Case Management for People with Developmental Disabilities. Options, Practices, and Issues (Second Edition)," National Association of State Directors of Developmental Disabilities, Inc., May 2006.

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

15. "2008-09 Governor's Budget November Estimate - Local Assistance for Regional Centers," California Department of Developmental Services, Estimates Section, January 10, 2008.

16. "Community Services Program – Expenditure and Caseload History," Department of Developmental Services, Budget Section, April 17, 2008.

17. "Regional Centers' Budget History," Department of Developmental Services, Budget Section, April 8, 2008.

ENDNOTES

[i] Wel. & Insti. Code §4621.5

[ii] Wel. & Insti. Code §4501.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[xviii] Wel. & Insti. Code §4501.

ATTACHMENT A

CORE STAFFING FORMULA

Attachment A
CORE STAFFING - BY 2013-14
Comparison of the 2013-14 Governor's Budget to the 2013 May Revision

	Governor's Budget	May Revision Budgeted Positions	Budgeted Salary	Cost	Difference
I. CORE STAFFING FORMULA					
A. PERSONAL SERVICES					
1. DIRECT SERVICES					
a. Clinical					
(1) Intake and Assessment					
(a) Physician	$10,598,533	**133.22**	**$79,271**	**$10,560,483**	-$38,050
(b) Psychologist	11,165,020	**266.43**	**41,754**	**11,124,518**	-40,502
(c) Nurse	4,969,763	**133.22**	**37,171**	**4,951,921**	-17,842
(d) Nutritionist	3,760,981	**133.22**	**28,130**	**3,747,479**	-13,502
(2) Clinical Support Teams					
(a) Physician/Psychiatrist	6,350,346	**69.00**	**92,034**	**6,350,346**	0
(b) Consulting Pharmacist	4,171,050	**69.00**	**60,450**	**4,171,050**	0
(c) Behavioral Psychologist	3,793,068	**69.00**	**54,972**	**3,793,068**	0
(d) Nurse	3,482,982	**69.00**	**50,478**	**3,482,982**	0
(3) SB 1038 Health Reviews					
(a) Physician	2,195,011	**22.12**	**92,034**	**2,035,792**	-159,219
(b) Nurse	5,618,201	**103.23**	**50,478**	**5,210,844**	-407,357
b. Intake / Case Management					
(1) Supervising Counselor (Intake) (1:10 Intake Workers in Item (2) below)	3,176,767	**82.74**	**38,036**	**3,147,099**	-29,668
(2) Intake Worker	26,333,950	**827.42**	**31,532**	**26,090,207**	-243,743
(3) Supervising Counselor (Case Management) (1:10 CPCs in Items (6) and (7) below)	22,073,797	**419.61**	**52,392**	**21,984,207**	-89,590
(4) Supervising Counselor (Capitol People First) (DC Case Management 1:10 CPCs)	242,592	**3.61**	**67,200**	**242,592**	0
(5) Client Program Coordinator (CPC), 1:66 DC Consumers Capitol People First	1,698,326	**36.12**	**47,019**	**1,698,326**	0
(6) CPC, 1:66 Consumers(Total Pop w/o DCs,CPP,ES)	66,394,390	**1,950.79**	**34,032**	**66,389,285**	-5,105
(7) CPC (Waiver, Early Start only), 1:62 Consumers	75,322,005	**2,197.06**	**34,032**	**74,770,346**	-551,659
(8) CPC, Quality Assurance for ARM	1,666,547	**48.25**	**34,032**	**1,642,044**	-24,503
(9) Supervising Counselor, DSS Incidental Medical Care Regulations (1:10 CPCs)	71,253	**1.36**	**52,392**	**71,253**	0
(10) CPC, DSS Incidental Medical Care Regs	515,541	**13.62**	**37,824**	**515,163**	-378
c. Quality Assurance / Quarterly Monitoring					
(1) Supervising Counselor	2,061,101	**40.08**	**52,392**	**2,099,871**	38,770
(2) CPC	13,387,168	**400.82**	**34,032**	**13,640,706**	253,538
d. Early Intervention					
(1) General					
(a) Prevention Coordinator	876,792	**21.00**	**41,752**	**876,792**	0
(b) High-Risk Infant Case Manager	856,905	**21.00**	**40,805**	**856,905**	0
(c) Genetics Associate	798,714	**21.00**	**38,034**	**798,714**	0
(2) Early Start / Part C					
(a) Supervising Counselor	1,142,670	**20.93**	**52,392**	**1,096,565**	-46,105
(b) CPC	7,423,740	**209.32**	**34,032**	**7,123,578**	-300,162
(c) Administrative and Clinical Support (see next page)					
e. Community Services					
(1) Special Incident Coordinator	1,100,232	**21.00**	**52,392**	**1,100,232**	0
(2) Vendor Fiscal Monitor	1,309,741	**21.88**	**50,844**	**1,112,467**	-197,274
(3) Program Evaluator	898,653	**21.00**	**42,793**	**898,653**	0
(4) Resource Developer	898,653	**21.00**	**42,793**	**898,653**	0
(5) Transportation Coordinator	898,653	**21.00**	**42,793**	**898,653**	0
(6) Administrative Services Analyst (SB 1039 Consumer Complaints)	449,327	**10.50**	**42,793**	**449,327**	0
(7) Developmental Center Liaison	226,695	**3.33**	**38,036**	**126,660**	-100,035
(8) Diversion	126,584	**4.00**	**31,646**	**126,584**	0
(9) Placement Continuation:					
(a) Supervising Counselor	6,287	**0.13**	**52,392**	**6,811**	524
(b) CPC (Supplement at 1:45 Consumers)	40,838	**1.34**	**34,032**	**45,603**	4,765
f. Special Incident Reporting (SIR)					
(1) Supervising Counselor	388,749	**7.40**	**52,392**	**387,701**	-1,048
(2) QA/CPC	2,525,855	**74.02**	**34,032**	**2,519,049**	-6,806
(3) Nurses	1,873,239	**37.01**	**50,478**	**1,868,191**	-5,048
g. Mediation					
(1) Clinical Staff	7,093	**0.11**	**64,484**	**7,093**	0
(2) Supervising Counselor	52,916	**1.01**	**52,392**	**52,916**	0
(3) CPC	17,356	**0.51**	**34,032**	**17,356**	0
h. Expansion of Autism Spectrum Disorders (ASD) Initiative					
(1) ASD Clinical Specialist	1,371,888	**21.00**	**65,328**	**1,371,888**	0
(2) ASD Program Coordinator	1,318,464	**21.00**	**62,784**	**1,318,464**	0
i. SUBTOTAL DIRECT SERVICES	**$293,658,436**	**7,669.41**		**$291,678,437**	-$1,979,999

Attachment A

CORE STAFFING, BY (continued)

	Governor's Budget	May Revision Positions	Budgeted Salary	Cost	Difference
2. ADMINISTRATION					
a. Executive Staff					
(1) Director	$1,279,698	**21.00**	**$60,938**	**$1,279,698**	$0
(2) Administrator	1,009,449	**21.00**	**48,069**	**1,009,449**	0
(3) Chief Counselor	986,643	**21.00**	**46,983**	**986,643**	0
b. Fiscal					
(1) Federal Program Coordinator (Enh. FFP, Phase I)	1,206,177	**21.00**	**57,437**	**1,206,177**	0
(2) Federal Compliance Specialist (Enh. FFP, Phase II)	4,221,241	**105.82**	**39,887**	**4,220,842**	-399
(3) Fiscal Manager	963,480	**21.00**	**45,880**	**963,480**	0
(4) Program Tech II (FCPP)	882,890	**24.21**	**36,468**	**882,890**	0
(5) Revenue Clerk	1,234,546	**60.82**	**20,617**	**1,253,926**	19,380
(6) Account Clerk (Enh. FFP, Phase II)	584,640	**21.00**	**27,840**	**584,640**	0
(7) Account Clerk	8,198,991	**444.05**	**18,397**	**8,169,188**	-29,803
c. Information Systems and Human Resources					
(1) Information Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(2) Information Systems Assistant	1,000,692	**21.00**	**47,652**	**1,000,692**	0
(3) Information Systems Assistant (SIR)	500,346	**10.50**	**47,652**	**500,346**	0
(4) Privacy Officer (HIPAA)	898,653	**21.00**	**42,793**	**898,653**	0
(5) Personal Computer Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(6) Training Officer	1,099,728	**21.00**	**52,368**	**1,099,728**	0
(7) Training Officer (SIR)	549,864	**10.50**	**52,368**	**549,864**	0
(8) Human Resources Manager	1,067,724	**21.00**	**50,844**	**1,067,724**	0
d. Clerical Support					
(1) Office Supervisor	489,867	**21.00**	**23,327**	**489,867**	0
(2) PBX/Mail/File Clerk	1,378,188	**63.00**	**21,876**	**1,378,188**	0
(3) Executive Secretary	1,148,490	**52.50**	**21,876**	**1,148,490**	0
(4) MD/Psychologist Secretary II	279,019	**11.06**	**23,388**	**258,671**	-20,348
(5) MD/Psychologist Secretary I	4,387,232	**199.83**	**21,876**	**4,371,481**	-15,751
(6) Secretary II	3,913,748	**166.77**	**23,388**	**3,900,417**	-13,331
(7) Secretary I	19,328,526	**1,023.64**	**18,757**	**19,200,415**	-128,111
(8) Secretary I (DC Case Management - Capitol People First)	210,834	**6.62**	**31,848**	**210,834**	0
e. SUBTOTAL ADMINISTRATION	**$59,616,354**	**2,452.32**		**$59,427,991**	**-$188,363**
3. TOTAL POSITIONS AND SALARIES (Item A.1.i. + Item A.2.e.)	$353,274,790	**10,121.73**		$351,106,428	-$2,168,362
a. CPCs	*168,476,225*			*167,846,293*	*-629,932*
b. All Other Staff	*184,798,565*			*183,260,135*	*-1,538,430*
4. Fringe Benefits					
a. CPCs 23.7%	**$39,928,865**			**$39,779,571**	-$149,294
b. All Other Staff 23.7%	**43,797,260**			**43,432,652**	-364,608
c. Total Fringe Benefits	**$83,726,125**			**$83,212,223**	-$513,902
5. Salary Savings					
a. CPCs 1.0%	**-$2,084,051**			**-$2,076,259**	$7,792
b. All Other Staff 5.5%	**-12,572,770**			**-12,468,103**	104,667
c. Total Salary Savings	**-$14,656,821**			**-$14,544,362**	$112,459
6. Early Start / Part C Administrative and Clinical Support (salaries, fringe benefits and salary savings)	$694,000			**$694,000**	$0
7. TOTAL PERSONAL SERVICES (Items A.3. + A.4. + A.5. + A.6.)	**$423,038,094**			**$420,468,289**	-$2,569,805
ROUNDED	**$423,038,000**	**10,122.00**		**$420,468,000**	-$2,570,000
B. OPERATING EXPENSES AND RENT					
1. Operating Expenses	**$39,785,000**			**$39,600,000**	-$185,000
2. Rent	**$52,022,000**			**$52,020,000**	-$2,000
a. Rent	*55,022,000*			*55,020,000*	
b. Elimination of Office Relocation and Modifications	*-3,000,000*			*-3,000,000*	
3. Subtotal Operating Expenses and Rent	**$91,807,000**			**$91,620,000**	-$187,000
C. TOTAL CORE STAFFING (Items A.7. + B.3.)	**$514,845,000**			**$512,088,000**	-$2,757,000

Attachment B

CORE STAFFING FORMULAS

CORE STAFFING CLASSIFICATION	STAFFING FORMULA
A. PERSONAL SERVICES	
1. DIRECT SERVICES	
a. Clinical	
(1) Intake and Assessment	
(a) Physician (minimum of 1)	1.0 position : 2,000 total consumers
(b) Psychologist	1.0 position : 1,000 total consumers
(c) Nurse (minimum of 1)	1.0 position : 2,000 total consumers
(d) Nutritionist (minimum of 1)	1.0 position : 2,000 total consumers
(2) Clinical Support Teams	
(a) Physician/Psychiatrist	1.0 position : 1,700 consumers in community care facilities (CCF) and supported living and those with severe behavior and/or medical problems
(b) Consulting Pharmacist	1.0 position : 1,700 " "
(c) Behavioral Psychologist	1.0 position : 1,700 " "
(d) Nurse	1.0 position : 1,700 " "
(3) SB 1038 Health Reviews	
(a) Physician	1.5 hours : Referral/1,778 hrs./ full-time equivalent (FTE) position
(b) Nurse	1.75 hours : Individual program plan (IPP) review/1,778 hrs./FTE position
b. Intake/Case Management	
(1) Supervising Counselor: Intake	1.0 position : 10 Intake Workers
(2) Intake Worker	1.0 position : 14 monthly intake cases (assume average intake case lasts 2 mos.)
(3) Supervising Counselor: Case Management	1.0 position : 10 CPCs in Items b.(4 and 5) below
(4) Client Program Coordinator (CPC)	1.0 position : 62 Waiver and Early Start consumers (excluding CPP placements)
(5) CPC	1.0 position : 66 consumers (all other consumers, excluding CPP placements)
(6) Supervising Counselor: Capitol People First	1.0 position : 10 CPCs in Items b.(7) below
(7) CPC Capitol People First	1.0 position : 66 consumers (Developmental Center residents)
(8) CPC, Quality Assurance for Alternative Residential Model	1.0 position : 527 CCF consumers
(9) Supervising Counselor: DSS Incidental Medical Care Regulations	1.0 position : 10 CPCs in item b.(10) below
(10) CPC, DSS Incidental Medical Care Regulations	1.0 position : 2.5 hrs x 8 visits per year to CCF consumers who rely on others to perform activities of daily living

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
1. DIRECT SERVICES (continued)		
c. Quality Assurance/Quarterly Monitoring		
(1) Supervising Counselor	1.0 position	10 CPCs in Item c.(2) below
(2) CPC	10 hrs/yr.	: CCF consumer/1,778 hrs./FTE
	14 hrs./yr.	: Supported/Independent Living consumer/1,778 hrs./FTE
	10 hrs/yr.	: Skilled Nursing Facility and Intermediate Care Facility consumer/1,778 hrs./FTE
	10 hrs/yr.	: Family Home Agency consumer/1,778 hrs./FTE
d. Early Intervention		
(1) General		
(a) Prevention Coordinator	1.0 position	: RC
(b) High-Risk Infant Case Mgr.	1.0 position	: RC
(c) Genetics Associate	1.0 position	: RC
(2) Early Start/Part C		
(a) Supervising Counselor	1.0 position	: 10 CPCs in Item d.(2)(b) below
(b) CPC:		
Marginal positions from:	1.0 position	: 62 children<age 3yrs.
to:	1.0 position	: 45 children<age 3yrs.*
e. Community Services		
(1) Special Incident Coordinator	1.0 position	: RC
(2) Vendor Fiscal Monitor	0.5 position	: RC plus 1: every 3,140 vendors
(3) Program Evaluator	1.0 position	: RC
(4) Resource Developer	1.0 position	: RC
(5) Transportation Coordinator	1.0 position	: RC
(6) Administrative Services Analyst (SB 1039, Chapter 414, Statutes of 1997) Consumer Complaints	0.5 position	: RC
(7) Developmental Center Liaison	1.0 position	: 400 DC consumers
(8) Diversion	4.0 positions	: 21 RCs
(9) Placement Continuation		
(a) Supervising Counselor	1.0 position	: 10 CPCs in Item e.(9)(b) below
(b) CPC:		
1. Marginal positions from:	1.0 position	: 62 CPP Placements
2. to:	1.0 position	: 45 CPP Placements

* Note: This 1:45 staffing ratio is a funding methodology, not a required caseload ratio.

CORE STAFFING CLASSIFICATION			STAFFING FORMULA
A. PERSONAL SERVICES (continued)			
1. DIRECT SERVICES (continued)			
f. Special Incident Reporting (SIR)			
(1) Supervising Counselor	1.0 position		10 CPCs in Item f. (2) below
(2) QA/CPC	1.0 position	:	RC plus 1:every 5,000 consumers
(3) Nurse	0.5 position	:	RC plus 0.5: every 5,000 consumers
g. Mediation			
(1) Clinical Staff	2.0 hours	:	25% of annual mediations/ 1,778 hrs /FTE position
(2) Supervising Counselor	4.5 hours	:	mediation/1,778 hrs./FTE position
(3) CPC	4.5 hours	:	50% of annual mediations/ 1,778 hrs./FTE position
h. Expansion of Autism Spectrum Disorders (ASD) Initiative			
(1) ASD Clinical Specialist (effective January 1, 2007)	1.0 position	:	RC
(2) ASD Program Coordinator (effective January 1, 2007)	1.0 position	:	RC
2. ADMINISTRATION			
a. Executive Staff			
(1) Director	1.0 position	:	RC
(2) Administrator	1.0 position	:	RC
(3) Chief Counselor	1.0 position	:	RC
b. Fiscal			
(1) Federal Program Coordinator (Enhancing FFP, Phase I)	1.0 position	:	RC
(2) Federal Compliance Specialist (Enhancing FFP, Phase II)	1.0 position	:	1,000 HCBS Waiver consumers
(3) Fiscal Manager	1.0 position	:	RC
(4) Program Technician II, FCPP	0.5 position	:	RC
	1.0 position	:	1,778 hours of FCPP determinations
(5) Revenue Clerk	1.0 position	:	400 consumers for whom RCs are representative payee
(6) Account Clerk (Enhancing FFP, Phase II)	1.0 position	:	RC
(7) Account Clerk	1.0 position	:	800 total consumers
c. Information Systems and Human Resources			
(1) Information Systems Manager	1.0 position	:	RC
(2) Information Systems Assistant	1.0 position	:	RC
(3) Information Systems Assistant, SIR	0.5 position	:	RC
(4) Privacy Officer, HIPAA	1.0 position	:	RC
(5) Personal Computer Systems Manager	1.0 position	:	RC
(6) Training Officer	1.0 position	:	RC
(7) Training Officer, SIR	0.5 position	:	RC
(8) Human Resources Manager	1.0 position	:	RC

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
2. ADMINISTRATION (continued)		
d. Clerical Support		
(1) Office Supervisor	1.0 position	: RC
(2) PBX/Mail/File Clerk	3.0 positions	: RC
(3) Executive Secretary	2.5 positions	: RC
(4) MD/Psychologist Secretary II	1.0 position	: 2 Physicians in Item 1.a.(3)(a), SB 1038 Health Reviews
(5) MD/Psychologist Secretary I	1.0 position	: 2 Physicians/Psychologists in Items 1.a.(1)(a) and (b), Clinical Intake and Assessment
(6) Secretary II	1.0 position	: 6 professionals in Items: 1.a.(3)(b), SB 1038 Health Reviews 1.b.(9) and (10), DDS Incidental Medical Care Regulations 1.c., Quality Assurance/ Quarterly Monitoring 1.e.(1), (2) and (9)(a) and (b) Community Services 1.e.(9)2., Community Services (see Secty I, line 1.e.(9)1., below) 1.f.(1) thru (3), Special Incident Reporting 2.b.(1), Federal Program Coordinators (FFP Phase I) 2.b.(2), Federal Compliance Coordinators (FFP Phase II) 2.c., Information Systems and Human Resources
(7) Secretary I	1.0 position	: 6 professionals in Items: 1.a.(1)(c) and (d), Clinical Intake and Assessment 1.b.(1) to (5) and (8), Intake/Case Mgt. 1.b.(6) and(7) Capitol People First 1.d., Early Intervention 1.e.(3), (4), (6) to (8), Community Services 1.e.(9)1., Community Services (see Secty II, line 1.e.(9)2., above)

ATTACHMENT B

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE ADDED SERVICES

PUBLISHED BY

FRANK D. LANTERMAN REGIONAL CENTER

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE-ADDED SERVICES

Over the years, as the state legislature has sought acceptable strategies to resolve repeated budget shortfalls, stakeholders in the developmental service system have offered a variety of remedies to reduce costs. Proposed solutions have included changing or reducing the entitlement defined by the Lanterman Act, implementing parental cost-sharing or co-payment requirements, cutting reimbursement to service providers, and reducing funding to regional centers and developmental centers.

One proposal to achieve savings in regional centers has been to cut regional center "operations". Those who recommend this as a solution argue that this would do no more than reduce "red tape," and that taking money away from what some perceive to be strictly administrative functions would leave more money for purchasing services for clients.

This argument fails to recognize that the vast majority of activities classified as operations in the regional center budget are actually direct services to clients and their families. As stated in the Lanterman Act, it was the intent of the Legislature that "the design and activities of regional centers reflect a strong commitment to the delivery of direct service coordination and that all other operational expenditures of regional centers are necessary to support and enhance the delivery of direct service coordination and services and supports identified in individual program plans (Section 4620)."

Most "operations" activities are direct services to clients and families.

In conceptualizing the model for the regional center system, the legislature found that "the service provided to individuals and their families by regional centers is of such a special and unique nature that it cannot be satisfactorily provided by state agencies." They reasoned that the array of services and supports required by people with developmental disabilities and their families was so complex that the necessary coordination could not be successfully managed by any existing agency. For this reason, the legislature made the decision to contract with private non-profit community-based agencies to be the organizing hub and center for coordinating services. The mission of these organizations – called regional centers – was two-fold: to ensure that people with developmental disabilities would be afforded the opportunity to live independent, productive and normal lives alongside their non-disabled peers in the community; and to minimize the risk of developmental disabilities and ameliorate developmental delays in infants and young children who are at risk.

In this paper, we attempt to show why the term "operations" when applied to the vast majority of activities of the regional center is a misnomer. We clarify what is included in this category and how many of these activities are more accurately described as direct services to clients and families. While regional centers do have an administrative role, it is small in comparison to the range of direct services provided by regional center staff to clients and families.

We begin by looking at the overall regional center budget and how funding is allocated within centers between purchase of service and operations. While most of this information is derived from Lanterman Regional Center, the general findings can be applied to the other regional centers in California.

How Regional Center Funds are Allocated

The regional center receives funding for two purposes:

- purchasing services for clients and families from community service providers (POS); and
- operating the center, including, for example, paying staff salaries and office rent and purchasing supplies and telephone service (Operations).

Figure 1, below, provides a graphical representation of the relative amounts of the regional center budget that are apportioned to POS and Operations. As can be seen from this chart, POS accounts for approximately 87% of the total regional center budget. The remaining 13% is allocated between what is often called *general administration* (2%) and activities that are *direct services* (11%) to clients and families.

Figure 1

Distribution of Regional Center Funds[1]

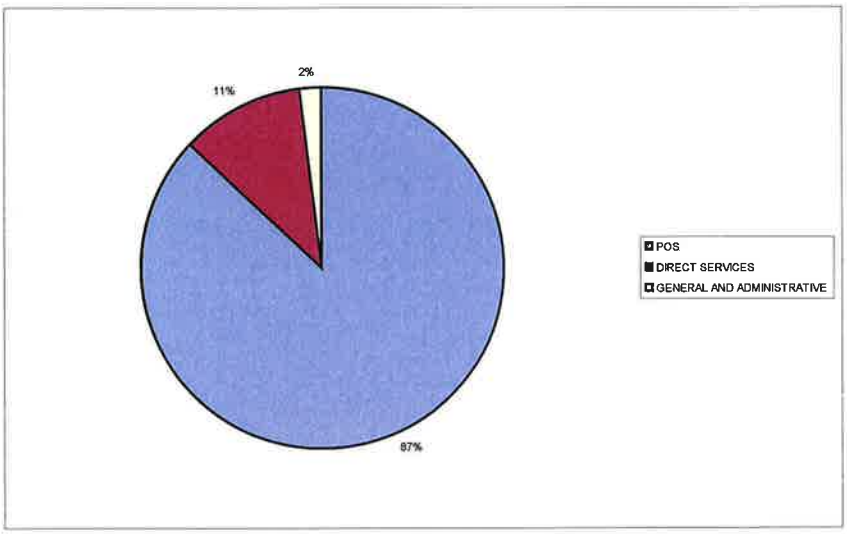
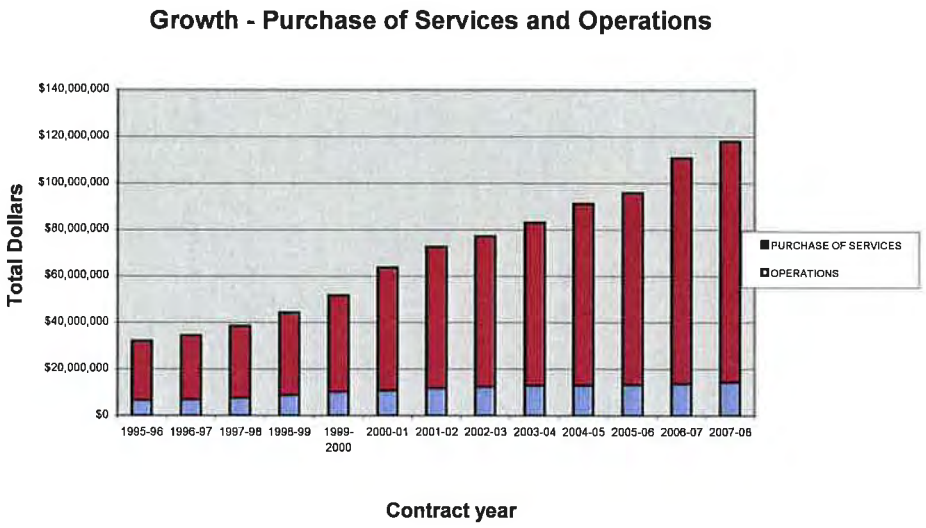


Figure 2, below, illustrates the comparative increases in purchase of service and total operations expenditures between 1995-96 and 2007-08.

[1] Figures are taken from Lanterman Regional Center independent audit report for 2007.

Figure 2



The figure shows that, during that 12-year period, POS expenditures grew at almost twice the growth rate for operations. In 1995-96, "operations" equaled 21% of the regional center budget, whereas currently this category accounts for slightly less than 13% of spending.

Regional centers have not received cost-of-living adjustments since 1991-92.

What is not shown in *Figure 2* is the significant disparity between regional center staff salaries as reflected in the "core staffing formula" used by DDS to fund centers and the actual salaries of regional center staff as demanded by the marketplace. The core staffing formula originally keyed regional center salaries to the mid-range salary of the equivalent state positions at the time each regional center position was added to the formula. Until 1991-92, regional center positions received annual cost-of-living adjustments equivalent to the adjustment received by state employees but the state ceased making these adjustments in 1991-92. From that year until the present, with one exception, the state has not authorized cost-of-living adjustments for regional center staff. The exception occurred in 1998-99 when the state authorized a one-time increase in the core staffing salary for service coordinators. This was in response to controversy surrounding a report[2] concluding that the risk of death increased for people moving from the developmental center into the community.

To highlight the disparities resulting from the failure to adjust regional center salaries, *Table 1* below compares salaries as reflected in the core staffing formula with actual salaries for two regional center positions.

[2] Strauss, D. J. and Kastner, T. A. (1996). Comparative mortality of people with mental retardation in institutions and the community. *American Journal of Mental Retardation* **101**, 26-40.

Table 1

Position	Core Staffing Salary	Regional Center[3] Average Salary
Service Coordinator	$34,032	$42,500
Accounting Associate	$18,397	$36,162

Currently, the actual salaries for LRC staff exceed the total in the core staffing formula by slightly more than 20%. Regional centers adjust for these disparities by employing fewer people than are allocated in the core staffing formula.

OPERATIONS: WHAT DOES IT INCLUDE?

In this section, we take a closer look at what is included in the operations category. We begin by looking at the direct services provided by regional center staff.

Service Coordination for Clients over Age 3

Service coordination consists of a unique set of responsibilities assigned to regional centers by the Lanterman Act. It is the cornerstone service provided by the regional center. This service is universally received by every client and is central to ensuring that the service system meets every client's needs.

Lanterman Regional Center employs approximately 110 professionals who help plan and coordinate services for 7,400 children and adults living at home, in the community, and in the developmental center. These service coordination activities occur in face-to-face meetings as well as via mail, telephone, and e-mail communications. Service coordinators (SCs) work with clients and families on the development of person-centered plans, called Individual Program Plans, or IPPs, and they conduct annual reviews of these plans.

For clients living in licensed residential homes and supported living, SCs also conduct quarterly face-to-face reviews at the home. LRC has approximately 1,000 clients living in these two settings and, for many of them who have no family or others to advocate for them, the SC plays a major role in ensuring that they receive the services, supports, and other opportunities that they need to be active members of their community. In 2007, SCs conducted more than 1,800 IPPs and 3,700 annual reviews, and nearly 4,000 additional quarterly face-to-face visits to clients' homes.

Service coordinators provide IPP development and periodic review, authorization of services, review of client progress, residential monitoring, assistance with IEPs and ITPs, linkage with generic services, advocacy, and crisis intervention.

[3] The regional center data reflects findings of a July, 2007 Hewitt Associates survey of compensation at 9 Southern California regional centers.

As part of each annual review, the SC also completes a health status review, intended to ensure that the client is receiving the recommended medical, mental health, and dental care, and an annual assessment of client adaptive behavior (the Client Development and Evaluation Record, or CDER). SCs whose clients live in a licensed home also participate with staff of the center's Community Services Department in monitoring the quality of services provided in those settings.

Prior to receiving most types of purchased services, a client is formally assessed to determine the necessity and appropriateness of the proposed service. SCs receive and review these reports and, if services are determined to be necessary, identify programs or professionals to provide the services and issue authorizations to purchase services. In many cases the search for a provider requires multiple phone calls to find a provider who is both appropriate and has the capacity to take on a new client. This is a particular problem with regard to speech therapy. Service coordinators typically contact three or four providers before identifying one who will accept a client. In some cases, service coordinators have been required to contact up to ten therapists.

For those clients who receive services, providers are required to submit periodic reports reflecting their progress toward achieving the goals identified in the service plan. Service coordinators have a quality control responsibility - reviewing such reports for all of their clients to ensure that appropriate services are accessed and that the client is making progress toward the stated goals. All reviews and authorizations – for new services, for continuations, and in situations where families or clients request changes in vendors, dates of service, etc. – must be completed in a timely manner so that there is no delay or interruption in services. An SC typically completes between 100 and 200 individual authorizations in a month.

SCs are responsible for receiving and reviewing medical records and, for children in school, Individual Educational Programs (IEPs) and Individual Transition Plans (ITPs). They also help parents prepare for IEP meetings and, at parents' request, attend the IEP and ITP meetings to help the parents advocate for needed services.

Family Cost Participation Program. Service coordinators play a role in implementing the Family Cost Participation Program, begun in 2005 and applying to families of children ages 3 to 17, inclusive, who are not covered by Medi-Cal. This program requires parents to share in the cost of certain services purchased by the regional center for their children. SCs review circumstances of families that meet the criteria for participation in this means-tested program, explain the program to the parents, obtain the required financial information for eligible families, and submit it to the center's fiscal monitor. During 2007, 257 additional families were evaluated for participation and 101 were assessed a share of cost. The number of families evaluated is expected to increase since, in 2008, the program was expanded to included children age birth to 3 receiving early intervention services.

Service Coordination for Children under Age 3 (Early Start)

Early Start is California's name for its early intervention program for children age 0 – 3. Lanterman Regional Center currently serves 1,330 children in this program. For these children, SCs coordinate development of an Individualized Family Service Plan (IFSP) every year and

review that plan every six months. In 2007, SCs completed 1,225 IFSPs and 407 six-month reviews.

Early Start SCs provide outreach and case finding through activities such as maintaining liaison relationships with six neonatal intensive care units serving the Lanterman area. They also have been very successful in helping toddlers gain entry to typical (integrated) preschools. In 2007, 480 children (more than 90% of the center's preschool age clients) were enrolled in community-based preschools.

In 2007, Early Start service coordinators helped more than 90% of the center's preschool age clients enroll in typical preschools in the community.

Children receiving early intervention services are evaluated a second time, when they reach 2 ½ years of age, to determine whether they will be eligible for continued regional center services after age 3. As a result of the services provided through the Early Start program, approximately two-thirds (68%) of these children have caught up with their typical peers and they "graduate out" of the program. These children are no longer eligible for regional center services, although some of them – for example, children with specific learning disabilities – may receive specialized services through the school district. For these children as well as for children who will remain regional center clients, Early Start service coordinators work with families to ease their transition into the public school program.

Coordination of Services

SCs are the *primary contact linking clients and families with services and supports* needed to implement IPPs and IFSPs. They must ensure cooperation and collaboration across agencies and service providers in the interest of clients. This linkage may be to public and community agencies serving the general public, such as the schools, the Department of Rehabilitation, and Social Security, or it may be to regional center authorized service providers. SCs monitor the service relationships to ensure that they are effective in helping clients achieve their desired outcomes, and they intervene when problems or questions arise. These responsibilities require SCs to maintain intensive communications, both verbal and written, with community agencies, direct service providers, and clients and families.

Social work responsibilities. In addition to their service coordination responsibilities, SCs do a significant amount of case management in the social work tradition. (Early in the history of regional centers, SCs were social workers.) For example, they routinely deal with a range of crises experienced by their clients and families, including parents attempting to come to terms with a new diagnosis. They also cope with issues related to domestic violence, divorce, eviction and homelessness, food insecurity, and death or illness of a primary caregiver. Particularly with younger adult clients, they may be called upon to become involved with law enforcement or the courts when a client is thought to have committed a crime.

Information. The SC is the primary keeper of information about the client, the services he or she receives, and significant events in his or her life. This responsibility involves a significant amount of clerical work that arguably would be more appropriately handled by clerical or

secretarial staff if they were available. In the early 1990s, budget pressures caused regional centers to reduce operations costs by eliminating selected support staff. As a result, for example, service coordination units at Lanterman Regional Center were left with one secretary to support 10-12 service coordinators and a regional manager. As a consequence, SCs responsibilities include word processing, handling their own mail, copying, and filing.

Community Placement Plan.

As the primary mechanism for implementing the state's commitment to moving people out of state developmental centers (DCs), Community Placement Plans are created by all regional centers and submitted to DDS for approval. These plans include the identification of DC residents whose needs, as judged by their ID teams, can be met in a community residential setting. For each of these individuals, the ID team assesses their support needs and preferences, and, in partnership with the regional center's Community Services Department, identifies or develops residential and other resources to support these clients in the community.

Lanterman's Community Living Options (CLO) team of four Community Living Specialists (CLS) currently provides specialized service coordination to 62 clients who have moved to the community from a developmental center under the Community Placement Plan. At this time, 101 individuals continue to reside in the DC and the appropriateness of community placement for these residents is discussed at every IPP meeting. An enhanced caseload ratio required for the CLO team (1:45) allows for monthly visits for the first six months after community placement, quarterly progress reviews, annual IPP development and semi-annual review, court reports, and special resource development and re-direction efforts to assist and maintain community placement. CLO staff are also responsible for "deflecting" clients in the Lanterman community who are at risk of being committed to a DC.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move. Since some DC residents are in that placement as the result of a judicial order, the transition process includes a series of court hearings and formal reports to keep the court informed about the status of the transition.

Federal and state laws, reinforced by judicial decisions, support the right of people with disabilities to live in the least restrictive setting. Parents or other family members, however, may be comfortable with the services their relative is receiving in the DC and reluctant to engage in what they view as "change for change sake." Staff of developmental centers are also sometimes resistant to residents leaving their protective environment. A major role for CLO service coordinators, therefore, is to develop a trusting relationship with the family that can serve as the basis for a mutual partnership focused on obtaining an appropriate home for the client in the community. Once such a relationship is developed, SCs work with the family and DC staff in identifying an appropriate community resource, orienting them to what will be necessary to support the client in this less

restrictive living arrangement, and working closely with them in an ongoing way as the transition progresses.

Coordination of appeals. The responsibility for appeals coordination, including both informal appeals at the regional center level and formal hearings with the Office of Administrative Hearings, rests with the division of Client and Family Services. In 2007, a total of 30 requests for fair hearing were filed in the following categories:

- Eligibility – 14 (47%)
- Intensive services for autism – 5 (17%)
- Legal services – 3 (10%)
- Other services – 8 (27%)

Emergency response. Regional center staff respond to urgent situations and emergencies after hours and on weekends. Clients, families, and service providers can contact an on-call staff person 24 hours a day, 7 days a week through the center's emergency line. The most frequently encountered emergency situations include clients who go missing, instances of potential abuse, emergency hospitalizations requiring consent from the regional center, and emergency placements (e.g., for clients whose family has an urgent need for respite). Calls from police departments are also common. When a person with no identification and an inability to communicate is brought to the attention of police, they frequently call the regional center seeking help in identifying the individual. The person may not be a client of the regional center called or may not even be a regional center client, but rather a person with a serious mental illness. In any case, the regional center is expected to provide assistance to the police in their attempt to identify the individual.

Managing risk. Service coordinators, in collaboration with staff of the center's departments of Community Services and Clinical Services, have the primary responsibility for investigating Special Incidents. Special Incidents are occurrences that potentially threaten the health or welfare of clients. Because of their potential serious consequences for the client, they must be handled expeditiously. The service coordinator and other involved staff members must immediately turn their full attention to the investigation of the incident. A service coordinator whose caseload consists of clients living in licensed homes typically has 1 – 2 special incidents to investigate per week, each of which requires a minimum of 3 to 4 hours. The most time consuming type of Special Incident investigation, potential abuse, requires an average of 8-10 hours to complete.

Special incidents include events such as unexpected hospitalizations, physical injury, lost or missing clients, and suspected abuse. The aim of a Special Incident investigation is to intervene quickly to resolve a problem, to determine whether the occurrence was preventable and, if it was, to develop strategies or interventions to prevent a recurrence.

In 2007, Lanterman staff members investigated and resolved 1903 Special Incidents. Many of these investigations required the service coordinator to intervene on behalf of the client with a community agency such as a hospital, the Department of Children and Family Services, the Department of Mental Health, a law enforcement agency or court, Adult Protective Services, or the county's Public Guardian Office. The center's Risk Management Committee monitors

Special Incidents at the aggregate level to determine if there are any systemic issues warranting action by the regional center – for example, implementation of training initiatives, changes to policies or procedures, or the development of new services and supports.

Targeted Case Management (TCM) Program. As a condition of the state obtaining federal financial participation in the funding of regional centers, service coordinators are required to document all of their direct service activities in the interdisciplinary (ID) notes section of their clients' records. The federal government has imposed strict requirements on this documentation – for example, services must be described precisely and in a specific format, and time must be recorded in 15-minute increments. This information is submitted by the regional center to the Department of Developmental Services on a monthly basis. DDS, in turn, bills the federal government for these services. The TCM program brings approximately $140 million in federal funding into the state each year.

Advocacy

The Lanterman Act assigned to regional center service coordinators the role of front line advocate, assisting clients and families in exercising their civil, legal, and service rights. In 1997 funding for advocacy was removed from regional center budgets and transferred to the Office of Client Rights Advocacy, but the primary responsibility for advocacy remains with regional centers and is an important function of service coordinators. SCs represent clients' interests with service providers in the community as well as with generic services such as the school system and the Department of Rehabilitation. In 2007, service coordinators attended Individual Education Program (IEP) meetings for more than 460 clients, and they helped more than 937 families gain inclusion for their sons and daughters in regular classrooms with their typical peers.

Service coordinators helped 937 families gain inclusion for their sons and daughters in regular classrooms with typical peers.

SCs also serve a critical advocacy function helping clients and families achieve and maintain eligibility for entitlements such as Medi-Cal and SSI, and they assist families dealing with criminal justice and immigration matters. For a majority of clients who become involved with the criminal justice system, regional center service coordinators are asked by the court to write a diversion plan to be implemented in lieu of incarceration. In this activity, they work with the public defender or probation department to create a plan of education, restitution, or correction with a goal of preventing the client's future involvement with the justice system. In these cases, service coordinators are required to monitor the client's progress on the plan and submit periodic reports to the court on the client's status.

Through the Koch-Young Resource Center, described below, the center offers an 8-hour course for Lanterman families to help them become more effective advocates for their family member with a disability. This course, called Service Coordinator and Advocacy Training (**SCAT**), is conducted four times a year, three times in English and once in Spanish. The center also offers more specialized educational and training opportunities to help families further sharpen their advocacy skills and learn about services and benefits available for their sons and daughters. These classes focus on transition into school, the individual educational program (IEP) process, transition from school to work, and SSI and employment benefits.

Clients are able to develop and practice their own self-advocacy skills though involvement with the regional center's governance board and committees and the Client Advisory Committee . They are also currently attempting to organize a local chapter of People First.

Three formal self-advocacy experiences, are available to adult clients through the center's Training and Development Department. These programs, which are the responsibility of the center's Peer Advocate, include:

- Women's Reproductive Health Self-Advocacy Training: A peer-advocacy-based training program for women with developmental disabilities; topics include basic anatomy, menstruation, menopause, pregnancy, sexually transmitted diseases, contraception, the importance of women's health exams, and using self-advocacy to communicate with your doctor.
- Abilities: A sexual abuse and exploitation risk-reduction program for adults with developmental disabilities, including topics such as what is sexual abuse, assertiveness training, self-esteem and communication, personal safety training, and what to do if a person is ever sexually abused or assaulted.
- Project Prepare: Disaster preparedness training for clients.

Resource Center staff also recruit students, arrange sites for, and coordinate delivery of two additional programs which are offered by outside organizations. These programs are:

- Get Safe: A personal safety program for adults, teens, and children, including topics such as assertiveness training, community safety awareness, setting limits, defining boundaries and creating healthy relationships.
- SHASTA: A sexual health and safety program for teens and adults.

Intake and Assessment

Intake staff members oversee the process through which prospective clients are assessed to determine whether they are eligible for regional center services – i.e., are at risk for a developmental disability or have such a diagnosis and are substantially handicapped. The Intake Unit completed 1,617 intake and assessments during 2007, completing the process within legally mandated time frames. Approximately 70% of these intakes were for infants and toddlers under age 3.

Regional center are allowed 45 days from the time of the first phone call from a family to complete the development of an Individual Family Serivce Plan for children under age 3.

Intake timelines for the Early Start program are particularly stringent. While 120 days is allowed for completing intake and assessment for applicants over age 3, for children under 3 regional centers are allowed only 45 days from the time of an initial phone call from a family to complete the development of the Individualized Family Service Plan (IFSP). During this time period regional center staff must meet with the family; ensure that formal assessments are completed; review assessment reports and consult with clinical staff to determine eligibility; decide, in cooperation with the family, what services and supports will be provided; complete the writing of the IFSP; and initiate the purchase of services.

For prospective clients who are determined not eligible for regional center services, intake and assessment staff serve as a source of information and referral to other public and private resources that might meet their needs and the needs of their families. These staff members also engage in outreach activities with agencies such as the Department of Children and Family Services, the Department of Mental Health, homeless shelters, and the Los Angeles City jail, to enhance case finding and ensure that referrals made by these agencies are appropriate.

Clinical Services

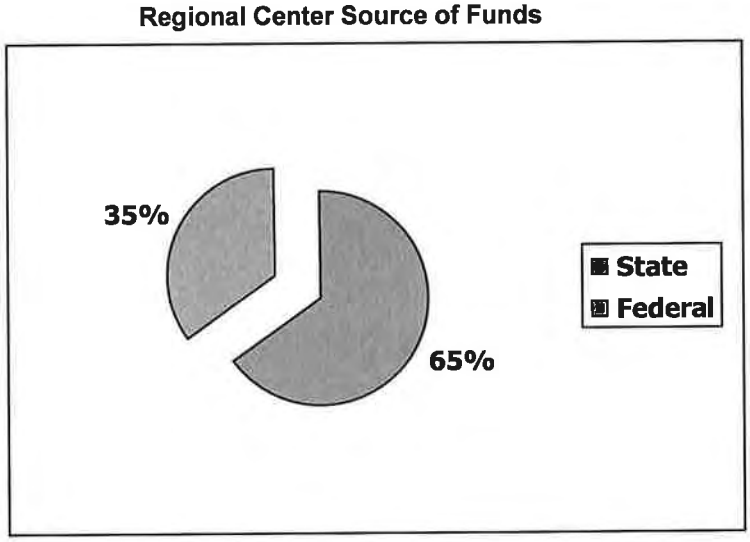
Using an interdisciplinary team approach, Clinical Services specialists conduct a variety of activities aimed at ensuring and improving the health and well-being of clients. Nurses, physicians, psychologists, a dental hygienist, and a dentist are involved in:

- individual clinical assessments of clients;
- review of services being provided to clients by community professionals, and direct consultation with these professionals;
- consultations with service coordination staff on specific clients' health issues;
- consultation with and technical assistance to service providers;
- participation in annual review meetings for clients who have significant health related issues or concerns;
- review of requests for the use of psychoactive medications with clients;
- consultation with service coordination staff on Medicare Part D issues;
- oversight of the review process required under the federal Nursing Home Reform program;
- review of requests for surgical and other interventions from medical professionals, consultation with those professionals about the requests, and providing consent, as appropriate, when no other party is authorized to assume this responsibility;
- mortality review in all cases of client death.

The center's Bio-ethics Committee reviews requests from physicians or families to impose a "Do Not Resuscitate Order" or order hospice or palliative care for a client. The committee develops a report with recommendations for the Executive Director who makes the final decision and forwards it to the institution's Bio-ethics Committee.

Medicaid Waiver. A major activity of Clinical Services is certification and annual re-certification of clients for eligibility under the Home and Community Based Waiver (HCBW) program. This is a collaborative effort of Clinical Services staff and service coordinators, and is part of a program that brings a very substantial amount of federal funding into the developmental services system. Approximately 1,900 of Lanterman's 7,400 clients are currently certified for the waiver. This number represents a 20% increase from the 2006 waiver enrollment. Statewide, the HCBW program brings more than $750 million into the Developmental Services system. *Figure 3* on the following page gives a graphical representation of the portion of the regional center system budget that is covered by federal financial participation, including Medicaid Waiver and Targeted Case Management. As can be seen, these federal funds constitute slightly more than one-third of the total budget for regional centers.

Figure 3



The Clinical Services Department also develops and manages special projects targeted at objectives such as improved dental health, prevention of unnecessary hospitalization, ensuring appropriate use of medications in group homes, enhanced access to psychiatric services, and improved support for aging clients to enable them to "age in place" in the community. For these projects, the regional center has partnered with organizations such as USC Schools of Medicine and Dentistry; UCLA Schools of Medicine, Dentistry, and Nursing; University of the Pacific Special Needs Dentistry; the Semel Institute at UCLA, Childrens Hospital Los Angeles, and LA Care and Health Net Health Plans.

Family Support

The Koch-Young Resource Center (KYRC) is dedicated to the provision of information and support to clients and families and to the professionals who support them. The Center maintains a Help Desk and associated telephone Help Line that responded to approximately 3,000 information and referral requests in 2007. It contains a multimedia lending library housing thousands of educational materials available to clients, families, service providers, and members of the larger community. Nearly 1,200 individuals are registered users of the library.

Nearly 1,200 individuals are registered users of the Koch-Young Resource Center Library.

During 2007, KYRC staff distributed over 1,000 Welcome Kits to new regional center families. These kits contain materials of general interest to new families as well as information that is specific to their children's disabilities. They also publish the ***Viewpoint*** newsletter and support the Lanterman web site, both critical tools for communicating with the Lanterman community. In 2007, the web site had approximately 30,000 unique visitors who viewed more than 70,000 unique pages. During the summer of 2007, the center launched the Network of Care through the center's website. This is a searchable database of more than 975 community resources that

integrate children and adults with developmental disabilities into regular programming and activities with their non-disabled peers. The network listing is continually updated and expanded.

The Resource Center currently coordinates 19 family support groups providing mutual support, education, information sharing, and advocacy. A service coordinator is involved in each of these groups in partnership with and as a mentor for the parent who acts as co-facilitator. The Resource Center also coordinates 3 client support groups and two intensive Sibling Support Groups for children and adolescents whose siblings are regional center clients. It also maintains the Peer Support Program where approximately 40 experienced parents are actively involved in offering one-to-one emotional support and information to families who are new to the center or families who request a partner for a specific purpose.

The KYRC coordinates the regional center's volunteer program. In 2007, approximately 20 volunteers, most of whom are clients, completed over 1,200 hours of volunteer effort on tasks such as mass mailings. Through the KYRC, the regional center has also developed internship opportunities intended to bring young people with non-traditional backgrounds, such as business and the sciences, into the regional center to apply their knowledge and skills while learning about developmental services. The capstone of that effort is the Roberta Happe Memorial Internship, established in 2001.

The Resource Center has been instrumental in developing and maintaining partnerships with community-based organizations with a goal of expanding educational, skill-building, and other opportunities for people with disabilities. In partnership with the Los Angeles Unified School District, Lanterman hosts two computer training classes each semester for clients, family members, and caregivers. As of the end of 2007, 120 students had graduated from these classes with beginner and intermediate computer skills. Up to 60 students are served in each class series and each series is offered four times per year.

The KYRC also maintains partnerships that offer more inclusive opportunities for people with disabilities in programs serving the general public. Such partnerships have been created with Community Technology Centers, offering clients who complete computer classes at LRC an opportunity to transition to advanced training in the community, and local public libraries to provide clients with a variety of opportunities generally available to the wider community.

Assistive Technology Project. Another valued component of the KYRC is the Assistive Technology Project (ATP) that provides consultations, information, and advice to clients and families of clients who might benefit from the use of technology to learn, communicate, or complete activities of daily living. This project is the result of a partnership between Lanterman Regional Center and the Assistive Technology Exchange Center (ATEC), a division of Goodwill of Orange County. The project has provided more than 40 AT "labs" where parents can explore assistive technology options, more than 500 consultations and 200 individualized assessment of need, and 4 AT workshops for service providers. The regional center also partnered with the USC Occupational Therapy program to offer an OT internship focused on assistive technology.

Quality Assurance and Improvement Activities

Residential services. The Community Services Department is responsible for a range of activities mandated by Title 17 and aimed at ensuring the health, safety, and well being of clients living in licensed homes and improving the quality of services provided there. Regular monitoring visits to group homes and other residential settings are also intended to ensure that the residents' rights are protected, that residents' personal funds are being appropriately managed, and that residential staff are helping residents maximize opportunities to participate in the life of the local community. Regional center staff also provide technical assistance and training to service providers to increase their skills and enhance the quality of services they provide. Four Community Services staff members currently monitor 120 homes, 13 of which are Community Placement Plan (CPP) homes.

The monitoring function requires regional center staff to conduct two unannounced visits to each licensed home each year. The regional center is also required to conduct an announced in-depth, day long, comprehensive team evaluation of each home every three years. Given the broad scope of the team evaluation, the Service Coordinator who acts as liaison to the home participates as a member of the team. The Quality Assurance staff conduct the mandated exit interview with the residential provider and write the evaluation report within the mandated timelines.

CPP homes are specialized homes for people moving out of the state developmental center. Given the complex and often intense needs of these clients, the Quality Assurance staff conduct quarterly monitoring of CPP homes to ensure that the client's needs are being met and their health and safety are being ensured.

Homes that do not meet regulatory standards are required to implement Corrective Action Plans. Quality Assurance staff provide technical assistance in development of these plans and they conduct additional unannounced visits to ensure that they are implemented appropriately. They also conduct two subsequent unannounced visits to ensure that the home continues to meet expectations of the CAP.

For all newly vendored residential providers, Quality Assurance staff conduct an orientation and two technical assistance visits in addition to the other required visits. The orientation and technical assistance visits aim to ensure that new providers understand and satisfy regulatory requirements and regional center expectations.

Work-related services. The four Community Services staff members who monitor licensed homes have additional mandated responsibilities with regard to work programs. These activities are aimed at ensuring that work programs are providing paid work opportunities to clients in a safe environment, and that work programs are in substantial compliance with national accreditation standards. Community Services staff provide technical assistance and training to these providers as needed or requested. Lanterman staff currently monitor 10 work programs. These responsibilities were transferred to the regional center from the Department of Rehabilitation in 2004, but no funding accompanied the transfer.

Other services. Community Services Quality Assurance staff members annually monitor day programs, independent living services (ILS), and supported living services (SLS) programs to ensure that they meet regulatory requirements and regional center expectations. These staff members provide technical assistance and training to these providers as needed or requested. They currently monitor 23 day programs, 10 ILS programs and 13 SLS programs. The center's budget does not include staffing to perform monitoring for these three types of services.

Complaint investigations. Community services staff investigate all complaints against vendored service providers. Depending on the nature of the complaint and the number of people who must be interviewed, a complaint investigation requires between one and five days. Community Services staff provide technical assistance and training to these providers as needed. A meeting is held with the provider to discuss the complaint and the findings of the investigation team. Following the meeting, a letter is sent to the provider summarizing the complaint, the results of the investigation, and any further actions needed. Community Services staff participated in 91 of these investigations in 2007.

Resource Development

The Community Services Department is responsible for ensuring that the service system includes the types and numbers of services necessary to meet the service needs of the more than 7,400 children and adults with developmental disabilities in the Lanterman service area. This responsibility includes the entire range of services – e.g., living options, day programs, work programs, autism services, and therapeutic services.

Resource Specialists provide technical assistance to all potential service providers, reviewing regulatory requirements and regional center procedures and expectations, and reviewing the vendor application packet to ensure that those who request vendorization are qualified to meet the needs of people they intend to serve. Site visits are conducted for all potential center-based services and transportation companies to ensure that a safe environment exists. Licenses and credentials, where applicable, are verified. Therapists who seek to conduct in-home services are required to submit three professional references, and these are verified. While not mandated by Title 17, these precautions are taken to ensure the health, safety and well being of all regional center clients who will potentially receive services from the provider.

Because the Centers for Medicare and Medicaid Services promote choice, residential and community based non-residential programs are required to prepare a program design that describes the services to be provided, curriculum, staff qualifications and training, and more. Community Services staff read each program design and provide written feedback to the potential provider. The average program design is 50 pages in length and is typically revised several times before it meets Title 17 standards and satisfies regional center expectations.

The Resource Developer also ensures that appropriate services are developed for clients moving into the community from developmental centers via the Community Placement Plan. These resources are specialized and require community services staff to do increased monitoring, technical assistance and training to ensure the client's needs are met.

Vendorization

The regional center's vendor list includes thousands of providers in the Lanterman area, each of which has a record that must be maintained and updated when changes are made to the provider's name, address, telephone number or rate, or when the provider begins providing a new service. This information must also be made available to other regional centers that use the service provider.

Families wishing to purchase their own diapers, respite, pre-school programs, or transportation are also required to be vendored and must work with community services staff to complete an application and obtain a vendor number. Clients and families seeking to be reimbursed for purchases they made for authorized services or products also must be vendored. The regional center newly vendored 128 providers and made changes to 386 vendor files in 2007.

The regional center requires that providers maintain appropriate insurance coverage as a condition of doing business with the center. A separate database is maintained by the regional center to ensure that providers purchase insurance and renew it annually. Reminder notices are sent to providers who fail to provide proof of annual renewal of coverage.

Client Benefits Coordination

Three staff members in the center's Administrative Services Department spend 100% of their time coordinating client benefits. They are responsible for managing the SSI funds and other public benefits for approximately 1125 clients for whom the regional center is the representative payee. These are clients who are unable to manage their own finances and have no family or other appropriate representatives able or willing to help them with this responsibility. These three staff members currently manage more than $9 million in clients' funds. They also manage the processing of applications for Supplemental Security income, Medi-Cal, and other programs for these 1125 clients as well the annual re-determination of eligibility for these programs. Finally, these employees process an additional 2,000 forms that are required by Social Security Administration for a variety of purposes.

Fiscal Monitoring

One staff member coordinates the development of and monitors more than 84 contracts related to the center's operations and purchase of service activities. Nearly 90% of these contracts pertain to direct services provided to clients. This task is essential to ensuring careful stewardship of funds entrusted to the regional center. The fiscal monitor completed 45 vendor audits in 2007, 11 of which were required, and coordinated recovery of overpayments. She also shares responsibility with service coordination staff for implementation of the Family Cost Participation Program. She receives income information on eligible families and assesses an appropriate share of cost for families who are determined to be participants. In the three years since the inception of this program, 459 families have been reviewed and 252 have been assessed a share of cost for services, as prescribed by law. With the expansion of this program to Early Start clients, the number of families involved in this program each year is expected to increase.

Training

The regional center creates, conducts, and coordinates a wide range of educational and skill development activities for clients, families, service providers, and regional center staff. A director and 1¼ members staff develop, coordinate, and conduct training programs tailored to the needs of clients, parents, services providers, and regional center staff. In 2007, they oversaw the delivery of or conducted 112 programs, including sexuality and socialization skills, personal safety, disaster preparedness, transition to work training, and leadership development. The center also supported the participation of 359 clients, parents, staff members, and providers in 111 local, state, and national conferences.

GOVERNANCE AND ADMINISTRATION

In terms of the entire budget, governance and administration costs – everything other than purchase of services and regional center direct services to clients and families – account for slightly more than 2% of total expenditures. We now take a closer look at what is included in that portion of the budget.

Board and executive activities. The regional center is a community-based, non-profit organization governed by a volunteer board of directors that includes parents, clients, and other interested citizens. The Board along with its executive staff has primary accountability to ensure that the center meets the requirements of all applicable federal and state laws and regulations, including those required for federal financial participation, and of its contract and performance plan with the state Department of Developmental Services, The Board has also committed the center to four strategic initiatives that are critical for our clients and their families: inclusion, information and technology, affordable housing, and employment.

The executive director and senior staff work together to create a climate of accountability and an environment that promotes quality, innovation, and cost-effectiveness within both the center and the center's network of community service providers. The Board and executive group also provide vision and leadership for the creation of special projects intended to enhance the service system and the quality of services provided. A particularly successful example of such projects is the UCLA/NPI/Lanterman Special Psychiatric Clinic.

Accounting and payment functions. The accounting department is charged with ensuring fiscal accountability within the center and among community service providers. In a typical month this department:

- inputs approximately 4,300 initiations, changes, or terminations to POS authorizations;
- adds about 166 new vendor records to the system;
- prints an average of 4,600 invoice forms for POS;
- prints an average of 2,400 checks, about 95% of which are to community providers and families for services delivered to clients;
- makes payments for more than 350 family voucher users.

Information technology support. One manager and three staff members support all mainframe and personal computer activities of the center. The center's mid-range mainframe computer handles client and financial data on most regional center activities and generates thousands of checks each month. Staff write and revise programs (250 in 2007) to analyze data and generate reports.

IT staff also support the personal computer use of 200 regional center employees. Their activities include training, technical support, help desk response, and maintenance and replacement of computer equipment and peripherals. In addition, these four individuals manage internal networks such as e-mail, shared files, and internet access; they coordinate disaster preparation efforts related to technology; and they assist staff with proprietary software systems that have been installed for specific projects and to automate center functions.

Human resources (HR) functions. The HR Department manages activities necessary to attract and retain knowledgeable, committed, competent staff able to carry out the complex mission of the regional center. In order to ensure that the center can continue to attract and retain such staff, HR personnel are constantly reviewing benefit programs (health, disability insurance, etc.) to provide maximum value to the center and its employees. In 2007, the HR staff worked with the appropriate units in recruiting 39 new hires, 19 of whom were service coordinators. This required the screening and interviewing of hundreds of applicants. HR staff also administer all aspects of personnel including payroll and performance evaluation.

Coordinating annual giving. The HR Department oversees a range of giving programs that, in 2007, brought the center more than $97,000 in cash and gift donations for clients and families.

Operations management. One manager and 2.5 staff members support the center's reception and mail functions. These include 15,000 pieces of mail sent out each month and hundreds of phone calls per day through the switchboard in addition to the calls routed through the automated call distribution system. This unit has the responsibility for coordinating the cleaning and maintenance of the physical plant including more than 40,000 square feet of floor space; they coordinate the ordering of office supplies and are responsible for maintenance, repair and replacement of office equipment; and they manage more than 3,000 boxes of records stored off-site. Finally, they coordinate overall disaster preparations, including the replenishment of supplies.

Insurance. Additional costs to the center's operating budget are incurred by items such as liability insurance and workers' compensation insurance. With no additional funds coming from the state, costs of such coverage have affected the regional center in the same way they have affected service providers. At the same time, interest earnings, used by centers to fund part of their operating budgets, are down dramatically. In 2006-2007, Lanterman had about $710,000 in interest earnings. For 2207-2008, that figure will be about $600,000, a loss of $110,000 in real dollars. This amount would support the hiring of two service coordinators.

Whether referred to as operations or regional center direct services, the activities described in this document are of direct and obvious benefit to clients and families and are value added to the service delivery system as a whole.

FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

Prepared by the Association of Regional Center Agencies

September 2013

CONTENTS

FUNDING THE WORK OF
CALIFORNIA'S REGIONAL CENTERS
EXECUTIVE SUMMARY

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

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

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

These problems can be categorized into four groups: (1) actions leading to a direct reduction in the OPS budget without a corresponding decrease in operations workload, (2) actions imposing additional workload for which no additional, or inadequate, funding

was added to the OPS budget, (3) inaction with respect to updating the OPS budgeting formula, and (4) design flaws inherent in the OPS budgeting formula.

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

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

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

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

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

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

The Lanterman Act specifies that regional centers must adhere to certain caseload ratios (ratios of Consumer Program Coordinators [CPCs] to consumers served).

However, since salaries have been frozen at 1991 levels, regional centers are unable to hire sufficient CPCs to meet the required caseload ratios and, consequently, puts over $1 billion in federal funds at risk.

4. Design Flaws in the OPS Formula

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

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

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

CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[ii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the

primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has "accepted a responsibility" is directly threatened.

I. INTRODUCTION

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

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

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

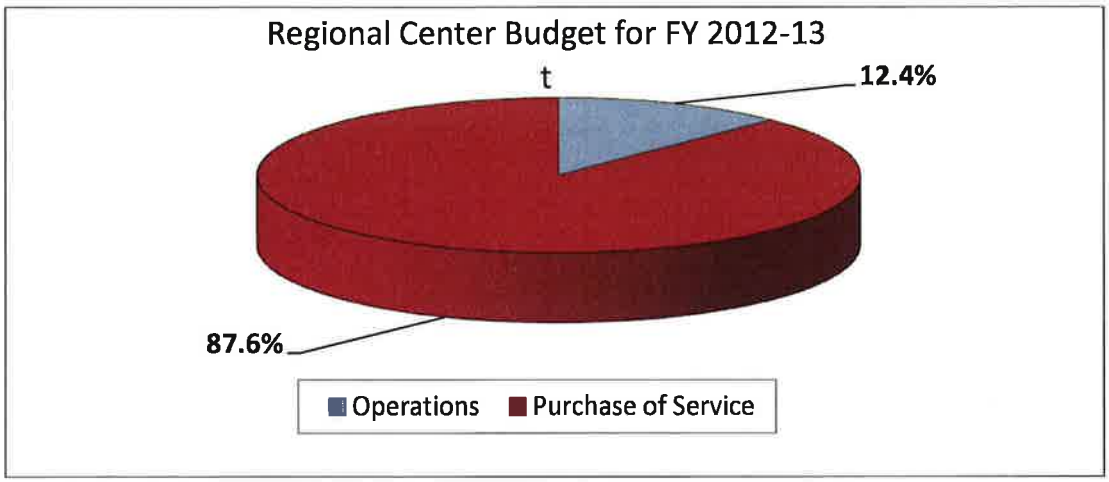
II. BACKGROUND

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

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

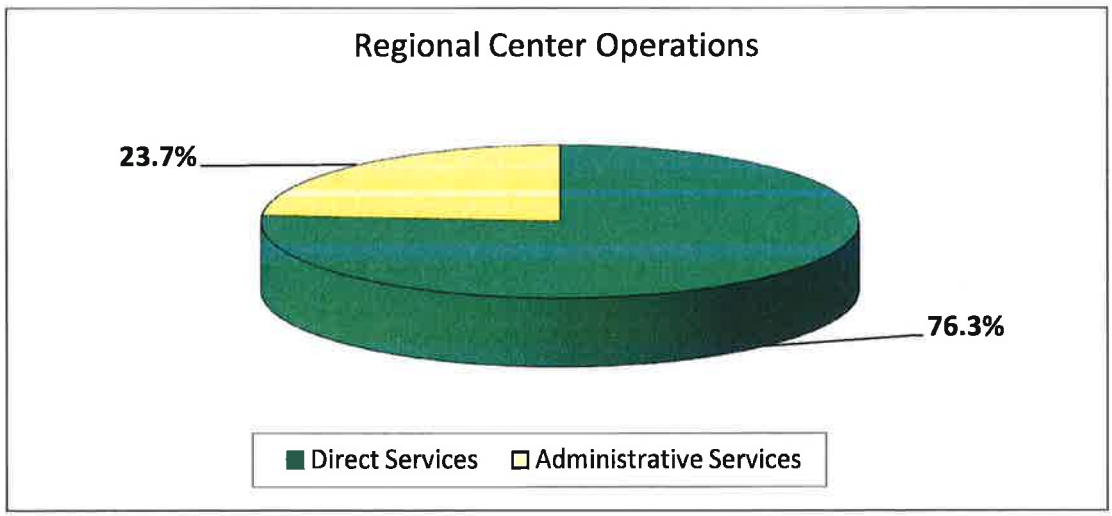
The OPS budget funds a regional center's costs related to personnel and benefits, insurance, leases, equipment, information technology, accounting/payment functions, personnel management, consultant services, independent financial audits, consulting/legal services, board support, travel, office facilities,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

Chart 1



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

Chart 2

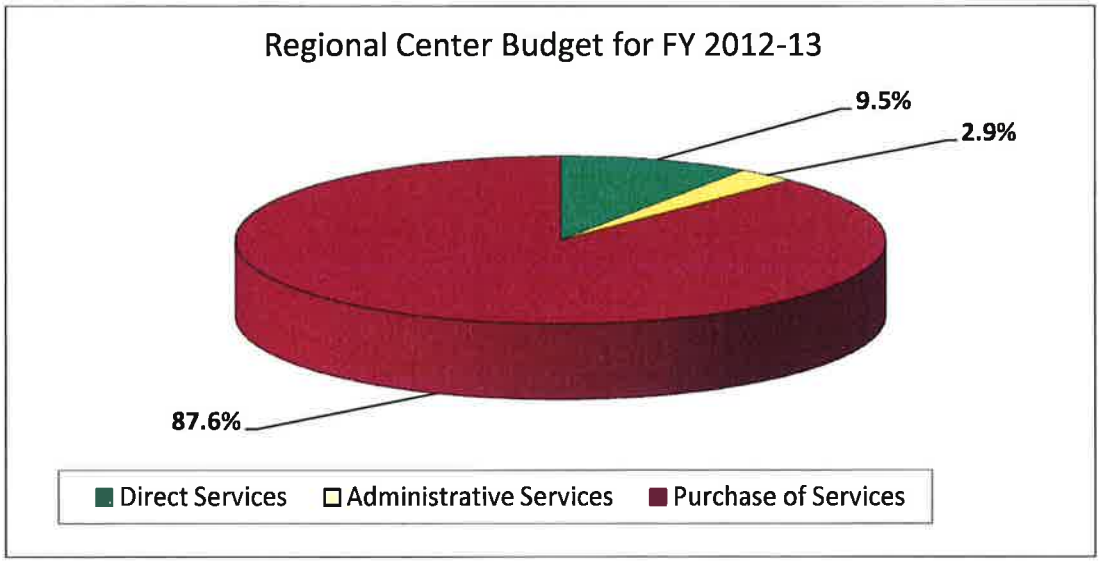


Direct services funded through the OPS budget include service coordination, assessment/diagnosis, individual program planning, consumer money/benefits management, clinical services, 24-hour emergency response, quality assurance,

advocacy, intake/assessment/referral, family support, training, special incident reporting/investigation, etc. Therefore, reductions in the regional-center OPS budget impact the provision of direct services to consumers. An attached publication prepared by Frank D. Lanterman Regional Center describes, in greater detail, the range of important direct services provided by regional centers.[iii]

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

Chart 3



B. Budgeting and Allocation Methodology - Prior to 1979-80, each regional center developed its own staffing pattern and budget through negotiations with the Department of Developmental Services (DDS). Each staffing pattern was based on a program-budget methodology, and the budget-allocation methodology for compensation was based on projected actual salaries and benefits. While this approach addressed local variation and provided for flexibility and innovation, there was also argument for a less

subjective and more equitable method for allocating staffing resources to regional centers taking into account the size of the regional center (based on caseload) and the resources necessary to accomplish the regional centers' statutory and contractual mandates. This led to the development of the current methodology for funding the regional centers' personnel and related operational costs, which is commonly referred to as the "core staffing formula." This formula, developed in 1978, was crafted by DDS personnel based on their knowledge of existing regional center staffing patterns that had previously been approved by DDS, and other standards that were available at the time. For example, the case management ratio of one service coordinator to 62 consumers was based on what county welfare offices used for the Absent Parent Program to receive federal funding. This 1978 formula was arguably an improvement over the initial approach to budgeting and allocating OPS funding, but the formula was still an *ad hoc* creation developed without the benefit of the specialized study that such an important and complex statewide publicly-funded service system needed. There is no written analysis, justification, or documentation supporting the 1978 base formula, which is the same formula used today, except for some "add-ons" and minor changes.

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

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

CHART 4

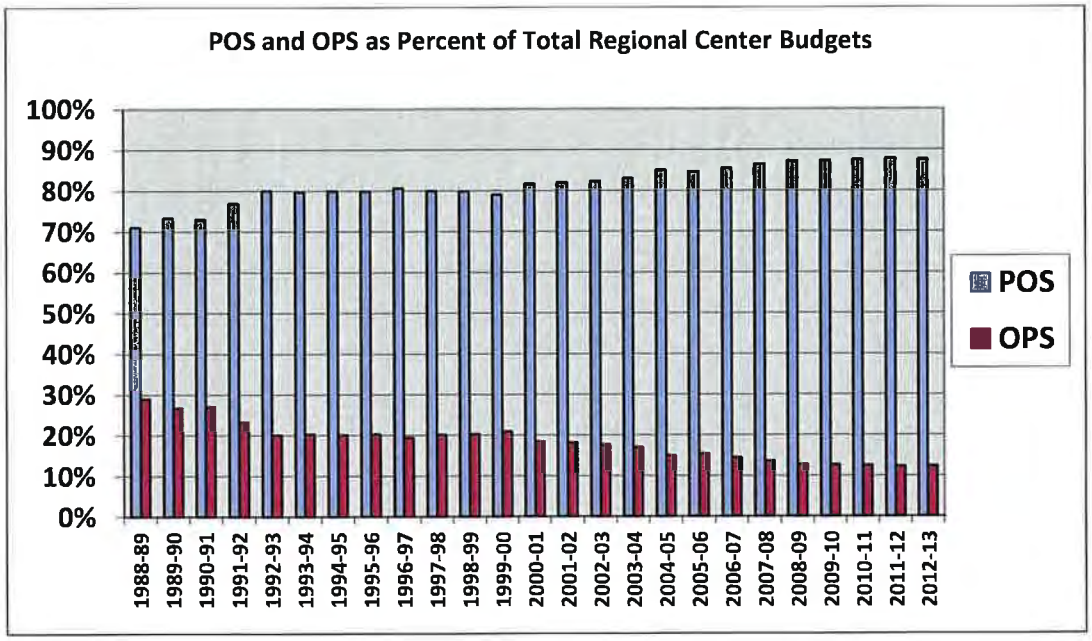
CATEGORY	FY 2013-14 MAY REVISION FY 2012-13 BUDGET *(Dollars in thousands)*	% OF TOTAL BUDGET
Operations	$537,415	12.8
Purchase of Services	3,647,976	86.7
Early Intervention and Prevention Programs	22,384	0.5
TOTAL	**$4,207,775**	**100.0**

CHART 5

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

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	TOTAL BUDGET *(Dollars in thousands)*	% POS	% OPS
2005-06	2,784,773	84.6	15.4
2006-07	3,167,170	85.5	14.5
2007-08	3,512,929	86.4	13.6
2008-09	3,861,302	87.2	12.8
2009-10	3,886,591	87.3	12.7
2010-11	3,909,604	87.5	12.5
2011-12	3,958,227	87.8	12.2
2012-13	4,162,793	87.6	12.4

CHART 6



C. Factors Leading to OPS Underfunding – The factors that have led to the diminution of regional centers' operating capacity and to the current regional center OPS funding crisis fall within four primary categories: (1) actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in

operational workload, (2) actions imposing additional workload for which the regional centers received no additional - or inadequate - funding, (3) inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business, and (4) design flaws in the OPS formula. While not an exhaustive list, these factors, broken out by category, are as follows:

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

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

- Extending Regional Center Assessment Timelines: Regional centers have mandated timelines for completing their assessment of prospective consumers and for developing an individual program plan or individualized family service plan for those found eligible for services.[vi] The timeline for completing the assessment phase

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

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

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

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

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

Another round of reductions to regional center budgets began again in 2009 with the passage of ABX4 9 and continued through 2012. Though many of these budget

reductions used euphemisms such as "cost containment," "operational efficiencies," and "General Fund savings," they were, in effect, unallocated reductions.

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

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

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

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

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

- Managing/Implementing the New Uniform Fiscal System: During 1984, DDS implemented the statewide Uniform Fiscal System to provide for uniform accounting procedures and centralized collection of client and fiscal data. There were numerous

implementation issues and unfunded workload related to maintaining this new system.

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

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

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

- Administering Vouchers: In 1991, the Department adopted new regulations establishing a voucher mechanism for paying for specified services. This new approach gave families and adult consumers a direct role in procuring nursing, day care, respite, transportation, diapers and nutritional supplements. While beneficial for many who choose to obtain their services through this purchasing mechanism,

the processing of billings and payments for individual families is very staff-intensive, which includes training family members on record keeping and payroll tax requirements, and for which regional centers received no additional resources to perform the increased workload.

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

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

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

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

5. Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.
6. Quality assurance expertise to assist the regional center in providing the necessary coordination and cooperation with the Area Board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

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

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

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

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

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

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

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

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

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

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

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

- Every two years screening all vendored service providers against federal and state databases to ensure vendors have not been disqualified from participating

in the Home and Community Based Services (HCBS) Waiver program [Wel. & Insti. Code §4648.12].

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

- Completing transition plans for all regional center consumers residing out-of-state and conduct statewide search for in-state services and development of appropriate services as needed [Wel. & Insti. Code § 4519(e)].

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

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

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

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

- Failure to Update Salaries in the Core Staffing Formula

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

state ceased providing regional centers cost-of-living adjustments for their personnel costs. **This policy change, which has continued through the current fiscal year, is the action that has impacted the OPS budget most significantly**.

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

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

- <u>Failure to Fully Fund Mandated Caseload Ratios</u>

  According to Wel. & Insti. Code § 4640.6, regional centers are required to maintain certain caseload ratios. For consumers on the HCBS Waiver or in Early

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. 1983 – *Personnel Task Force Report.* ARCA establishes a Personnel Task Force to (1) pursue a core staffing study, and (2) coordinate a study comparing the state's classification and pay plan with that of the regional center core staffing formula. Cooperative Personnel Services (at that time an entity within the State Personnel Board) conducts the comparison classification study and issues its report in February of 1984. The report finds that the regional center position salaries lag the state equivalent positions by 12.4%. The Task Force develops a recommended staffing allocation formula reflecting the resources needed for regional centers to comply with their contractual and statutory obligations. The Personnel Task Force releases its report in February 1984, including a copy of the CPS study as an

appendix. DDS, while sympathetic, is not able to gain support within the Administration to implement the report's recommendations.

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

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

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

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

DDS uses the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal is supported within the

Administration, but is not included in the Governor's budget because of a severe economic downturn.

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

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

CHANGES IN THE OPERATIONS BUDGETING FORMULA

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

YEAR	CHANGE	FUNDING (Millions)	REASON
	sufficient staffing for performing quarterly monitoring visits.		
98-99	Establishing 14 additional regional center clinical teams.	4.5	Same as above
98-99	Increasing monitoring frequency of consumers with health conditions living in CCFs. Regional center are provided addition staff for new activities.	5.3	New DSS Title 22 regulatory requirements.
98-99	Reducing CPC caseloads to 1:62 (included reduction of CPC salary savings requirement; updating CPC salaries; restoration of unallocated reduction for CPCs; and funding other essential positions). (Half-year funding)	27.9	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
99-00	Additional funds to fully implement the above reduction of CPC caseloads to 1:62.	27.9	Same as above
98-99	Establishing a consumer complaint process in statute. Regional centers each provided ½ position for new workload.	0.7	Legislation (SB 1039) establishing a consumer complaint process, i.e., Wel. & Insti. Code 4731.
98-99	Fund Essential Regional Center Positions – Information Systems manager, Personal Computer Systems Manager, Training Officer, Special Incident Coordinator, Vendor Fiscal Monitor, Human Resources Manager, and Information Systems Assistant (half-year funding)	6.7	Fund essential positions previously not included in the core staffing formula
99-00	Additional funds to fully implement the above new positions.	6.7	Same as above
99-00	Performing health status reviews of consumers during a part of the IPP process.	3.2	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
00-01	Establishing 1:45 maximum caseload ratios for service coordinators for consumers placed out of state developmental centers.	0.6	Same as above
01-02	Implementing a statewide risk management system, including regional center risk management committees.	6.7	Same as above
02-03	Establishing Federal Program Coordinators and providing unfunded rent relief.	15.2	State initiative to increase and maintain federal financial participation.
03-04	Establishing Federal Compliance Specialists and fiscal/contract documentation staff.	4.4	Same as above
03-04	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	1.4	State initiative to increase federal financial participation.
03-04	Complying with requirements of the federal	1.4	Congressional enactment

YEAR	CHANGE	FUNDING (Millions)	REASON
	Health Insurance Portability and Accountability Act (HIPPA)		of HIPPA legislation.
04-05	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	2.8	State initiative to increase federal financial participation.
04-05	Funding for regional center administrative activities associated with implementing the Family Cost Participation Program.	.6	Enactment of legislation establishing the Family Cost Participation Program.
05-06	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.8	State initiative to increase federal financial participation.
06-07	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.3	Same as above
07-08	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.1	Same as above
06-07	Funding for expansion of Autism Spectrum Disorder Initiative	1.7	State initiative to better serve consumers with autism spectrum disorder
07-08	Additional funds to implement the expansion of the Autism Spectrum Disorder Initiative.	1.8	Same as above
08-09	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	.9	State initiative to increase federal financial participation.
09-10	Fund additional case managers to participate in IPP meetings of consumers residing in state developmental centers	3.1	Pursuant to the Capitol People First lawsuit settlement

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

III. THREAT TO FEDERAL FUNDING

In a 1992 oversight hearing before a Senate Budget Subcommittee, the DDS Director testified that *"the Department believes that regional centers have sustained the most serious and damaging budget reductions of all entities in the developmental services system. The Department is concerned that two years of unallocated reductions to*

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

One of the key issues identified by CMS during its review were the inordinately high caseloads of regional center service coordinators, which is a situation directly related to insufficient resources, since service coordinators, and their associated costs, comprise about 60% of the entire regional center OPS budget.[xiv] The CMS review noted that

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

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

IV. CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[xviii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to

severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has "accepted a responsibility" is directly threatened.

REFERENCES

1. Annual California State Budget Acts, from Chapter 359, Statutes of 1978 through Chapter 118, Statutes of 1991, Witkin State Law Library of California.

2. "Association of Regional Centers Salary Comparison Study," California State Personnel Board, Cooperative Personnel Services, February 23, 1984.

3. "Fiscal and Program Compliance Review of Department of Developmental Services Regional Center Operations," State of California, Department of Finance, Fiscal Management Audits, April 1979.

4. "Regional Center and CCSB Differential Caseload Staffing," State of California, Department of Finance, Program Evaluation Unit, April 1980.

5. "Personnel Task Force Report," Association of Regional Center Agencies, February 1984.

6. "California Regional Centers Journal Special Edition 1989."

7. "Personnel Task Force Report," Association of Regional Center Agencies, February 1984.

8. "Personnel Task Force Report," Association of Regional Center Agencies, January 1990.

9. "Report on Regional Center Administrative and Service Activities," California Department of Developmental Services, April 1, 1992.

10. Dennis Amundson, Testimony for the Oversight Hearing of the Senate Budget Subcommittee #3 on Health, Human Services and Labor, Department of Developmental Services, November 5, 1992.

11. "Regional Center Core Staffing Study – Final Report," prepared by Citygate Associates for the California Department of Developmental Services, September 1999.

12. "What Is This Thing Called Regional Center 'Operations'," Published in *Viewpoint*, the Frank D. Lanterman Regional Center newsletter, Summer 2003.

13. "Medicaid and Case Management for People with Developmental Disabilities. Options, Practices, and Issues (Second Edition)," National Association of State Directors of Developmental Disabilities, Inc., May 2006.

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

15. "2008-09 Governor's Budget November Estimate - Local Assistance for Regional Centers," California Department of Developmental Services, Estimates Section, January 10, 2008.

16. "Community Services Program – Expenditure and Caseload History," Department of Developmental Services, Budget Section, April 17, 2008.

17. "Regional Centers' Budget History," Department of Developmental Services, Budget Section, April 8, 2008.

ENDNOTES

[i] Wel. & Insti. Code §4621.5

[ii] Wel. & Insti. Code §4501.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[xviii] Wel. & Insti. Code §4501.

ATTACHMENT A

CORE STAFFING FORMULA

ATTACHMENT A

Attachment A
CORE STAFFING - BY 2013-14
Comparison of the 2013-14 Governor's Budget to the 2013 May Revision

I. CORE STAFFING FORMULA		May Revision			
A. PERSONAL SERVICES			Budgeted		
1. DIRECT SERVICES	Governor's Budget	Positions	Salary	Cost	Difference
a. Clinical					
(1) Intake and Assessment					
(a) Physician	$10,598,533	133.22	$79,271	$10,560,483	-$38,050
(b) Psychologist	11,165,020	266.43	41,754	11,124,518	-40,502
(c) Nurse	4,969,763	133.22	37,171	4,951,921	-17,842
(d) Nutritionist	3,760,981	133.22	28,130	3,747,479	-13,502
(2) Clinical Support Teams					
(a) Physician/Psychiatrist	6,350,346	69.00	92,034	6,350,346	0
(b) Consulting Pharmacist	4,171,050	69.00	60,450	4,171,050	0
(c) Behavioral Psychologist	3,793,068	69.00	54,972	3,793,068	0
(d) Nurse	3,482,982	69.00	50,478	3,482,982	0
(3) SB 1038 Health Reviews					
(a) Physician	2,195,011	22.12	92,034	2,035,792	-159,219
(b) Nurse	5,618,201	103.23	50,478	5,210,844	-407,357
b. Intake / Case Management					
(1) Supervising Counselor (Intake) (1:10 Intake Workers in Item (2) below)	3,176,767	82.74	38,036	3,147,099	-29,668
(2) Intake Worker	26,333,950	827.42	31,532	26,090,207	-243,743
(3) Supervising Counselor (Case Management) (1:10 CPCs in Items (6) and (7) below)	22,073,797	419.61	52,392	21,984,207	-89,590
(4) Supervising Counselor (Capitol People First) (DC Case Management 1:10 CPCs)	242,592	3.61	67,200	242,592	0
(5) Client Program Coordinator (CPC), 1:66 DC Consumers Capitol People First	1,698,326	36.12	47,019	1,698,326	0
(6) CPC, 1:66 Consumers(Total Pop w/o DCs,CPP,ES)	66,394,390	1,950.79	34,032	66,389,285	-5,105
(7) CPC (Waiver, Early Start only), 1:62 Consumers	75,322,005	2,197.06	34,032	74,770,346	-551,659
(8) CPC, Quality Assurance for ARM	1,666,547	48.25	34,032	1,642,044	-24,503
(9) Supervising Counselor, DSS Incidental Medical Care Regulations (1:10 CPCs)	71,253	1.36	52,392	71,253	0
(10) CPC, DSS Incidental Medical Care Regs	515,541	13.62	37,824	515,163	-378
c. Quality Assurance / Quarterly Monitoring					
(1) Supervising Counselor	2,061,101	40.08	52,392	2,099,871	38,770
(2) CPC	13,387,168	400.82	34,032	13,640,706	253,538
d. Early Intervention					
(1) General					
(a) Prevention Coordinator	876,792	21.00	41,752	876,792	0
(b) High-Risk Infant Case Manager	856,905	21.00	40,805	856,905	0
(c) Genetics Associate	798,714	21.00	38,034	798,714	0
(2) Early Start / Part C					
(a) Supervising Counselor	1,142,670	20.93	52,392	1,096,565	-46,105
(b) CPC	7,423,740	209.32	34,032	7,123,578	-300,162
(c) Administrative and Clinical Support (see next page)					
e. Community Services					
(1) Special Incident Coordinator	1,100,232	21.00	52,392	1,100,232	0
(2) Vendor Fiscal Monitor	1,309,741	21.88	50,844	1,112,467	-197,274
(3) Program Evaluator	898,653	21.00	42,793	898,653	0
(4) Resource Developer	898,653	21.00	42,793	898,653	0
(5) Transportation Coordinator	898,653	21.00	42,793	898,653	0
(6) Administrative Services Analyst (SB 1039 Consumer Complaints)	449,327	10.50	42,793	449,327	0
(7) Developmental Center Liaison	226,695	3.33	38,036	126,660	-100,035
(8) Diversion	126,584	4.00	31,646	126,584	0
(9) Placement Continuation:					
(a) Supervising Counselor	6,287	0.13	52,392	6,811	524
(b) CPC (Supplement at 1:45 Consumers)	40,838	1.34	34,032	45,603	4,765
f. Special Incident Reporting (SIR)					
(1) Supervising Counselor	388,749	7.40	52,392	387,701	-1,048
(2) QA/CPC	2,525,855	74.02	34,032	2,519,049	-6,806
(3) Nurses	1,873,239	37.01	50,478	1,868,191	-5,048
g. Mediation					
(1) Clinical Staff	7,093	0.11	64,484	7,093	0
(2) Supervising Counselor	52,916	1.01	52,392	52,916	0
(3) CPC	17,356	0.51	34,032	17,356	0
h. Expansion of Autism Spectrum Disorders (ASD) Initiative					
(1) ASD Clinical Specialist	1,371,888	21.00	65,328	1,371,888	0
(2) ASD Program Coordinator	1,318,464	21.00	62,784	1,318,464	0
i. SUBTOTAL DIRECT SERVICES	$293,658,436	7,669.41		$291,678,437	-$1,979,999

Attachment A

CORE STAFFING, BY (continued)

	Governor's Budget	May Revision Positions	Budgeted Salary	Cost	Difference
2. ADMINISTRATION					
a. Executive Staff					
(1) Director	$1,279,698	**21.00**	**$60,938**	**$1,279,698**	$0
(2) Administrator	1,009,449	**21.00**	**48,069**	**1,009,449**	0
(3) Chief Counselor	986,643	**21.00**	**46,983**	**986,643**	0
b. Fiscal					
(1) Federal Program Coordinator (Enh. FFP, Phase I)	1,206,177	**21.00**	**57,437**	**1,206,177**	0
(2) Federal Compliance Specialist (Enh. FFP, Phase II)	4,221,241	**105.82**	**39,887**	**4,220,842**	-399
(3) Fiscal Manager	963,480	**21.00**	**45,880**	**963,480**	0
(4) Program Tech II (FCPP)	882,890	**24.21**	**36,468**	**882,890**	0
(5) Revenue Clerk	1,234,546	**60.82**	**20,617**	**1,253,926**	19,380
(6) Account Clerk (Enh. FFP, Phase II)	584,640	**21.00**	**27,840**	**584,640**	0
(7) Account Clerk	8,198,991	**444.05**	**18,397**	**8,169,188**	-29,803
c. Information Systems and Human Resources					
(1) Information Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(2) Information Systems Assistant	1,000,692	**21.00**	**47,652**	**1,000,692**	0
(3) Information Systems Assistant (SIR)	500,346	**10.50**	**47,652**	**500,346**	0
(4) Privacy Officer (HIPAA)	898,653	**21.00**	**42,793**	**898,653**	0
(5) Personal Computer Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(6) Training Officer	1,099,728	**21.00**	**52,368**	**1,099,728**	0
(7) Training Officer (SIR)	549,864	**10.50**	**52,368**	**549,864**	0
(8) Human Resources Manager	1,067,724	**21.00**	**50,844**	**1,067,724**	0
d. Clerical Support					
(1) Office Supervisor	489,867	**21.00**	**23,327**	**489,867**	0
(2) PBX/Mail/File Clerk	1,378,188	**63.00**	**21,876**	**1,378,188**	0
(3) Executive Secretary	1,148,490	**52.50**	**21,876**	**1,148,490**	0
(4) MD/Psychologist Secretary II	279,019	**11.06**	**23,388**	**258,671**	-20,348
(5) MD/Psychologist Secretary I	4,387,232	**199.83**	**21,876**	**4,371,481**	-15,751
(6) Secretary II	3,913,748	**166.77**	**23,388**	**3,900,417**	-13,331
(7) Secretary I	19,328,526	**1,023.64**	**18,757**	**19,200,415**	-128,111
(8) Secretary I (DC Case Management - Capitol People First)	210,834	**6.62**	**31,848**	**210,834**	0
e. SUBTOTAL ADMINISTRATION	**$59,616,354**	**2,452.32**		**$59,427,991**	**-$188,363**
3. TOTAL POSITIONS AND SALARIES (Item A.1.i. + Item A.2.e.)	$353,274,790	**10,121.73**		$351,106,428	-$2,168,362
a. CPCs	*168,476,225*			*167,846,293*	*-629,932*
b. All Other Staff	*184,798,565*			*183,260,135*	*-1,538,430*
4. Fringe Benefits					
a. CPCs 23.7%	**$39,928,865**			**$39,779,571**	-$149,294
b. All Other Staff 23.7%	**43,797,260**			**43,432,652**	-364,608
c. Total Fringe Benefits	**$83,726,125**			**$83,212,223**	-$513,902
5. Salary Savings					
a. CPCs 1.0%	**-$2,084,051**			**-$2,076,259**	$7,792
b. All Other Staff 5.5%	**-12,572,770**			**-12,468,103**	104,667
c. Total Salary Savings	**-$14,656,821**			**-$14,544,362**	$112,459
6. Early Start / Part C Administrative and Clinical Support (salaries, fringe benefits and salary savings)	$694,000			**$694,000**	$0
7. TOTAL PERSONAL SERVICES (Items A.3. + A.4. + A.5. + A.6.)	**$423,038,094**			**$420,468,289**	-$2,569,805
ROUNDED	**$423,038,000**	**10,122.00**		**$420,468,000**	-$2,570,000
B. OPERATING EXPENSES AND RENT					
1. Operating Expenses	**$39,785,000**			**$39,600,000**	-$185,000
2. Rent	**$52,022,000**			**$52,020,000**	-$2,000
a. Rent	*55,022,000*			*55,020,000*	
b. Elimination of Office Relocation and Modifications	*-3,000,000*			*-3,000,000*	
3. Subtotal Operating Expenses and Rent	**$91,807,000**			**$91,620,000**	-$187,000
C. TOTAL CORE STAFFING (Items A.7. + B.3.)	**$514,845,000**			**$512,088,000**	-$2,757,000

Attachment B

CORE STAFFING FORMULAS

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES			
1. DIRECT SERVICES			
a. Clinical			
(1) Intake and Assessment			
(a) Physician (minimum of 1)	1.0 position	:	2,000 total consumers
(b) Psychologist	1.0 position	:	1,000 total consumers
(c) Nurse (minimum of 1)	1.0 position	:	2,000 total consumers
(d) Nutritionist (minimum of 1)	1.0 position	:	2,000 total consumers
(2) Clinical Support Teams			
(a) Physician/Psychiatrist	1.0 position	:	1,700 consumers in community care facilities (CCF) and supported living and those with severe behavior and/or medical problems
(b) Consulting Pharmacist	1.0 position	:	1,700 " "
(c) Behavioral Psychologist	1.0 position	:	1,700 " "
(d) Nurse	1.0 position	:	1,700 " "
(3) SB 1038 Health Reviews			
(a) Physician	1.5 hours	:	Referral/1,778 hrs./ full-time equivalent (FTE) position
(b) Nurse	1.75 hours	:	Individual program plan (IPP) review/1,778 hrs./FTE position
b. Intake/Case Management			
(1) Supervising Counselor: Intake	1.0 position	:	10 Intake Workers
(2) Intake Worker	1.0 position	:	14 monthly intake cases (assume average intake case lasts 2 mos.)
(3) Supervising Counselor: Case Management	1.0 position	:	10 CPCs in Items b.(4 and 5) below
(4) Client Program Coordinator (CPC)	1.0 position	:	62 Waiver and Early Start consumers (excluding CPP placements)
(5) CPC	1.0 position	:	66 consumers (all other consumers, excluding CPP placements)
(6) Supervising Counselor: Capitol People First	1.0 position	:	10 CPCs in Items b.(7) below
(7) CPC Capitol People First	1.0 position	:	66 consumers (Developmental Center residents)
(8) CPC, Quality Assurance for Alternative Residential Model	1.0 position	:	527 CCF consumers
(9) Supervising Counselor: DSS Incidental Medical Care Regulations	1.0 position	:	10 CPCs in item b.(10) below
(10) CPC, DSS Incidental Medical Care Regulations	1.0 position	:	2.5 hrs x 8 visits per year to CCF consumers who rely on others to perform activities of daily living

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
1. DIRECT SERVICES (continued)		
c. Quality Assurance/Quarterly Monitoring		
(1) Supervising Counselor	1.0 position	10 CPCs in Item c.(2) below
(2) CPC	10 hrs/yr.	: CCF consumer/1,778 hrs./FTE
	14 hrs./yr.	: Supported/Independent Living consumer/1,778 hrs./FTE
	10 hrs/yr.	: Skilled Nursing Facility and Intermediate Care Facility consumer/1,778 hrs./FTE
	10 hrs/yr.	: Family Home Agency consumer/1,778 hrs./FTE
d. Early Intervention		
(1) General		
(a) Prevention Coordinator	1.0 position	: RC
(b) High-Risk Infant Case Mgr.	1.0 position	: RC
(c) Genetics Associate	1.0 position	: RC
(2) Early Start/Part C		
(a) Supervising Counselor	1.0 position	: 10 CPCs in Item d.(2)(b) below
(b) CPC:		
Marginal positions from:	1.0 position	: 62 children<age 3yrs.
to:	1.0 position	: 45 children<age 3yrs.*
e. Community Services		
(1) Special Incident Coordinator	1.0 position	: RC
(2) Vendor Fiscal Monitor	0.5 position	: RC plus 1: every 3,140 vendors
(3) Program Evaluator	1.0 position	: RC
(4) Resource Developer	1.0 position	: RC
(5) Transportation Coordinator	1.0 position	: RC
(6) Administrative Services Analyst (SB 1039, Chapter 414, Statutes of 1997) Consumer Complaints	0.5 position	: RC
(7) Developmental Center Liaison	1.0 position	: 400 DC consumers
(8) Diversion	4.0 positions	: 21 RCs
(9) Placement Continuation		
(a) Supervising Counselor	1.0 position	: 10 CPCs in Item e.(9)(b) below
(b) CPC:		
1. Marginal positions from:	1.0 position	: 62 CPP Placements
2. to:	1.0 position	: 45 CPP Placements

* Note: This 1:45 staffing ratio is a funding methodology, not a required caseload ratio.

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
1. DIRECT SERVICES (continued)		
f. Special Incident Reporting (SIR)		
(1) Supervising Counselor	1.0 position	10 CPCs in Item f. (2) below
(2) QA/CPC	1.0 position :	RC plus 1:every 5,000 consumers
(3) Nurse	0.5 position :	RC plus 0.5: every 5,000 consumers
g. Mediation		
(1) Clinical Staff	2.0 hours :	25% of annual mediations/ 1,778 hrs /FTE position
(2) Supervising Counselor	4.5 hours :	mediation/1,778 hrs./FTE position
(3) CPC	4.5 hours :	50% of annual mediations/ 1,778 hrs./FTE position
h. Expansion of Autism Spectrum Disorders (ASD) Initiative		
(1) ASD Clinical Specialist (effective January 1, 2007)	1.0 position :	RC
(2) ASD Program Coordinator (effective January 1, 2007)	1.0 position :	RC
2. ADMINISTRATION		
a. Executive Staff		
(1) Director	1.0 position :	RC
(2) Administrator	1.0 position :	RC
(3) Chief Counselor	1.0 position :	RC
b. Fiscal		
(1) Federal Program Coordinator (Enhancing FFP, Phase I)	1.0 position :	RC
(2) Federal Compliance Specialist (Enhancing FFP, Phase II)	1.0 position :	1,000 HCBS Waiver consumers
(3) Fiscal Manager	1.0 position :	RC
(4) Program Technician II, FCPP	0.5 position :	RC
	1.0 position :	1,778 hours of FCPP determinations
(5) Revenue Clerk	1.0 position :	400 consumers for whom RCs are representative payee
(6) Account Clerk (Enhancing FFP, Phase II)	1.0 position :	RC
(7) Account Clerk	1.0 position :	800 total consumers
c. Information Systems and Human Resources		
(1) Information Systems Manager	1.0 position :	RC
(2) Information Systems Assistant	1.0 position :	RC
(3) Information Systems Assistant, SIR	0.5 position :	RC
(4) Privacy Officer, HIPAA	1.0 position :	RC
(5) Personal Computer Systems Manager	1.0 position :	RC
(6) Training Officer	1.0 position :	RC
(7) Training Officer, SIR	0.5 position :	RC
(8) Human Resources Manager	1.0 position :	RC

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
2. ADMINISTRATION (continued)		
d. Clerical Support		
(1) Office Supervisor	1.0 position :	RC
(2) PBX/Mail/File Clerk	3.0 positions :	RC
(3) Executive Secretary	2.5 positions :	RC
(4) MD/Psychologist Secretary II	1.0 position :	2 Physicians in Item 1.a.(3)(a), SB 1038 Health Reviews
(5) MD/Psychologist Secretary I	1.0 position :	2 Physicians/Psychologists in Items 1.a.(1)(a) and (b), Clinical Intake and Assessment
(6) Secretary II	1.0 position :	6 professionals in Items: 1.a.(3)(b), SB 1038 Health Reviews 1.b.(9) and (10), DDS Incidental Medical Care Regulations 1.c., Quality Assurance/ Quarterly Monitoring 1.e.(1), (2) and (9)(a) and (b) Community Services 1.e.(9)2., Community Services (see Secty I, line 1.e.(9)1., below) 1.f.(1) thru (3), Special Incident Reporting 2.b.(1), Federal Program Coordinators (FFP Phase I) 2.b.(2), Federal Compliance Coordinators (FFP Phase II) 2.c., Information Systems and Human Resources
(7) Secretary I	1.0 position :	6 professionals in Items: 1.a.(1)(c) and (d), Clinical Intake and Assessment 1.b.(1) to (5) and (8), Intake/Case Mgt. 1.b.(6) and(7) Capitol People First 1.d., Early Intervention 1.e.(3), (4), (6) to (8), Community Services 1.e.(9)1., Community Services (see Secty II, line 1.e.(9)2., above)

ATTACHMENT B

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE ADDED SERVICES

PUBLISHED BY

FRANK D. LANTERMAN REGIONAL CENTER

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE-ADDED SERVICES

Over the years, as the state legislature has sought acceptable strategies to resolve repeated budget shortfalls, stakeholders in the developmental service system have offered a variety of remedies to reduce costs. Proposed solutions have included changing or reducing the entitlement defined by the Lanterman Act, implementing parental cost-sharing or co-payment requirements, cutting reimbursement to service providers, and reducing funding to regional centers and developmental centers.

One proposal to achieve savings in regional centers has been to cut regional center "operations". Those who recommend this as a solution argue that this would do no more than reduce "red tape," and that taking money away from what some perceive to be strictly administrative functions would leave more money for purchasing services for clients.

This argument fails to recognize that the vast majority of activities classified as operations in the regional center budget are actually direct services to clients and their families. As stated in the Lanterman Act, it was the intent of the Legislature that "the design and activities of regional centers reflect a strong commitment to the delivery of direct service coordination and that all other operational expenditures of regional centers are necessary to support and enhance the delivery of direct service coordination and services and supports identified in individual program plans (Section 4620)."

Most "operations" activities are direct services to clients and families.

In conceptualizing the model for the regional center system, the legislature found that "the service provided to individuals and their families by regional centers is of such a special and unique nature that it cannot be satisfactorily provided by state agencies." They reasoned that the array of services and supports required by people with developmental disabilities and their families was so complex that the necessary coordination could not be successfully managed by any existing agency. For this reason, the legislature made the decision to contract with private non-profit community-based agencies to be the organizing hub and center for coordinating services. The mission of these organizations – called regional centers – was two-fold: to ensure that people with developmental disabilities would be afforded the opportunity to live independent, productive and normal lives alongside their non-disabled peers in the community; and to minimize the risk of developmental disabilities and ameliorate developmental delays in infants and young children who are at risk.

In this paper, we attempt to show why the term "operations" when applied to the vast majority of activities of the regional center is a misnomer. We clarify what is included in this category and how many of these activities are more accurately described as direct services to clients and families. While regional centers do have an administrative role, it is small in comparison to the range of direct services provided by regional center staff to clients and families.

We begin by looking at the overall regional center budget and how funding is allocated within centers between purchase of service and operations. While most of this information is derived from Lanterman Regional Center, the general findings can be applied to the other regional centers in California.

How Regional Center Funds are Allocated

The regional center receives funding for two purposes:

- purchasing services for clients and families from community service providers (POS); and
- operating the center, including, for example, paying staff salaries and office rent and purchasing supplies and telephone service (Operations).

Figure 1, below, provides a graphical representation of the relative amounts of the regional center budget that are apportioned to POS and Operations. As can be seen from this chart, POS accounts for approximately 87% of the total regional center budget. The remaining 13% is allocated between what is often called *general administration* (2%) and activities that are *direct services* (11%) to clients and families.

Figure 1

Distribution of Regional Center Funds[1]

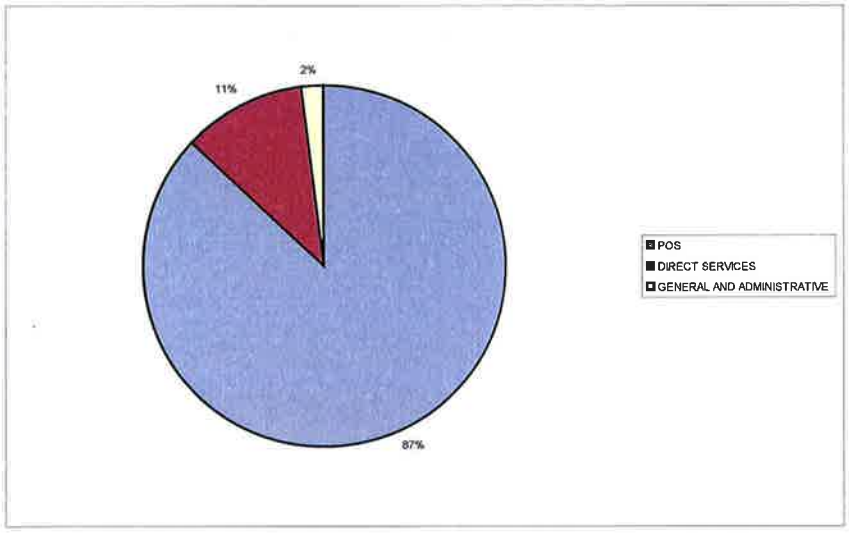
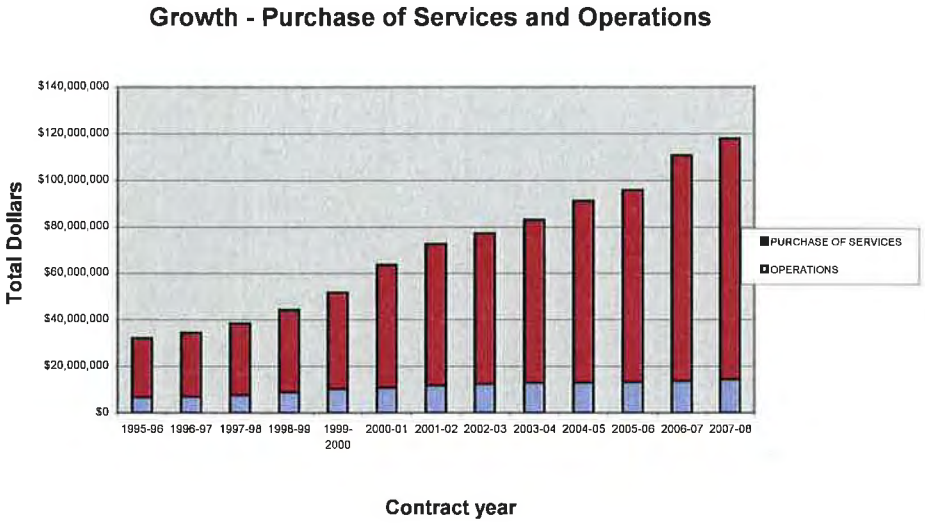


Figure 2, below, illustrates the comparative increases in purchase of service and total operations expenditures between 1995-96 and 2007-08.

[1] Figures are taken from Lanterman Regional Center independent audit report for 2007.

Figure 2



The figure shows that, during that 12-year period, POS expenditures grew at almost twice the growth rate for operations. In 1995-96, "operations" equaled 21% of the regional center budget, whereas currently this category accounts for slightly less than 13% of spending.

Regional centers have not received cost-of-living adjustments since 1991-92.

What is not shown in *Figure 2* is the significant disparity between regional center staff salaries as reflected in the "core staffing formula" used by DDS to fund centers and the actual salaries of regional center staff as demanded by the marketplace. The core staffing formula originally keyed regional center salaries to the mid-range salary of the equivalent state positions at the time each regional center position was added to the formula. Until 1991-92, regional center positions received annual cost-of-living adjustments equivalent to the adjustment received by state employees but the state ceased making these adjustments in 1991-92. From that year until the present, with one exception, the state has not authorized cost-of-living adjustments for regional center staff. The exception occurred in 1998-99 when the state authorized a one-time increase in the core staffing salary for service coordinators. This was in response to controversy surrounding a report[2] concluding that the risk of death increased for people moving from the developmental center into the community.

To highlight the disparities resulting from the failure to adjust regional center salaries, *Table 1* below compares salaries as reflected in the core staffing formula with actual salaries for two regional center positions.

[2] Strauss, D. J. and Kastner, T. A. (1996). Comparative mortality of people with mental retardation in institutions and the community. *American Journal of Mental Retardation* **101**, 26-40.

Table 1

Position	Core Staffing Salary	Regional Center[3] Average Salary
Service Coordinator	$34,032	$42,500
Accounting Associate	$18,397	$36,162

Currently, the actual salaries for LRC staff exceed the total in the core staffing formula by slightly more than 20%. Regional centers adjust for these disparities by employing fewer people than are allocated in the core staffing formula.

OPERATIONS: WHAT DOES IT INCLUDE?

In this section, we take a closer look at what is included in the operations category. We begin by looking at the direct services provided by regional center staff.

Service Coordination for Clients over Age 3

Service coordination consists of a unique set of responsibilities assigned to regional centers by the Lanterman Act. It is the cornerstone service provided by the regional center. This service is universally received by every client and is central to ensuring that the service system meets every client's needs.

Lanterman Regional Center employs approximately 110 professionals who help plan and coordinate services for 7,400 children and adults living at home, in the community, and in the developmental center. These service coordination activities occur in face-to-face meetings as well as via mail, telephone, and e-mail communications. Service coordinators (SCs) work with clients and families on the development of person-centered plans, called Individual Program Plans, or IPPs, and they conduct annual reviews of these plans.

For clients living in licensed residential homes and supported living, SCs also conduct quarterly face-to-face reviews at the home. LRC has approximately 1,000 clients living in these two settings and, for many of them who have no family or others to advocate for them, the SC plays a major role in ensuring that they receive the services, supports, and other opportunities that they need to be active members of their community. In 2007, SCs conducted more than 1,800 IPPs and 3,700 annual reviews, and nearly 4,000 additional quarterly face-to-face visits to clients' homes.

Service coordinators provide IPP development and periodic review, authorization of services, review of client progress, residential monitoring, assistance with IEPs and ITPs, linkage with generic services, advocacy, and crisis intervention.

[3] The regional center data reflects findings of a July, 2007 Hewitt Associates survey of compensation at 9 Southern California regional centers.

As part of each annual review, the SC also completes a health status review, intended to ensure that the client is receiving the recommended medical, mental health, and dental care, and an annual assessment of client adaptive behavior (the Client Development and Evaluation Record, or CDER). SCs whose clients live in a licensed home also participate with staff of the center's Community Services Department in monitoring the quality of services provided in those settings.

Prior to receiving most types of purchased services, a client is formally assessed to determine the necessity and appropriateness of the proposed service. SCs receive and review these reports and, if services are determined to be necessary, identify programs or professionals to provide the services and issue authorizations to purchase services. In many cases the search for a provider requires multiple phone calls to find a provider who is both appropriate and has the capacity to take on a new client. This is a particular problem with regard to speech therapy. Service coordinators typically contact three or four providers before identifying one who will accept a client. In some cases, service coordinators have been required to contact up to ten therapists.

For those clients who receive services, providers are required to submit periodic reports reflecting their progress toward achieving the goals identified in the service plan. Service coordinators have a quality control responsibility - reviewing such reports for all of their clients to ensure that appropriate services are accessed and that the client is making progress toward the stated goals. All reviews and authorizations – for new services, for continuations, and in situations where families or clients request changes in vendors, dates of service, etc. – must be completed in a timely manner so that there is no delay or interruption in services. An SC typically completes between 100 and 200 individual authorizations in a month.

SCs are responsible for receiving and reviewing medical records and, for children in school, Individual Educational Programs (IEPs) and Individual Transition Plans (ITPs). They also help parents prepare for IEP meetings and, at parents' request, attend the IEP and ITP meetings to help the parents advocate for needed services.

Family Cost Participation Program. Service coordinators play a role in implementing the Family Cost Participation Program, begun in 2005 and applying to families of children ages 3 to 17, inclusive, who are not covered by Medi-Cal. This program requires parents to share in the cost of certain services purchased by the regional center for their children. SCs review circumstances of families that meet the criteria for participation in this means-tested program, explain the program to the parents, obtain the required financial information for eligible families, and submit it to the center's fiscal monitor. During 2007, 257 additional families were evaluated for participation and 101 were assessed a share of cost. The number of families evaluated is expected to increase since, in 2008, the program was expanded to included children age birth to 3 receiving early intervention services.

Service Coordination for Children under Age 3 (Early Start)

Early Start is California's name for its early intervention program for children age 0 – 3. Lanterman Regional Center currently serves 1,330 children in this program. For these children, SCs coordinate development of an Individualized Family Service Plan (IFSP) every year and

review that plan every six months. In 2007, SCs completed 1,225 IFSPs and 407 six-month reviews.

Early Start SCs provide outreach and case finding through activities such as maintaining liaison relationships with six neonatal intensive care units serving the Lanterman area. They also have been very successful in helping toddlers gain entry to typical (integrated) preschools. In 2007, 480 children (more than 90% of the center's preschool age clients) were enrolled in community-based preschools.

In 2007, Early Start service coordinators helped more than 90% of the center's preschool age clients enroll in typical preschools in the community.

Children receiving early intervention services are evaluated a second time, when they reach 2 ½ years of age, to determine whether they will be eligible for continued regional center services after age 3. As a result of the services provided through the Early Start program, approximately two-thirds (68%) of these children have caught up with their typical peers and they "graduate out" of the program. These children are no longer eligible for regional center services, although some of them – for example, children with specific learning disabilities – may receive specialized services through the school district. For these children as well as for children who will remain regional center clients, Early Start service coordinators work with families to ease their transition into the public school program.

Coordination of Services

SCs are the *primary contact linking clients and families with services and supports* needed to implement IPPs and IFSPs. They must ensure cooperation and collaboration across agencies and service providers in the interest of clients. This linkage may be to public and community agencies serving the general public, such as the schools, the Department of Rehabilitation, and Social Security, or it may be to regional center authorized service providers. SCs monitor the service relationships to ensure that they are effective in helping clients achieve their desired outcomes, and they intervene when problems or questions arise. These responsibilities require SCs to maintain intensive communications, both verbal and written, with community agencies, direct service providers, and clients and families.

Social work responsibilities. In addition to their service coordination responsibilities, SCs do a significant amount of case management in the social work tradition. (Early in the history of regional centers, SCs were social workers.) For example, they routinely deal with a range of crises experienced by their clients and families, including parents attempting to come to terms with a new diagnosis. They also cope with issues related to domestic violence, divorce, eviction and homelessness, food insecurity, and death or illness of a primary caregiver. Particularly with younger adult clients, they may be called upon to become involved with law enforcement or the courts when a client is thought to have committed a crime.

Information. The SC is the primary keeper of information about the client, the services he or she receives, and significant events in his or her life. This responsibility involves a significant amount of clerical work that arguably would be more appropriately handled by clerical or

secretarial staff if they were available. In the early 1990s, budget pressures caused regional centers to reduce operations costs by eliminating selected support staff. As a result, for example, service coordination units at Lanterman Regional Center were left with one secretary to support 10-12 service coordinators and a regional manager. As a consequence, SCs responsibilities include word processing, handling their own mail, copying, and filing.

Community Placement Plan.

As the primary mechanism for implementing the state's commitment to moving people out of state developmental centers (DCs), Community Placement Plans are created by all regional centers and submitted to DDS for approval. These plans include the identification of DC residents whose needs, as judged by their ID teams, can be met in a community residential setting. For each of these individuals, the ID team assesses their support needs and preferences, and, in partnership with the regional center's Community Services Department, identifies or develops residential and other resources to support these clients in the community.

Lanterman's Community Living Options (CLO) team of four Community Living Specialists (CLS) currently provides specialized service coordination to 62 clients who have moved to the community from a developmental center under the Community Placement Plan. At this time, 101 individuals continue to reside in the DC and the appropriateness of community placement for these residents is discussed at every IPP meeting. An enhanced caseload ratio required for the CLO team (1:45) allows for monthly visits for the first six months after community placement, quarterly progress reviews, annual IPP development and semi-annual review, court reports, and special resource development and re-direction efforts to assist and maintain community placement. CLO staff are also responsible for "deflecting" clients in the Lanterman community who are at risk of being committed to a DC.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move. Since some DC residents are in that placement as the result of a judicial order, the transition process includes a series of court hearings and formal reports to keep the court informed about the status of the transition.

Federal and state laws, reinforced by judicial decisions, support the right of people with disabilities to live in the least restrictive setting. Parents or other family members, however, may be comfortable with the services their relative is receiving in the DC and reluctant to engage in what they view as "change for change sake." Staff of developmental centers are also sometimes resistant to residents leaving their protective environment. A major role for CLO service coordinators, therefore, is to develop a trusting relationship with the family that can serve as the basis for a mutual partnership focused on obtaining an appropriate home for the client in the community. Once such a relationship is developed, SCs work with the family and DC staff in identifying an appropriate community resource, orienting them to what will be necessary to support the client in this less

restrictive living arrangement, and working closely with them in an ongoing way as the transition progresses.

Coordination of appeals. The responsibility for appeals coordination, including both informal appeals at the regional center level and formal hearings with the Office of Administrative Hearings, rests with the division of Client and Family Services. In 2007, a total of 30 requests for fair hearing were filed in the following categories:

- Eligibility – 14 (47%)
- Intensive services for autism – 5 (17%)
- Legal services – 3 (10%)
- Other services – 8 (27%)

Emergency response. Regional center staff respond to urgent situations and emergencies after hours and on weekends. Clients, families, and service providers can contact an on-call staff person 24 hours a day, 7 days a week through the center's emergency line. The most frequently encountered emergency situations include clients who go missing, instances of potential abuse, emergency hospitalizations requiring consent from the regional center, and emergency placements (e.g., for clients whose family has an urgent need for respite). Calls from police departments are also common. When a person with no identification and an inability to communicate is brought to the attention of police, they frequently call the regional center seeking help in identifying the individual. The person may not be a client of the regional center called or may not even be a regional center client, but rather a person with a serious mental illness. In any case, the regional center is expected to provide assistance to the police in their attempt to identify the individual.

Managing risk. Service coordinators, in collaboration with staff of the center's departments of Community Services and Clinical Services, have the primary responsibility for investigating Special Incidents. Special Incidents are occurrences that potentially threaten the health or welfare of clients. Because of their potential serious consequences for the client, they must be handled expeditiously. The service coordinator and other involved staff members must immediately turn their full attention to the investigation of the incident. A service coordinator whose caseload consists of clients living in licensed homes typically has 1 – 2 special incidents to investigate per week, each of which requires a minimum of 3 to 4 hours. The most time consuming type of Special Incident investigation, potential abuse, requires an average of 8-10 hours to complete.

Special incidents include events such as unexpected hospitalizations, physical injury, lost or missing clients, and suspected abuse. The aim of a Special Incident investigation is to intervene quickly to resolve a problem, to determine whether the occurrence was preventable and, if it was, to develop strategies or interventions to prevent a recurrence.

In 2007, Lanterman staff members investigated and resolved 1903 Special Incidents. Many of these investigations required the service coordinator to intervene on behalf of the client with a community agency such as a hospital, the Department of Children and Family Services, the Department of Mental Health, a law enforcement agency or court, Adult Protective Services, or the county's Public Guardian Office. The center's Risk Management Committee monitors

Special Incidents at the aggregate level to determine if there are any systemic issues warranting action by the regional center – for example, implementation of training initiatives, changes to policies or procedures, or the development of new services and supports.

Targeted Case Management (TCM) Program. As a condition of the state obtaining federal financial participation in the funding of regional centers, service coordinators are required to document all of their direct service activities in the interdisciplinary (ID) notes section of their clients' records. The federal government has imposed strict requirements on this documentation – for example, services must be described precisely and in a specific format, and time must be recorded in 15-minute increments. This information is submitted by the regional center to the Department of Developmental Services on a monthly basis. DDS, in turn, bills the federal government for these services. The TCM program brings approximately $140 million in federal funding into the state each year.

Advocacy

The Lanterman Act assigned to regional center service coordinators the role of front line advocate, assisting clients and families in exercising their civil, legal, and service rights. In 1997 funding for advocacy was removed from regional center budgets and transferred to the Office of Client Rights Advocacy, but the primary responsibility for advocacy remains with regional centers and is an important function of service coordinators. SCs represent clients' interests with service providers in the community as well as with generic services such as the school system and the Department of Rehabilitation. In 2007, service coordinators attended Individual Education Program (IEP) meetings for more than 460 clients, and they helped more than 937 families gain inclusion for their sons and daughters in regular classrooms with their typical peers.

Service coordinators helped 937 families gain inclusion for their sons and daughters in regular classrooms with typical peers.

SCs also serve a critical advocacy function helping clients and families achieve and maintain eligibility for entitlements such as Medi-Cal and SSI, and they assist families dealing with criminal justice and immigration matters. For a majority of clients who become involved with the criminal justice system, regional center service coordinators are asked by the court to write a diversion plan to be implemented in lieu of incarceration. In this activity, they work with the public defender or probation department to create a plan of education, restitution, or correction with a goal of preventing the client's future involvement with the justice system. In these cases, service coordinators are required to monitor the client's progress on the plan and submit periodic reports to the court on the client's status.

Through the Koch-Young Resource Center, described below, the center offers an 8-hour course for Lanterman families to help them become more effective advocates for their family member with a disability. This course, called Service Coordinator and Advocacy Training (**SCAT**), is conducted four times a year, three times in English and once in Spanish. The center also offers more specialized educational and training opportunities to help families further sharpen their advocacy skills and learn about services and benefits available for their sons and daughters. These classes focus on transition into school, the individual educational program (IEP) process, transition from school to work, and SSI and employment benefits.

Clients are able to develop and practice their own self-advocacy skills though involvement with the regional center's governance board and committees and the Client Advisory Committee . They are also currently attempting to organize a local chapter of People First.

Three formal self-advocacy experiences, are available to adult clients through the center's Training and Development Department. These programs, which are the responsibility of the center's Peer Advocate, include:

- Women's Reproductive Health Self-Advocacy Training: A peer-advocacy-based training program for women with developmental disabilities; topics include basic anatomy, menstruation, menopause, pregnancy, sexually transmitted diseases, contraception, the importance of women's health exams, and using self-advocacy to communicate with your doctor.
- Abilities: A sexual abuse and exploitation risk-reduction program for adults with developmental disabilities, including topics such as what is sexual abuse, assertiveness training, self-esteem and communication, personal safety training, and what to do if a person is ever sexually abused or assaulted.
- Project Prepare: Disaster preparedness training for clients.

Resource Center staff also recruit students, arrange sites for, and coordinate delivery of two additional programs which are offered by outside organizations. These programs are:

- Get Safe: A personal safety program for adults, teens, and children, including topics such as assertiveness training, community safety awareness, setting limits, defining boundaries and creating healthy relationships.
- SHASTA: A sexual health and safety program for teens and adults.

Intake and Assessment

Intake staff members oversee the process through which prospective clients are assessed to determine whether they are eligible for regional center services – i.e., are at risk for a developmental disability or have such a diagnosis and are substantially handicapped. The Intake Unit completed 1,617 intake and assessments during 2007, completing the process within legally mandated time frames. Approximately 70% of these intakes were for infants and toddlers under age 3.

Regional center are allowed 45 days from the time of the first phone call from a family to complete the development of an Individual Family Serivce Plan for children under age 3.

Intake timelines for the Early Start program are particularly stringent. While 120 days is allowed for completing intake and assessment for applicants over age 3, for children under 3 regional centers are allowed only 45 days from the time of an initial phone call from a family to complete the development of the Individualized Family Service Plan (IFSP). During this time period regional center staff must meet with the family; ensure that formal assessments are completed; review assessment reports and consult with clinical staff to determine eligibility; decide, in cooperation with the family, what services and supports will be provided; complete the writing of the IFSP; and initiate the purchase of services.

For prospective clients who are determined not eligible for regional center services, intake and assessment staff serve as a source of information and referral to other public and private resources that might meet their needs and the needs of their families. These staff members also engage in outreach activities with agencies such as the Department of Children and Family Services, the Department of Mental Health, homeless shelters, and the Los Angeles City jail, to enhance case finding and ensure that referrals made by these agencies are appropriate.

Clinical Services

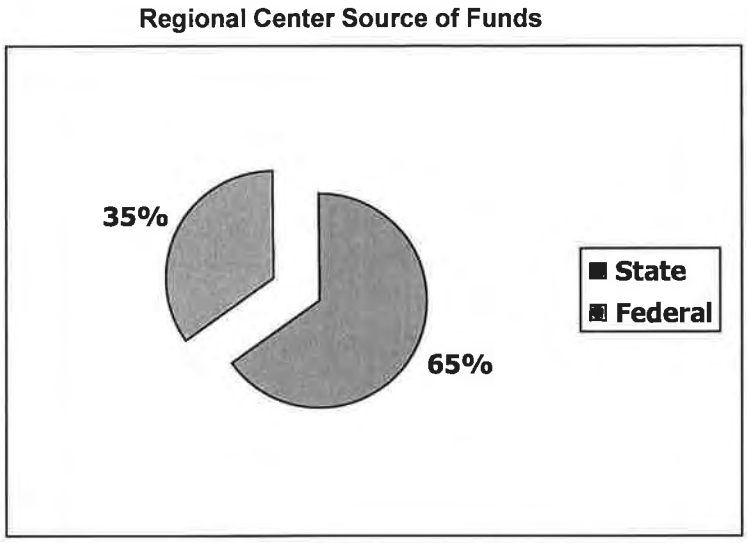
Using an interdisciplinary team approach, Clinical Services specialists conduct a variety of activities aimed at ensuring and improving the health and well-being of clients. Nurses, physicians, psychologists, a dental hygienist, and a dentist are involved in:

- individual clinical assessments of clients;
- review of services being provided to clients by community professionals, and direct consultation with these professionals;
- consultations with service coordination staff on specific clients' health issues;
- consultation with and technical assistance to service providers;
- participation in annual review meetings for clients who have significant health related issues or concerns;
- review of requests for the use of psychoactive medications with clients;
- consultation with service coordination staff on Medicare Part D issues;
- oversight of the review process required under the federal Nursing Home Reform program;
- review of requests for surgical and other interventions from medical professionals, consultation with those professionals about the requests, and providing consent, as appropriate, when no other party is authorized to assume this responsibility;
- mortality review in all cases of client death.

The center's Bio-ethics Committee reviews requests from physicians or families to impose a "Do Not Resuscitate Order" or order hospice or palliative care for a client. The committee develops a report with recommendations for the Executive Director who makes the final decision and forwards it to the institution's Bio-ethics Committee.

Medicaid Waiver. A major activity of Clinical Services is certification and annual re-certification of clients for eligibility under the Home and Community Based Waiver (HCBW) program. This is a collaborative effort of Clinical Services staff and service coordinators, and is part of a program that brings a very substantial amount of federal funding into the developmental services system. Approximately 1,900 of Lanterman's 7,400 clients are currently certified for the waiver. This number represents a 20% increase from the 2006 waiver enrollment. Statewide, the HCBW program brings more than $750 million into the Developmental Services system. *Figure 3* on the following page gives a graphical representation of the portion of the regional center system budget that is covered by federal financial participation, including Medicaid Waiver and Targeted Case Management. As can be seen, these federal funds constitute slightly more than one-third of the total budget for regional centers.

Figure 3



The Clinical Services Department also develops and manages special projects targeted at objectives such as improved dental health, prevention of unnecessary hospitalization, ensuring appropriate use of medications in group homes, enhanced access to psychiatric services, and improved support for aging clients to enable them to "age in place" in the community. For these projects, the regional center has partnered with organizations such as USC Schools of Medicine and Dentistry; UCLA Schools of Medicine, Dentistry, and Nursing; University of the Pacific Special Needs Dentistry; the Semel Institute at UCLA, Childrens Hospital Los Angeles, and LA Care and Health Net Health Plans.

Family Support

The Koch-Young Resource Center (KYRC) is dedicated to the provision of information and support to clients and families and to the professionals who support them. The Center maintains a Help Desk and associated telephone Help Line that responded to approximately 3,000 information and referral requests in 2007. It contains a multimedia lending library housing thousands of educational materials available to clients, families, service providers, and members of the larger community. Nearly 1,200 individuals are registered users of the library.

Nearly 1,200 individuals are registered users of the Koch-Young Resource Center Library.

During 2007, KYRC staff distributed over 1,000 Welcome Kits to new regional center families. These kits contain materials of general interest to new families as well as information that is specific to their children's disabilities. They also publish the ***Viewpoint*** newsletter and support the Lanterman web site, both critical tools for communicating with the Lanterman community. In 2007, the web site had approximately 30,000 unique visitors who viewed more than 70,000 unique pages. During the summer of 2007, the center launched the Network of Care through the center's website. This is a searchable database of more than 975 community resources that

integrate children and adults with developmental disabilities into regular programming and activities with their non-disabled peers. The network listing is continually updated and expanded.

The Resource Center currently coordinates 19 family support groups providing mutual support, education, information sharing, and advocacy. A service coordinator is involved in each of these groups in partnership with and as a mentor for the parent who acts as co-facilitator. The Resource Center also coordinates 3 client support groups and two intensive Sibling Support Groups for children and adolescents whose siblings are regional center clients. It also maintains the Peer Support Program where approximately 40 experienced parents are actively involved in offering one-to-one emotional support and information to families who are new to the center or families who request a partner for a specific purpose.

The KYRC coordinates the regional center's volunteer program. In 2007, approximately 20 volunteers, most of whom are clients, completed over 1,200 hours of volunteer effort on tasks such as mass mailings. Through the KYRC, the regional center has also developed internship opportunities intended to bring young people with non-traditional backgrounds, such as business and the sciences, into the regional center to apply their knowledge and skills while learning about developmental services. The capstone of that effort is the Roberta Happe Memorial Internship, established in 2001.

The Resource Center has been instrumental in developing and maintaining partnerships with community-based organizations with a goal of expanding educational, skill-building, and other opportunities for people with disabilities. In partnership with the Los Angeles Unified School District, Lanterman hosts two computer training classes each semester for clients, family members, and caregivers. As of the end of 2007, 120 students had graduated from these classes with beginner and intermediate computer skills. Up to 60 students are served in each class series and each series is offered four times per year.

The KYRC also maintains partnerships that offer more inclusive opportunities for people with disabilities in programs serving the general public. Such partnerships have been created with Community Technology Centers, offering clients who complete computer classes at LRC an opportunity to transition to advanced training in the community, and local public libraries to provide clients with a variety of opportunities generally available to the wider community.

Assistive Technology Project. Another valued component of the KYRC is the Assistive Technology Project (ATP) that provides consultations, information, and advice to clients and families of clients who might benefit from the use of technology to learn, communicate, or complete activities of daily living. This project is the result of a partnership between Lanterman Regional Center and the Assistive Technology Exchange Center (ATEC), a division of Goodwill of Orange County. The project has provided more than 40 AT "labs" where parents can explore assistive technology options, more than 500 consultations and 200 individualized assessment of need, and 4 AT workshops for service providers. The regional center also partnered with the USC Occupational Therapy program to offer an OT internship focused on assistive technology.

Quality Assurance and Improvement Activities

Residential services. The Community Services Department is responsible for a range of activities mandated by Title 17 and aimed at ensuring the health, safety, and well being of clients living in licensed homes and improving the quality of services provided there. Regular monitoring visits to group homes and other residential settings are also intended to ensure that the residents' rights are protected, that residents' personal funds are being appropriately managed, and that residential staff are helping residents maximize opportunities to participate in the life of the local community. Regional center staff also provide technical assistance and training to service providers to increase their skills and enhance the quality of services they provide. Four Community Services staff members currently monitor 120 homes, 13 of which are Community Placement Plan (CPP) homes.

The monitoring function requires regional center staff to conduct two unannounced visits to each licensed home each year. The regional center is also required to conduct an announced in-depth, day long, comprehensive team evaluation of each home every three years. Given the broad scope of the team evaluation, the Service Coordinator who acts as liaison to the home participates as a member of the team. The Quality Assurance staff conduct the mandated exit interview with the residential provider and write the evaluation report within the mandated timelines.

CPP homes are specialized homes for people moving out of the state developmental center. Given the complex and often intense needs of these clients, the Quality Assurance staff conduct quarterly monitoring of CPP homes to ensure that the client's needs are being met and their health and safety are being ensured.

Homes that do not meet regulatory standards are required to implement Corrective Action Plans. Quality Assurance staff provide technical assistance in development of these plans and they conduct additional unannounced visits to ensure that they are implemented appropriately. They also conduct two subsequent unannounced visits to ensure that the home continues to meet expectations of the CAP.

For all newly vendored residential providers, Quality Assurance staff conduct an orientation and two technical assistance visits in addition to the other required visits. The orientation and technical assistance visits aim to ensure that new providers understand and satisfy regulatory requirements and regional center expectations.

Work-related services. The four Community Services staff members who monitor licensed homes have additional mandated responsibilities with regard to work programs. These activities are aimed at ensuring that work programs are providing paid work opportunities to clients in a safe environment, and that work programs are in substantial compliance with national accreditation standards. Community Services staff provide technical assistance and training to these providers as needed or requested. Lanterman staff currently monitor 10 work programs. These responsibilities were transferred to the regional center from the Department of Rehabilitation in 2004, but no funding accompanied the transfer.

Other services. Community Services Quality Assurance staff members annually monitor day programs, independent living services (ILS), and supported living services (SLS) programs to ensure that they meet regulatory requirements and regional center expectations. These staff members provide technical assistance and training to these providers as needed or requested. They currently monitor 23 day programs, 10 ILS programs and 13 SLS programs. The center's budget does not include staffing to perform monitoring for these three types of services.

Complaint investigations. Community services staff investigate all complaints against vendored service providers. Depending on the nature of the complaint and the number of people who must be interviewed, a complaint investigation requires between one and five days. Community Services staff provide technical assistance and training to these providers as needed. A meeting is held with the provider to discuss the complaint and the findings of the investigation team. Following the meeting, a letter is sent to the provider summarizing the complaint, the results of the investigation, and any further actions needed. Community Services staff participated in 91 of these investigations in 2007.

Resource Development

The Community Services Department is responsible for ensuring that the service system includes the types and numbers of services necessary to meet the service needs of the more than 7,400 children and adults with developmental disabilities in the Lanterman service area. This responsibility includes the entire range of services – e.g., living options, day programs, work programs, autism services, and therapeutic services.

Resource Specialists provide technical assistance to all potential service providers, reviewing regulatory requirements and regional center procedures and expectations, and reviewing the vendor application packet to ensure that those who request vendorization are qualified to meet the needs of people they intend to serve. Site visits are conducted for all potential center-based services and transportation companies to ensure that a safe environment exists. Licenses and credentials, where applicable, are verified. Therapists who seek to conduct in-home services are required to submit three professional references, and these are verified. While not mandated by Title 17, these precautions are taken to ensure the health, safety and well being of all regional center clients who will potentially receive services from the provider.

Because the Centers for Medicare and Medicaid Services promote choice, residential and community based non-residential programs are required to prepare a program design that describes the services to be provided, curriculum, staff qualifications and training, and more. Community Services staff read each program design and provide written feedback to the potential provider. The average program design is 50 pages in length and is typically revised several times before it meets Title 17 standards and satisfies regional center expectations.

The Resource Developer also ensures that appropriate services are developed for clients moving into the community from developmental centers via the Community Placement Plan. These resources are specialized and require community services staff to do increased monitoring, technical assistance and training to ensure the client's needs are met.

Vendorization

The regional center's vendor list includes thousands of providers in the Lanterman area, each of which has a record that must be maintained and updated when changes are made to the provider's name, address, telephone number or rate, or when the provider begins providing a new service. This information must also be made available to other regional centers that use the service provider.

Families wishing to purchase their own diapers, respite, pre-school programs, or transportation are also required to be vendored and must work with community services staff to complete an application and obtain a vendor number. Clients and families seeking to be reimbursed for purchases they made for authorized services or products also must be vendored. The regional center newly vendored 128 providers and made changes to 386 vendor files in 2007.

The regional center requires that providers maintain appropriate insurance coverage as a condition of doing business with the center. A separate database is maintained by the regional center to ensure that providers purchase insurance and renew it annually. Reminder notices are sent to providers who fail to provide proof of annual renewal of coverage.

Client Benefits Coordination

Three staff members in the center's Administrative Services Department spend 100% of their time coordinating client benefits. They are responsible for managing the SSI funds and other public benefits for approximately 1125 clients for whom the regional center is the representative payee. These are clients who are unable to manage their own finances and have no family or other appropriate representatives able or willing to help them with this responsibility. These three staff members currently manage more than $9 million in clients' funds. They also manage the processing of applications for Supplemental Security income, Medi-Cal, and other programs for these 1125 clients as well the annual re-determination of eligibility for these programs. Finally, these employees process an additional 2,000 forms that are required by Social Security Administration for a variety of purposes.

Fiscal Monitoring

One staff member coordinates the development of and monitors more than 84 contracts related to the center's operations and purchase of service activities. Nearly 90% of these contracts pertain to direct services provided to clients. This task is essential to ensuring careful stewardship of funds entrusted to the regional center. The fiscal monitor completed 45 vendor audits in 2007, 11 of which were required, and coordinated recovery of overpayments. She also shares responsibility with service coordination staff for implementation of the Family Cost Participation Program. She receives income information on eligible families and assesses an appropriate share of cost for families who are determined to be participants. In the three years since the inception of this program, 459 families have been reviewed and 252 have been assessed a share of cost for services, as prescribed by law. With the expansion of this program to Early Start clients, the number of families involved in this program each year is expected to increase.

Training

The regional center creates, conducts, and coordinates a wide range of educational and skill development activities for clients, families, service providers, and regional center staff. A director and 1¼ members staff develop, coordinate, and conduct training programs tailored to the needs of clients, parents, services providers, and regional center staff. In 2007, they oversaw the delivery of or conducted 112 programs, including sexuality and socialization skills, personal safety, disaster preparedness, transition to work training, and leadership development. The center also supported the participation of 359 clients, parents, staff members, and providers in 111 local, state, and national conferences.

GOVERNANCE AND ADMINISTRATION

In terms of the entire budget, governance and administration costs – everything other than purchase of services and regional center direct services to clients and families – account for slightly more than 2% of total expenditures. We now take a closer look at what is included in that portion of the budget.

Board and executive activities. The regional center is a community-based, non-profit organization governed by a volunteer board of directors that includes parents, clients, and other interested citizens. The Board along with its executive staff has primary accountability to ensure that the center meets the requirements of all applicable federal and state laws and regulations, including those required for federal financial participation, and of its contract and performance plan with the state Department of Developmental Services, The Board has also committed the center to four strategic initiatives that are critical for our clients and their families: inclusion, information and technology, affordable housing, and employment.

The executive director and senior staff work together to create a climate of accountability and an environment that promotes quality, innovation, and cost-effectiveness within both the center and the center's network of community service providers. The Board and executive group also provide vision and leadership for the creation of special projects intended to enhance the service system and the quality of services provided. A particularly successful example of such projects is the UCLA/NPI/Lanterman Special Psychiatric Clinic.

Accounting and payment functions. The accounting department is charged with ensuring fiscal accountability within the center and among community service providers. In a typical month this department:

- inputs approximately 4,300 initiations, changes, or terminations to POS authorizations;
- adds about 166 new vendor records to the system;
- prints an average of 4,600 invoice forms for POS;
- prints an average of 2,400 checks, about 95% of which are to community providers and families for services delivered to clients;
- makes payments for more than 350 family voucher users.

Information technology support. One manager and three staff members support all mainframe and personal computer activities of the center. The center's mid-range mainframe computer handles client and financial data on most regional center activities and generates thousands of checks each month. Staff write and revise programs (250 in 2007) to analyze data and generate reports.

IT staff also support the personal computer use of 200 regional center employees. Their activities include training, technical support, help desk response, and maintenance and replacement of computer equipment and peripherals. In addition, these four individuals manage internal networks such as e-mail, shared files, and internet access; they coordinate disaster preparation efforts related to technology; and they assist staff with proprietary software systems that have been installed for specific projects and to automate center functions.

Human resources (HR) functions. The HR Department manages activities necessary to attract and retain knowledgeable, committed, competent staff able to carry out the complex mission of the regional center. In order to ensure that the center can continue to attract and retain such staff, HR personnel are constantly reviewing benefit programs (health, disability insurance, etc.) to provide maximum value to the center and its employees. In 2007, the HR staff worked with the appropriate units in recruiting 39 new hires, 19 of whom were service coordinators. This required the screening and interviewing of hundreds of applicants. HR staff also administer all aspects of personnel including payroll and performance evaluation.

Coordinating annual giving. The HR Department oversees a range of giving programs that, in 2007, brought the center more than $97,000 in cash and gift donations for clients and families.

Operations management. One manager and 2.5 staff members support the center's reception and mail functions. These include 15,000 pieces of mail sent out each month and hundreds of phone calls per day through the switchboard in addition to the calls routed through the automated call distribution system. This unit has the responsibility for coordinating the cleaning and maintenance of the physical plant including more than 40,000 square feet of floor space; they coordinate the ordering of office supplies and are responsible for maintenance, repair and replacement of office equipment; and they manage more than 3,000 boxes of records stored off-site. Finally, they coordinate overall disaster preparations, including the replenishment of supplies.

Insurance. Additional costs to the center's operating budget are incurred by items such as liability insurance and workers' compensation insurance. With no additional funds coming from the state, costs of such coverage have affected the regional center in the same way they have affected service providers. At the same time, interest earnings, used by centers to fund part of their operating budgets, are down dramatically. In 2006-2007, Lanterman had about $710,000 in interest earnings. For 2207-2008, that figure will be about $600,000, a loss of $110,000 in real dollars. This amount would support the hiring of two service coordinators.

Whether referred to as operations or regional center direct services, the activities described in this document are of direct and obvious benefit to clients and families and are value added to the service delivery system as a whole.

Attachment #7

California LEGISLATIVE INFORMATION

SB-367 Developmental services: regional centers: cultural and linguistic competency. (2013-2014)

Senate Bill No. 367

CHAPTER 682

An act to amend Section 4622 of the Welfare and Institutions Code, relating to developmental services.

[Approved by Governor October 09, 2013. Filed with Secretary of State October 09, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 367, Block. Developmental services: regional centers: cultural and linguistic competency.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is required to contract with regional centers to provide support and services to individuals with developmental disabilities. Existing law requires the governing board of the regional center to satisfy specified requirements, including annually reviewing the performance of the director of the regional center, and providing necessary training and support to board members.

This bill would require that this training and support include issues relating to linguistic and cultural competency, and would require each regional center to post on its Internet Web site information regarding the training and support provided. The bill would require the governing board to annually review the performance of the regional center in providing services that are linguistically and culturally appropriate and would authorize the governing board to provide recommendations to the director of the regional center based on the results of that review.

Vote: majority Appropriation: no Fiscal Committee: no Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4622 of the Welfare and Institutions Code is amended to read:

4622. The state shall contract only with agencies, the governing boards of which conform to all of the following criteria:

(a) The governing board shall be composed of individuals with demonstrated interest in, or knowledge of, developmental disabilities.

(b) The membership of the governing board shall include persons with legal, management, public relations, and developmental disability program skills.

(c) The membership of the governing board shall include representatives of the various categories of disability to be served by the regional center.

(d) The governing board shall reflect the geographic and ethnic characteristics of the area to be served by the regional center.

(e) A minimum of 50 percent of the members of the governing board shall be persons with developmental disabilities or their parents or legal guardians. No less than 25 percent of the members of the governing board shall be persons with developmental disabilities.

(f) Members of the governing board shall not be permitted to serve more than seven years within each

eight-year period.

(g) (1) The regional center shall provide necessary training and support to these board members to facilitate their understanding and participation, including issues relating to linguistic and cultural competency.

(2) As part of its monitoring responsibility, the department shall review and approve the method by which training and support are provided to board members to ensure maximum understanding and participation by board members.

(3) Each regional center shall post on its Internet Web site information regarding the training and support provided to board members.

(h) The governing board may appoint a consumers' advisory committee composed of persons with developmental disabilities representing the various categories of disability served by the regional center.

(i) The governing board shall appoint an advisory committee composed of a wide variety of persons representing the various categories of providers from which the regional center purchases client services. The advisory committee shall provide advice, guidance, recommendations, and technical assistance to the regional center board in order to assist the regional center in carrying out its mandated functions. The advisory committee shall designate one of its members to serve as a member of the regional center board.

(j) (1) The governing board shall annually review the performance of the director of the regional center.

(2) The governing board shall annually review the performance of the regional center in providing services that are linguistically and culturally appropriate and may provide recommendations to the director of the regional center based on the results of that review.

(k) No member of the board who is an employee or member of the governing board of a provider from which the regional center purchases client services shall do any of the following:

(1) Serve as an officer of the board.

(2) Vote on any fiscal matter affecting the purchase of services from any regional center provider.

(3) Vote on any issue other than as described in paragraph (2), in which the member has a financial interest, as defined in Section 87103 of the Government Code, and determined by the regional center board. The member shall provide a list of his or her financial interests, as defined in Section 87103, to the regional center board.

Nothing in this section shall prevent the appointment to a regional center governing board of a person who meets the criteria for more than one of the categories listed above.

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1595

Introduced by Assembly Member Chesbro

February 3, 2014

An act relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1595, as introduced, Chesbro. State Council on Developmental Disabilities.

Existing federal law, the Developmental Disabilities Assistance and Bill of Rights Act of 2000, provides federal funds to assist the state in planning, coordinating, monitoring, and evaluating services for persons with developmental disabilities and in establishing a system to protect and advocate the legal and civil rights of persons with developmental disabilities.

Existing law establishes the State Council on Developmental Disabilities to, among other things, serve as the state planning council responsible for developing the California Developmental Disabilities State Plan and monitoring and evaluating the implementation of the plan.

This bill would state the intent of the Legislature to enact legislation amending specified provisions pertaining to the operations, structure, and responsibilities of the State Council on Developmental Disabilities.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares the following:

(a) The State Council on Developmental Disabilities engages in advocacy, capacity building, and systems change activities so that individuals with developmental disabilities and their families are assisted by a comprehensive system of services and supports to achieve self-determination, independence, productivity, and inclusion in all aspects of community life.

(b) The council is funded through an appropriation governed by the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Public Law 106-402)(42 U.S.C. 15001 et seq.).

SEC. 2. It is the intent of the Legislature to enact legislation to amend Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, as it pertains to the operations, structure, and responsibilities of the State Council on Developmental Disabilities. These changes will bring state law into full compliance with federal law in order to provide for the continued operation of the council.

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ATTACHMENT B - PROPOSED LEGISLATIVE CONCEPTS

To Ensure State Law Regarding the California State Council on Developmental Disabilities is Consistent With the Requirements of the Federal Developmental Disability Act

INTRODUCTION & BACKGROUND

This document summarizes the major concepts for changes to state law that are needed to ensure that state law complies with federal law. The proposed legislation will not change people's rights and services under the Lanterman Act as it does not affect the Individual Program Planning (IPP) or the Regional Center system. The proposed legislation will focus only on those parts of state law that describe the structure and function of the State Council and the Area Boards. For a state as large and diverse as California the State Council is unwavering in its commitment to have regional offices to address the geographic, racial and ethnic diversity of the state. Consistent with federal law the proposed legislation is intended to clarify that there is one State Council unified in purpose, direction and responsibility to define and carry out the California State Plan for advocacy, capacity building and systemic change to improve service systems for individuals with developmental disabilities.

The Administration on Intellectual and Developmental Disabilities (AIDD) is a unit within the Administration for Community Living (ACL), which is part of the United States Department of Health and Human Services. AIDD is responsible for administering the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act). The DD Act provides the federal authority for and funds the DD Network and programs across the nation, including the State Councils on Developmental Disabilities (SCDDs), Protection & Advocacy Systems (P&As), University Centers for Excellence in Developmental Disabilities Education, Research and Service (UCEDDs) and Projects of National Significance (PNSs).

California has various legal "Codes" that together form statutory law for the state, one of these Codes is the Welfare and Institutions Code (WIC). The WIC contains Division 4.5 that is known as the "Lanterman Act". The Act includes various sections intended by the State Legislature to "secure full compliance with the requirements of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 … which provides federal funds to assist the state … in establishing a system to protect and advocate the legal and civil rights of persons with developmental disabilities." The Act includes the language that establishes the State Council in California with "… authority independent of any single state service agency is needed and is hereby created". This section of the Act further describes the structure and functions of the California State Council on Developmental Disabilities and the regional offices known as Area Boards.

In January 2013, representatives from AIDD conducted a site visit to assess California's operations and compliance with the federal DD Act requirements. AIDD issued a "Monitoring and Technical Assistance Review System" (MTARS) report in November of 2013 identifying various Findings including several provisions of state law that AIDD concluded conflicted with the federal DD Act. This document summarizes the major concepts for changes to state law that are needed to ensure the state law complies with the federal law.

AB 1595 (Chesbro), State Council on Developmental Disabilities. On February 3, 2014, Assemblymember Wesley Chesbro introduced AB 1595 with intent language to bring California

law governing the Council and Area Boards into compliance with the requirements of the DD Act. On March 20, 2014, it is intended that the Council will approve further detailed legislative concepts that will be introduced by March 26, in time for policy committee hearings and passage in the current legislative session. This legislation will focus only on those parts of the state law that describe the responsibilities and functioning of the State Council and the Area Boards. This will not affect people's rights and services under the Lanterman Act, nor the IPP or the Regional Center system. The bill as introduced is included as Attachment C and can be found on the Legislature's website at http://www.leginfo.ca.gov/bilinfo.html.

LEGISLATIVE TIMELINE

January 17:	Assemblymember Wes Chesbro agrees to author legislation.
January 24:	Intent language submitted to Legislative Counsel
January 31:	MTARS Committee approves draft legislative concepts and establishes a community engagement plan.
February 3:	AB 1595 (Chesbro) introduced.
February:	Initiate community engagement plan and distribute fact sheet. Community engagement continues through passage of legislation and implementation of statutory changes.
March 7:	MTARS or Exec Committee finalize summary of legislative proposal to submit to Council (Council packet deadline March10).
March 20:	Council takes public input on legislative concepts and approves concepts for legislation.
March 26:	Council staff submits bill language to Legislature.
May 2:	Deadline to pass from policy committee to fiscal committee.
August 31:	Last day for Legislature to pass bills.
September 30:	Last day for Governor to sign bills.

PROPOSED STATUTORY CHANGES (PENDING STATE COUNCIL REVIEW / REVISION / APPROVAL)

Structure and Functions of the California State Council on Developmental Disabilities

The federal DD Act funds operations of the Council including those of its staff in regional offices (currently referred to as Area Boards in state law). The proposed legislation seeks to ensure, as required by federal law, that there is one State Council unified in purpose, direction and responsibility to define and carry out the California State Plan. The Council will carry out its work across this large and diverse state through its headquarters and regional offices. The regional offices are vital to the structure of the Council in order to address the geographic, ethnic and language diversity of the state. The change in statute will make clear that the Council and its State Council Regional Offices are part of the same state-wide entity. These changes will maintain the regional advisory committees that are currently known as the Boards of the Area Boards but clarify the role and structure of the committees to conform to the criteria for clarity of Council authority in federal law.

1. Clarify that the Council shall have the authority to establish the Council organizational structure and remove the provisions in current statute that mandate to the Council the establishment of deputy director positions within Council staff.

2. Clarify that the Area Boards are State Council Regional Offices

3. Add language that the Council shall establish State Council Regional Offices that are accessible to and responsive to the diverse geographic, ethnic and language needs of consumers and families throughout the state. As required by federal law, provide that the Council has the full authority on how it uses its funds in establishing, maintaining and operating the regional offices.

4. Add language to ensure that the State Plan is responsive to the needs of California's diverse geographic, racial, ethnic and language communities, the Council and its regional offices, as appropriate, shall obtain input from consumers, families and other stakeholders throughout the various regions of California.

5. Ensure involvement of consumers and families and others at the regional level by transforming the appointed Area Boards to State Council Regional Advisory Committees.
   a. Add provisions that State Council Regional Offices shall have State Council Regional Advisory Committees which reflect the geographic, disability, and racial, ethnic and language diversity of the local region.
   b. Add provisions which ensure that the responsibilities of the State Council Regional Advisory Committees advise the Council on local issues, providing input for the Council to consider in the formulation of the State Plan, and provide a source of data for the Council's Regional Office reporting on the State Plan implementation.

6. Adjust language throughout state statute to change current references to "the area boards" to refer to "the Council", "State Council Regional Offices", or "State Council Regional Advisory Committees," as appropriate.

7. The Council, including its regional offices, shall continue to perform its functions as delineated in the DD Act and state law.

California State Council on Developmental Disabilities Membership

The following changes to state law seek to ensure compliance with federal law by eliminating a perception of a conflict of interest of the Council and the Area Board members appointed to the Council, reducing the complexity of the appointments process, reducing vacancies in Council membership, and giving the Governor full appointment authority for Council members by eliminating the requirement that candidates be chosen only from a pre-selected nomination by the Area Board.

1. Provide that the Governor shall have the sole authority to appoint Council members.

2. Make the following changes to the membership requirements to reduce unnecessary vacancies and allow for a more efficient appointment process:

    a. Specify that a member's term begins on the date of their appointment;
    b. Ensure that while there are membership terms, a member may serve until a replacement is named as required by federal law.
    c. Require that the Council notifies the Governor in writing six months in advance of the expiration of a Council member's term or immediately if a vacancy is experienced for other reasons.
    d. Ensure better coordination between the Council and the Governor regarding appointments by ensuring that members of the Council, including non-agency members of the Council and State Council Regional Advisory Committees have the opportunity to provide the Governor with information about potential Council members. The Council is proceeding to establish a membership committee in bylaws that will coordinate with the Governor's Office and make recommendations on appointments to Council.

3. Current statute requires one "at large" member to be an immediate relative/conservator of a current DC resident. As required by the DD Act, change the language to read: "At least one is an immediate relative or conservator of an individual with developmental disabilities who resides or previously resided in an institution or an individual with developmental disabilities who currently/previously resided in an institution."

4. Ensure that the SCDD is free from potential conflicts of interest by changing the requirement that 13 Council members be appointed by the Governor from the Area Boards. Instead the Governor will appoint 20 "non-agency" members, as currently defined, who reflect the geographic, disability and racial, ethnic and language diversity of the state. Of these 20 non-agency members, at least one shall be from the geographic area of each of the Council's regional offices. Each non-agency member of the Council shall be a liaison of the State Council to the local region constituency and to a State Council Regional Advisory Committee.

Authority of the California State Council Executive Director to Hire Staff

This section brings state statute into compliance with the federal DD Act provision that the Council Executive Director shall have the authority to hire Council staff.

1. Provide that the Executive Director of the Council shall have the authority to hire all Council staff by removing conflicting provisions in state law:
    a. Remove the requirement that the Governor appoints any Council staff positions.
    b. Remove the requirement that the executive directors of the Council's regional offices are hired or removed after obtaining the approval of the Area Board.

<< END OF ATTACHMENT B>>