TRI-COUNTIES REGIONAL CENTER
EXECUTIVE DIRECTOR REPORT
March 9, 2013

I. FY 2013-2014 BUDGET UPDATE

- **Attachment #1**: FY 2013-2014 Governor's Budget Highlights for Department of Developmental Services
- **Attachment #2**: ARCA Analysis of FY 2013-2014 Governor's Budget Proposal
- **Attachment #3**: CDCAN Report #003-2013- No New Cuts Proposed in Developmental Services Budget - 1.25% Payment Reduction for Regional Center Operations and Providers Will Sunset As Scheduled June 30, 2013
- **Attachment #4**: CDCAN Report #005-2013- Schedule of Legislative Budget Hearings

Governor Brown issued his official annual State Budget Proposal on January 10, 2013. After almost a decade of ongoing reductions, the Governor's proposed 2013-2014 State Budget Proposal does not call for any new reductions to the Developmental Services budget. Adding to the positive news, the existing 1.25% payment reduction to both Regional Center Operations and Service Provider rates will sunset as previously scheduled on June 30, 2013. The Governor's Budget proposes FY 2013-2014 funding for regional centers at $4.3 billion ($2.5 billion General Fund), an increase of$203.5 million ($140.2 million General Fund) over the enacted 2012-2013 budget. The number of individuals with developmental disabilities served in the community by Regional Centers is expected to increase from 256,872 in the current year to 266,100 in FY 2013-2014 (**Attachments #1- #3**).

Legislative budget hearings in Sacramento are scheduled to begin as of the week of January 21, 2013 and will most likely continue for the next few months until a final State Budget agreement is reached by the Governor and the Legislature (**Attachment #4**).

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.

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II. AUTISM HEALTH INSURANCE PLAN MANDATE (SB 946) IMPLEMENTATION PLAN UPDATE

- **Attachment #5:** SB 946 Letter to Families
- **Attachment #6:** SB 946 Flow Chart
- **Attachment #7:** TCRC SB 946 Insurance Co-Payment Fact Sheet
- **Attachment #8:** SB 946 FAQ- Updated September 28,2012
- **Attachment #9:** TCADD Service Policy and Guidelines 10601
- **Attachment #10:** SB 946 Implementation & Outreach Activities "By the Numbers" Update From TCRC Autism Coordinator

On July 1, 2012 Senate Bill946 (Steinberg) went into effect, making California the28th state in the nation to pass an Autism Insurance Mandate. This new law requires California private insurance companies to contract with Qualified Autism Services Providers and cover behavioral intervention (ABA services). This new law also requires TCRC ensure individuals and families (current and those new to the regional center system) seek payment of all behavioral services through their health insurance carrier or service plan prior to seeking payment from regional centers. Families with Medi-Cal only and Cal-PERS PPO plans are not affected by this new law. However, Department of Managed Health Care recently released new draft regulations regarding the implementation of SB 946 that emphasize the expectation of Healthy Families (will be merged with Medi-Cal) and Cal-PERS plans to provide services based upon the original intent of AB 88, CA Mental Health Parity Act.

TCRC has developed a SB 946 local implementation plan. This plan includes a written notice sent out to all the individuals and families impacted informing them of the new law and inviting them to attend one of six informational sessions that were held at each TCRC office in June, 2012 to better understand the law and to answer their questions **(Attachment #5).** Additionally, TCRC held seven follow-up informational meetings in the Month of August, 2012 at each of the TCRC offices to offer families additional opportunities to learn about the SB 946 requirements and to answer questions. A final round of informational meetings were held at each of the TCRC offices in the month of December, 2012 to provide yet another opportunity for families to learn about the law and to answer questions. TCRC has also developed a flow chart on how the process will work, a SB 946 Co-Payments Fact Sheet and a Frequently Asked Question (FAQ) document for persons served and families- with the assistance of ARCA **(Attachments #6-#8).**

TCRC will continue to work collaboratively with all individuals and families impacted by this change, utilizing the individual planning team process, to ensure as smooth a transition as possible. TCRC staff will support the person and family through their insurance company's process for accessing SB 946 services. When the insurance company approves services, the TCRC Service Coordinator will work with the family to request that the health plan waive any co-payments. If this is not possible, TCRC will offer to pay any co-payments for SB 946 services directly to the ABA service provider, using a service code that maximizes federal funding. Co- payments will be capped at $45 per co-payment to ensure cost-effectiveness. This cap was determined using Service Code 620 median rate minus a 15% administrative overhead. TCRC is addressing relevant deductibles and co-insurance costs on a case-by-case basis through the exception process. The Governor's recently released FY 2013-2014 State Budget Proposal calls for all SB 946 co-pays to be based on the family's ability to pay and to prohibit the payment of insurance deductibles. These two issues will most likely receive considerable attention at the upcoming legislative budget hearings. TCRC may need to make revisions in the future to our existing practices depending on the new requirements approved in the enacted budget for FY 2013-2014.

To date many families have been able to work with their existing ABA service provider to transition services to their insurance. Families who are currently being served by ABA service providers who are not paneled with the family's insurance will be required to switch to an ABA service provider that can accept their insurance. Some health plans are implementing services relatively smoothly, while others continue to have limited network availability, confusing diagnostic reporting requirements, low reimbursement rates, and delays in service approval. By far the greatest challenge has surfaced with Kaiser and their exclusive contract with one ABA provider in Ventura County. The ABA provider does not seem to have the staffing capacity to handle the large inflow of new clients causing a delay in the transition from regional center funded ABA services to Kaiser funded ABA services. TCRC has reported this information to ARCA and is working with families and Area Board 9 to file complaints and appeals per the law.

Service Coordinators continue to work with families who have not started to access their insurance for ABA services. Letters are being sent to these families informing them of the requirement to access and use their insurance coverage for ABA services and to offer assistance from TCRC in helping them with the transition process. The TCRC Autism Coordinator, Colleen Duncan, continues to work with staff internally, families, service providers, insurance companies, Area Board 9 and ARCA to address individual and systemic issues (**Attachments #9-#10**).

In the event that a planning team is unable to agree on the transition steps or the transition to insurance is unsatisfactory, the Lanterman Act Notice of Action and Fair Hearing procedures remain available to TCRC, persons served by TCRC and their families to seek resolution.

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III. TCRC BENEFITS COORDINATOR POSITION

Pedro Mendoza has been selected to fill the newly created TCRC Benefits Coordinator position. Mr. Mendoza has worked at TCRC as Service Coordinator for 13 years serving individuals across the age span from Early Start to Adults. This bilingual position was created to provide additional support to TCRC staff, families and persons served by the regional center to better understand and access generic resources that are available by law to persons and families served by TCRC. This position will also attempt to work closely with personnel from local generic resource agencies to provide education and training about the needs and rights of individuals and families served by the regional center.

IV. ARCA 2013-2015 STRATEGIC PLAN

- **Attachment #11:** ARCA Draft 2013-2015 Strategic Plan

ARCA is in the process of developing a three year Strategic Plan to guide the work of the Association. ARCA has not had a working Strategic Plan since 2005. The ARCA Strategic Planning Committee led by Co-Chairs Omar Noorzad of TCRC and Jim Shorter of Golden Gate Regional Center has contracted with Kinetic Flow Inc. to support the development of a three year Strategic Plan. The Strategic Planning process includes the following: Strategic Thinking Survey, BOD Planning Retreat, Organizational Assessment, Committee Strategies Development Survey and One-on- One Interviews with key partners. Late last year a Strategic Thinking Survey was conducted and the BOD convened a Planning Retreat in October. During the Retreat, work began on the development of a Vision, Mission, Values and Priorities for the Association. ARCA is at this time making available to the Regional Center Boards of Directors the beginning of a draft Strategic Plan for review and feedback to be sent directly to Ami Sullivan, Kinetic Flow at Ami.Sulivan@KineticFlowCorp.com by **March 22, 2013**. Specifically, input on the proposed Mission, Vision, Values and the Priorities is being requested while input on the other components of the initial draft Strategic Plan is welcomed by ARCA as well (**Attachment #11**).

TRI-COUNTIES REGIONAL CENTER
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V. CALIFORNIA'S DEVELOPMENTAL CENTERS

- **Attachment #12:** DDS Withdraws Four Living Units at Sonoma Developmental Center From Federal Certification

- **Attachment #13:** California Watch Panel Discussion on the Future of Developmental Centers in California

California's Department of Developmental Services (DDS) operates four institutional Developmental Centers (DCs) and one smaller state-operated community facility that care for approximately 1650 adults and children with developmental disabilities. Numerous issues pertaining to the DCs was the focus of an informational joint hearing held on October 23, 2012 by the Subcommittee #3 of the Senate Committee on Budget & Fiscal Review and by the Senate Human Services Committee of California's Legislature. The informational hearing titled "Developmental Centers: A System in Transition" consisted of four panels covering (1) Overview of Developmental Centers and their Utilization in California, (2) Licensing Citations and Patient Care at Sonoma Developmental Center due to recent allegations of abuse and mistreatment of several residents, (3) Update on closure process at Lanterman Developmental Center, and (4) Implementation of recent legislation regarding services for individuals with complex needs. The six hour hearing provided detailed information to the Legislature from numerous stakeholder groups regarding the necessity, cost, challenges, and recommendations on the future of the Developmental Centers.

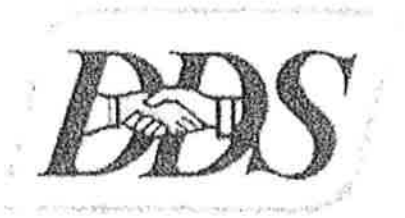
The most recent development stemming from the health and safety allegations at Sonoma Developmental Center was the announcement by the Department of Developmental Services that it will be withdrawing four living units at Sonoma Developmental Center from Federal Certification. This will most likely result in millions of dollars per year in lost federal funding to the State of California. Also, California Watch and the Center for Investigative Reporting which reported extensively on the health and safety issues at Sonoma Developmental Center hosted a panel discussion on the future of California's Developmental Centers that was broadcasted live on January, 30, 2012. This issue will most likely receive considerable attention and debate in the upcoming Legislative Budget hearings (**Attachments #12-13**)

VI. 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

Terri Delgadillo
Director
Department of Developmental Services

January 2013

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 258,424 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 256,872 in the current year to 266,100 in Fiscal Year (FY) 2013-14. The number of individuals living in state-operated residential facilities will be 1,186 by the end of FY 2013-14.

The January 2013 Governor's Budget includes $4.9 billion total funds ($2.8 billion General Fund) for the Department in 2013-14; a net increase of $178.7 million above the revised 2012-13 budget, a 3.8 percent increase; and $193.1 million above the 2012-13 enacted budget.

COMMUNITY SERVICES PROGRAM

2012-13

To provide services and support to 256,872 persons with developmental disabilities in the community, the Governor's Budget updates FY 2012-13 funding to $4.2 billion total funds ($2.3 billion GF). The Governor's Budget includes an increase of $20.2 million total funds (-$18.9 million GF decrease) for regional center operations (OPS) and purchase of services (POS). This is composed of:

Caseload and Utilization

$36.0 million increase (-$3.0 million GF decrease) in regional center OPS and POS costs due to updated caseload and expenditure data including Home and Community Based Services (HCBS) waiver enrollment above budgeted levels.

Impacts from Other Departments

-$30.8 million decrease GF in POS to reflect the Department of Health Care Services (DHCS) withdrawal of implementation of Medi-Cal copayments for physician and dental office visits, emergency room visits, and hospital inpatient days.

Copayments for Health Care Related Services

$15.0 million increase GF to reflect increased expenditures associated with a recent regional center legal opinion that is expected to change regional center practices regarding funding of health insurance copayments and deductibles.

2013-14

The Governor's Budget projects an average community caseload of 266,100 individuals in the budget year, an increase of 10,128 consumers over the enacted budget. The estimate proposes 2013-14 funding for services and support to persons with developmental disabilities in the community at $4.3 billion total funds ($2.5 billion GF), an increase of $203.5 million ($140.2 million GF) over the enacted 2012-13 budget. The regional center budget changes include:

Caseload and Utilization

$177.5 million ($89.2 million GF) increase in regional center OPS and POS due to updated caseload and expenditure data including HCBS waiver enrollment above budgeted levels.

Sunset of 1.25 Percent Payment Reduction

$46.7 million ($31.9 million GF) increase in OPS and POS to reflect the June 30, 2013 sunset of the 1.25 percent payment reduction.

Impacts from Other Departments

-$30.8 million decrease GF in POS to reflect the DHCS withdrawal of implementation of Medi-Cal copayments for physician and dental office visits, emergency room visits, and hospital inpatient days.

Copayments for Health Care Related Services

$9.9 million increase GF to reflect increased expenditures associated with a recent regional center legal opinion that is expected to change regional center practices regarding funding of health insurance copayments and deductibles. Proposed statute will limit the funding of health insurance copayments based on the family's ability to pay, modeled after existing programs, and prohibit the payment of deductibles.

Fund Shift:

$40.0 million fund shift from the California First Five Commission (Proposition 10) to GF for a net program change of $0.0 million.

Quality Assurance Fee (QAF)

$0.2 million increase ($0.0 million GF) in POS to reflect updated administration and service expenditures for day treatment and transportation costs of ICF-DD residents.

DEVELOPMENTAL CENTERS PROGRAM

2012-13

To provide services and support for 1,552 residents in developmental centers (average in-center population) the Governor's Budget updates FY 2012-13 funding to $545.1 million ($283.8 million GF), a decrease of $5.1 million ($2.4 million GF) over the FY 2012-13 enacted budget. Authorized positions decrease by 2.5. The developmental center budget changes include:

- Savings Shift of $2.9 million from Operating Expenses and Equipment (OE&E) to Personal Services (PS) based on a reduction of -36.0 positions driven by admissions and residential program reductions, and increased placements. The 2012 May Revision reflected a net decrease of $9.1 million which represented the DC's portion of the $200 million General Fund Savings Solutions. The Department initially displayed the savings in OE&E. This fund shift more accurately reflects the savings solutions as partially funded through position reductions.

- Net decrease of $7.2 million ($3.6 million GF) due to changes in State employee retirement and health benefit rates, and employee compensation reductions.

- $2.1 million ($1.3 million GF) and 33.5 position increase due to a higher than anticipated resident population on July 1, 2012, primarily based on fewer individuals transitioning from Lanterman Developmental Center to community settings. The increase includes $1.7 million ($0.9 million GF) and 27 positions in Level of Care (LOC) and $0.4 million ($0.3 million GF) and 6.5 positions in Non-Level of Care (NLOC).

2013-14

For FY 2013-14, the Governor's Budget provides services and support for 1,304 residents (average in-center population) in developmental centers, a decrease of 240 residents from the 2012-13 enacted budget. Funding decreases to $539.0 million ($279.3 million GF); a decrease of $11.2 million ($7.0 million GF) and authorized positions decreases to 4,768; a decrease of 388.5 positions below the enacted budget. By the end of the budget year there is expected to be 1,186 individuals residing in the state operated facilities. Adjustments to the enacted budget for the developmental centers include:

- -$25.4 million (-$14.4 million GF) and -352.5 position reduction due to the anticipated decrease of 223 residents primarily from the continuing transition of individuals into the community. Lanterman DC makes up almost half of the

residential decline as 110 individuals are expected to transition into community living arrangements in the budget year. This reduction, along with unit consolidations results in a reduction of -$19.2 million (-$11.0 million GF) and -245 positions in LOC and -$6.2 million (-$3.4 million GF) and -107.5 positions NLOC.

- Savings shift of $2.9 million from OE&E to Personal Services (PS) based on a reduction of -36.0 positions and -17 residents driven by admissions and residential program reductions, and increased placements. The 2012 May Revision reflected a net decrease of $9.1 million which represented the DC's portion of the $200 million General Fund Savings Solutions. The Department initially displayed the savings in OE&E. This fund shift more accurately reflects the savings solutions.

- Net increase of $11.9 million ($6.2 million GF) due to changes in State employee retirement and health benefit rates, and employee compensation. Savings associated with the personal leave program (PLP) are not reflected in 2013-14 as most bargaining agreements expire at the end of this FY.

- $2.4 million ($1.3 million GF) for additional staff on residential units to ensure the supervisors (shift leads) on 10 ICF units are able to oversee and support the employees delivering direct care which are critical to the health and safety of residents. This change was necessary to help address licensing concerns regarding staffing levels.

LANTERMAN DEVELOPMENTAL CENTER CLOSURE UPDATE

The Governor's Budget continues to support Developmental Center and Community efforts towards closure of the Lanterman facility. The Department, working with regional centers, anticipates the transition of approximately 110 Lanterman Developmental Center (Lanterman) residents in FY 2012-13 consistent with the enacted budget. The Governor's Budget anticipates the transition of another 110 residents to community living arrangements in FY 2013-14.

- The Governor's Budget retains $0.7 million ($0.5 million GF) and 25.0 positions in 2012-13:

    - $2.0 million ($1.1 million GF) and 27.0 positions are retained (24 positions and $1.9 million LOC and 3 positions and $0.1 million NLOC) to reflect an additional 20 residents at Lanterman at the beginning of the year based on fewer residential placements in 2011-12.

    - Reduction of -2.0 positions associated with the fund shift from OE&E to personal services to more accurately reflect the previous $200 million General Fund Savings Solutions detailed above.

    - -$1.3 million (-$0.6 million GF) reduction due to changes in State employee retirement and health benefit rates, and employee compensation.

- The Governor's Budget reflects a net decrease in 2013-14 of -$10.3 million ($-5.7 million GF) and -178.0 positions:

    - -$12.4 million (-$6.8 million GF) reduction and -178.0 fewer positions due to the anticipated decline in the average in-center population from 184 to 85 residents, as compared to the enacted budget. This includes a reduction of -111 positions and -$8.6 million in LOC and -65 positions and -$3.8 million in NLOC.

    - $2.1 million ($1.1 million GF) increase due to changes in State employee retirement and health benefit rates, and employee compensation. Savings associated with the personal leave program (PLP) are not reflected in 2013-14 as explained above.

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

CAPITAL OUTLAY

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

HEADQUARTERS

2012-13

The Governor's Budget for FY 2012-13 updates funding for Headquarters' operations to $37.8 million ($24.2 million GF), a decrease of -$0.7 million (-$0.3 million GF) compared to the FY 2012-13 enacted budget. The Headquarters budget changes are due to changes in State employee retirement and health benefit rates, and employee compensation reductions.

2013-14

The Governor's Budget proposes headquarters operations funding for FY 2013-14 of $39.3 million ($25.0 million GF), an increase of $0.8 million ($0.5 million GF) compared to the FY 2012-13 enacted budget. The FY 2013-14 budget changes are due to changes in State employee retirement and health benefit rates, and employee compensation. Savings associated with the personal leave program (PLP) are not reflected in 2013-14 as explained above.

DEPARTMENT OF DEVELOPMENTAL SERVICES
2013-14 Governor's Budget

FUNDING SUMMARY
(Dollars in Thousands)

	2012-13	2013-14	Difference
BUDGET SUMMARY			
COMMUNITY SERVICES	$4,166,367	$4,349,632	$183,265
DEVELOPMENTAL CENTERS	545,075	539,022	-6,053
HEADQUARTERS SUPPORT	37,796	39,280	1,484
TOTALS, ALL PROGRAMS	**$4,749,238**	**$4,927,934**	**$178,696**
FUND SOURCES			
General Fund	$2,604,142	$2,759,396	$155,254
Reimbursements: Totals All	2,092,322	2,117,716	25,394
Medicaid (aka HCBS) Waiver	*1,129,428*	*1,169,109*	*39,681*
Medicaid (HCBS) Waiver Administration	*9,216*	*9,921*	*705*
Medicaid Administration (NHR)	*11,761*	*12,081*	*320*
Targeted Case Management	*138,693*	*142,347*	*3,654*
Targeted Case Management Admin.	*3,840*	*3,892*	*52*
Medi-Cal	*254,729*	*252,809*	*-1,920*
Title XX Block Grant	*225,060*	*225,060*	*0*
ICF-DD/State Plan Amendment	*52,915*	*55,630*	*2,715*
Quality Assurance Fees (DHCS)	*9,620*	*9,845*	*225*
California First Five Commission	*40,000*	*0*	*-40,000*
1915(i) State Plan Amendment	*161,804*	*169,122*	*7,318*
1915(k) Medicaid State Plan	*1,924*	*7,000*	*5,076*
Money Follows the Person	*14,867*	*14,867*	*0*
Homeland Security Grant	*57*	*391*	*334*
Race to the Top	*286*	*286*	*0*
Early Periodic Screening Diagnostic & Treatment	*11,793*	*16,516*	*4,723*
Other	*26,329*	*28,840*	*2,511*
Federal Trust Fund	55,083	55,041	-42
Lottery Education Fund	465	465	0
Program Development Fund (PDF)	9,553	9,553	0
Mental Health Services Fund	1,129	1,128	-1
Developmental Disabilities Svs Acct	150	150	0
AVERAGE CASELOAD			
Developmental Centers	1,552	1,304	-248
Regional Centers	256,872	266,100	9,228
AUTHORIZED POSITIONS			
Developmental Centers	5,154.0	4,768.0	-386.0
Headquarters	374.5	374.5	0.0

DEPARTMENT OF DEVELOPMENTAL SERVICES
2013-14 Governor's Budget

(Dollars In Thousands)

	2012-13	2013-14	Difference
Community Services Program			
Regional Centers	$4,166,367	$4,349,632	$183,265
Totals, Community Services	**$4,166,367**	**$4,349,632**	**$183,265**
General Fund	$2,296,105	$2,455,125	$159,020
Dev Disabilities PDF	9,267	9,267	0
Developmental Disabilities Svs Acct	150	150	0
Federal Trust Fund	52,006	52,006	0
Reimbursements	1,808,099	1,832,344	24,245
Mental Health Services Fund	740	740	0
Developmental Centers Program			
Personal Services	$439,481	$434,912	-$4,569
Operating Expense & Equipment	105,594	104,110	-1,484
Total, Developmental Centers	**$545,075**	**$539,022**	**-$6,053**
General Fund	$283,837	$279,264	-$4,573
Federal Trust Fund	510	510	0
Lottery Education Fund	465	465	0
Reimbursements	260,263	258,783	-1,480
Headquarters Support			
Personal Services	$33,353	$34,880	$1,527
Operating Expense & Equipment	4,443	$4,400	-43
Total, Headquarters Support	**$37,796**	**$39,280**	**$1,484**
General Fund	$24,200	$25,007	$807
Federal Trust Fund	2,567	2,525	-42
PDF	286	286	0
Reimbursements	10,354	11,074	720
Mental Health Services Fund	389	388	-1
Totals, All Programs	**$4,749,238**	**$4,927,934**	**$178,696**
Total Funding			
General Fund	$2,604,142	$2,759,396	$155,254
Federal Trust Fund	55,083	55,041	-42
Lottery Education Fund	465	465	0
Dev Disabilities PDF	9,553	9,553	0
Developmental Disabilities Svs Acct	150	150	0
Reimbursements	2,078,716	2,102,201	23,485
Mental Health Services Fund	1,129	1,128	-1
Caseloads			
Developmental Centers	1,552	1,304	-248
Regional Centers	256,872	266,100	9,228
Authorized Positions			
Developmental Centers	5,154.0	4,768.0	-386.0
Headquarters	374.5	374.5	0.0

Attachment #2

ASSOCIATION OF REGIONAL CENTER AGENCIES
ANALYSIS OF THE FY 2013-14 NOVEMBER ESTIMATE
(GOVERNOR'S BUDGET)
JANUARY 10, 2013

SPECIAL NOTE

The 1.25% payment reduction will sunset June 30, 2013.

FY 2012-13 (Current Year)

1. CASELOAD

The FY 2012-13 May Revision estimated the regional center Community Caseload to be 255,972 consumers for January 31, 2013. The November Estimate increases the January 31, 2013 caseload to 256,872, an increase of 900 consumers (a 0.35% increase).

2. PURCHASE OF SERVICE - $16.8 million Increase (0.5% Increase)

- $32.6 million increase to Purchase of Services due to updated caseload and expenditure data.
- $30.8 million decrease in Impacts from Other Departments due to DHCS's decision to withdraw its proposal to charge Medi-Cal copayments for physician and dental office visits, pharmacy copayments, emergency room visits, and hospital inpatient days. Only the hard cap on hearing aids remains in effect.
- $15 million increase to cover the cost of copayments for services paid for by health insurance companies pursuant to AB 946.

3. OPERATIONS - $3.4 Million Increase (0.6% Increase)

- $3.2 million increase to reflect updated caseload data.
- $63 thousand increase in Federal Compliance to reflect updated caseload data.
- $68 thousand decrease to reflect updated costs for various projects.
- $158 thousand increase to reflect updated regional center costs for State Employees in the Community.

FY 2013-14 (Budget Year)

1. CASELOAD

The budget anticipates an increase of 9,228 consumers (a 3.6% increase) over the 256,872 consumers projected for January 31, 2013.

2. PURCHASE OF SERVICE - $156.9 Million Increase (4.4% Increase)

- $121.7 million increase over current fiscal year for caseload and utilization growth.
- $40.0 million for the restoration of funds due to the sunset of the 1.25% payment reduction.
- $206 thousand increase in Quality Assurance fees related to the ICF-SPA to reflect updated utilization data.
- $5.1 million decrease to copayments for services paid by health insurance providers. This decrease is due to Trailer Bill Language which will limit regional center payments for insurance copayments based on the family's ability to pay and to prohibit the payment of insurance deductibles.

3. OPERATIONS – $26.4 Million Increase Over Current Year (4.9% Increase)

- $18.6 million increase in Staffing due to the projected increase in caseload.
- $6.7 million for the restoration of funds due to the sunset of the 1.25% payment reduction.
- $0.5 million increase in Federal Compliance due to the projected increase in caseload.
- $0.5 million increase in Projects to reflect updated costs for various projects.
- $38,000 increase in ICF-DD administrative fees for processing bills on behalf of the ICFs for payments made to day programs and transporters for services provided to consumers who reside in the ICFs.

ASSOCIATION OF REGIONAL CENTER AGENCIES
ANALYSIS OF NOVEMBER ESTIMATE FOR FISCAL YEAR 2013-14
JANUARY 14, 2013

PURCHASE OF SERVICE BUDGET

	Purchase of Service	Quality Assurance Fees	Impacts from Other Departments	Copayments	Total POS
FY 2012-13 Enacted Budget	**$3,548,845,000**	**$8,804,000**	**$31,187,000**	**$0**	**$3,588,836,000**
Update of Caseload, Utilization, and Expenditure Data	$32,646,000				$32,646,000
Decrease due to DHCS's Withdrawal of Proposed Copayments for Certain services			($30,832,000)		($30,832,000)
Copayments for Services Paid by Health Insurance				$15,000,000	$15,000,000
Updated FY 2012-13 Budget	**$3,581,491,000**	**$8,804,000**	**$355,000**	**$15,000,000**	**$3,605,650,000**
Update of Caseload, Utilization, and Expenditure Data	$121,760,000	$206,000			$121,966,000
Sunset of 1.25% Payment Reduction	$40,029,000				$40,029,000
Effect of TBL to Limit Copayments and Prohibit Paying Insurance Deductibles				($5,135,000)	($5,135,000)
Proposed FY 2013-14 Budget	**$3,743,280,000**	**$9,010,000**	**$355,000**	**$9,865,000**	**$3,762,510,000**

REGIONAL CENTER OPERATIONS BUDGET

	Operations	ICF-DD Administrative Fees	Total Operations
FY 2012-13 Enacted Budget	**$533,326,000**	**$1,631,000**	**$534,957,000**
Caseload and Expenditure Update	$3,376,000	$0	$3,376,000
Updated FY 2012-13 Budget	**$536,702,000**	**$1,631,000**	**$538,333,000**
Caseload and Expenditure Update	$19,695,000	$38,000	$19,733,000
Sunset of 1.25% Payment Reduction	$6,672,000		$6,672,000
Proposed FY 2013-14 Budget	**$563,069,000**	**$1,669,000**	**$564,738,000**

Attachment #3

Omar Noorzad - Re: CDCAN REPORT #003-2013 (JAN 10 2013): BREAKING NEWS - NO NEW CUTS TO DEVELOPMENTAL SERVICES BUDGET - 1.25% PAYMENT CUT WILL SUNSET AS SCHEDULED JUNE 30, 2013

From: "Marty Omoto - CDCAN (California Disability Community Action Network)" <martyomoto@rcip.com>
To: <CDCANreportlist01@rcip.com>
Date: 1/10/2013 10:11 AM
Subject: Re: CDCAN REPORT #003-2013 (JAN 10 2013): BREAKING NEWS - NO NEW CUTS TO DEVELOPMENTAL SERVICES BUDGET - 1.25% PAYMENT CUT WILL SUNSET AS SCHEDULED JUNE 30, 2013

CDCAN

CDCAN DISABILITY RIGHTS REPORT

CALIFORNIA DISABILITY COMMUNITY ACTION NETWORK

#003-2013 – January 10, 2013 – Thursday

Advocacy Without Borders: One Community – Accountability With Action

CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com Twitter: martyomoto New Phone: 916-757-9549

California Budget Crisis – Breaking News:

NO NEW CUTS PROPOSED IN DEVELOPMENTAL SERVICES BUDGET – 1.25% PAYMENT REDUCTION FOR REGIONAL CENTER OPERATIONS AND PROVIDERS WILL SUNSET AS SCHEDULED JUNE 30, 2013

SACRAMENTO, CA (CDCAN) [Last updated 01/10/2013 10:02 AM] – After more than a decade of on-going major reductions, Governor Jerry Brown's proposed 2013-2014 State Budget will not call for any new reductions to the developmental services budget that funds programs and services for over 260,000 children and adults with developmental disabilities.

The Governor's proposed budget, released this morning, assumes that the existing 1.25% payment reduction to both regional center operations and most regional center providers will end, as scheduled, on June 30, 2013.

CDCAN will report within the hour details of the Governor's other proposals impacting people with disabilities, mental health needs, seniors including Medi-Cal, In-Home Supportive Services and other programs.

3PM CONFERENCE CALL ON STATE BUDGET WITH CALIFORNIA HEALTH & HUMAN SERVICES SECRETARY DIANA DOOLEY

- As previously reported yesterday, Governor Brown's top health and human services official will host a statewide conference call on the Governor's proposed 2013-2014 State Budget plan, this afternoon (January 10th) at 3:00 PM (Pacific Time).
- The call is open to the public.

- In previous such calls, there was time allocated for brief questions from the public. Instructions on how and when to ask questions will be announced during the call.
- California Health and Human Services Agency Secretary Dooley oversees all the health and human services departments including those dealing with Medi-Cal, senior services, health facilities, developmental services, CalWORKS, mental health, licensing of various health and community facilities and workers.
- Dooley will also have on hand during the conference call department directors and other senior department officials – including those dealing with Medi-Cal, developmental services, public health, CalWORKS, In-Home Supportive Services, to provide information

CONFERENCE CALL INFORMATION
WHEN: January 10, 2013 – Thursday
TIME: 3:00 PM (agency officials advise, given the expected large numbers, that people call in 10 minutes – 2:50 PM – to register with the conference call operator in order to be placed into the conference call in time)
TOLL FREE CONFERENCE CALL NUMBER: (800) 857-9660
PASSCODE: ***CHHS Budget***

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VERY URGENT!!!!!!
January 10, 2013
PLEASE HELP CDCAN CONTINUE ITS WORK
WE MAY NOT BE ABLE TO CONTINUE!!!

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

CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833
[replaces 1225 8th Street Suite 480, Sacramento, CA 95814]
NEW Phone: 916-757-9549 (replaces 916-212-0237)

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

Attachment #4

Omar Noorzad - Re: CDCAN REPORT #005-2013 (JAN 22 2013): BRIEFING AT CAPITOL ON DEVELOPMENTAL SERVICES SYSTEM JAN 23rd 2 PM; CA BUILDING STANDARDS COMMISSION MTG ON DISABILITY ACCESS JAN 23-24th; GOVERNOR'S "STATE OF STATE" THURSDAY

From: "Marty Omoto - CDCAN (California Disability Community Action Network)" <martyomoto@rcip.com>
To: <CDCANreportlist01@rcip.com>
Date: 1/23/2013 3:03 AM
Subject: Re: CDCAN REPORT #005-2013 (JAN 22 2013): BRIEFING AT CAPITOL ON DEVELOPMENTAL SERVICES SYSTEM JAN 23rd 2 PM; CA BUILDING STANDARDS COMMISSION MTG ON DISABILITY ACCESS JAN 23-24th; GOVERNOR'S "STATE OF STATE" THURSDAY

CDCAN DISABILITY RIGHTS REPORT

CALIFORNIA DISABILITY COMMUNITY ACTION NETWORK

#005-2013 – January 22, 2013 – Tuesday Night

Advocacy Without Borders: One Community – Accountability With Action

CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com Twitter: martyomoto New Phone: 916-757-5949

State Capitol Calendar:

- **JAN 23rd (WED) – CAPITOL BRIEFING ON DEVELOPMENTAL DISABILITIES SERVICE SYSTEM HOSTED BY SEN. BEALL FOR LEGISLATORS & STAFF**
- **JAN 23rd (WED) – CALIFORNIA BUILDING STANDARDS COMMISSION (DISABILITY ACCESS ISSUES); CONTINUES TO THURSDAY MORNING**
- **JAN 24th (THU) – GOVERNOR'S "STATE OF THE STATE"**
- **JAN 24th (THU) – SENATE BUDGET COMMITTEE OVERVIEW OF GOVERNOR'S PROPOSED BUDGET INFO HEARING**
- **JAN 31st (THU) – ASSEMBLY BUDGET COMMITTEE OVERVIEW OF GOVERNOR'S PROPOSED BUDGET INFO HEARING**

SACRAMENTO, CA (CDCAN) [Last updated 01/22/2013 10:30 PM] – Several hearings and others events are scheduled at the State Capitol in the final weeks of January that will have some impact on people with disabilities and seniors, including a two day public meeting of the California Building Standards Commission dealing with approval of building code regulations impacting disability access on January 23rd at 1:00 PM, and a briefing on California's developmental disabilities service system hosted by Sen. Jim Beall (Democrat – San Jose), also set for Wednesday (January 23rd) from 2:00 to 4:00 PM at the State Capitol in Room 112 (see below for details).

Also this week is the annual "State of the State" address before a special joint session of both the

Assembly and State Senate by Governor Jerry Brown, scheduled for Thursday, January 24th at 09:00 AM at the State Capitol in the Assembly Chambers. That address will be followed by an informational hearing by the Senate Budget and Fiscal Review Committee for an overview of the Governor's budget plan at the State Capitol in Room 4203.

The address will be televised live by CalChannel (check your local cable listings) and also streamed live on the internet on the CalChannel website at www.calchannel.com).

The Governor's "State of the State" will likely touch on education issues and also further plans on California's implementation of the federal health care reform act, that includes major expansion of the state's Medicaid program called "Medi-Cal". Some of the key changes to the Medi-Cal program will have major impact to hundreds of thousands of children and adults with disabilities – including developmental, people with mental health needs, the blind and seniors in the coming year.

Other sweeping changes to the program have already been implemented including:

- Eliminating several Medi-Cal benefits that the State is not required to offer (called "optional benefits")
- Elimination of the Adult Day Health Care Medi-Cal benefit and transition to a new Community-based Adult Services program
- Transition since June 2011 of thousands of people with disabilities and seniors on "straight Medi-Cal" (meaning not also eligible for Medicare) from Medi-Cal fee-for-service to Medi-Cal managed care plans in several counties including Los Angeles.
- Transition underway impacting hundreds of thousands of children from families with low incomes from the Healthy Families program to Medi-Cal managed care plans.
- The 8 county demonstration project to shift people with disabilities and seniors eligible for both Medicare and Medi-Cal (referred to as "dual eligible") into Medi-Cal managed care type plans is still pending final federal approval and is slated to begin September 2013.

JAN 23rd CAPITOL BRIEFING DAY OVERVIEW OF CALIFORNIA'S DEVELOPMENTAL DISABILITIES SERVICE SYSTEM

- Sen. Jim Beall Jr. (Democrat – San Jose) is hosting for legislators and staff (the event is open to the public), especially those newly elected this past November, a briefing on California's unique developmental disabilities service system, Wednesday afternoon, January 23rd, from 2:00 to 4:00 PM at the State Capitol in Room 112.
- The event is sponsored by the Association of Regional Center Agencies (ARCA), the California Disability Services Association and The Arc and UCP of California.
- Representatives from various advocacy organizations and groups will present information about their organizations and their role in developmental disabilities service system.
- California is the only state in the nation to have a sweeping landmark civil rights law – called the "Lanterman Developmental Disabilities Services Act" – that provides protections and rights for children and adults with developmental disabilities. That landmark act was authored by Republican Assemblymember Frank Lanterman and signed into law by then Governor Ronald Reagan in 1969.

- That act eventually established a unique system of 21 non-profit regional centers, under contract with the Department of Developmental Services to determine eligibility, provide assessments and to coordinate funding of an array of community-based services for about 260,000 children and adults with developmental disabilities provided by community-based organizations and individuals across the State.
- In addition the Department of Developmental Services operates several large health facilities called

"developmental centers" where about 1,600 adults with developmental disabilities reside.

- One of the facilities, Lanterman Developmental Center in Pomona, is slated for closure with current residents and their families and state workers involved in a long transition process.

AGENDA FOR JANUARY 23rd CAPITOL BRIEFING

Welcome and Introduction

- *Senator Jim Beall, Jr. (Democrat - San Jose)*
- *Rick Rollens, program moderator, parent advocate, and Legislative Advisor to the Association of Regional Center Agencies (ARCA)*

Speakers

- *Association of Regional Center Agencies (ARCA): Santi Rogers, Executive Director, San Andreas Regional Center [covering Santa Clara, Santa Cruz, San Benito and Monterey counties]*
- *The Arc and United Cerebral Palsy of California: Tony Anderson, Executive Director*
- *California Disabilities Services Association: Chris Rice, Executive Director*
- *People First of California: Joe Meadours, Advocacy Trainer/Consultant*
- *State Council on Developmental Disabilities: Roberta Newton, Acting Executive Director*
- *Disability Rights California (DRC): Catherine Blakemore, Executive Director*
- *California Disability Community Action Network (CDCAN): Marty Omoto, Executive Director*

Question and Answer Forum

JAN 23rd: ISSUE OF REGULATIONS IMPACTING DISABILITY ACCESS FOCUS OF CA BUILDING STANDARDS COMMISSION MEETING JANUARY 23-24

- The California Building Standards Commission is scheduled to meet January 23rd (through January 24th) to consider approval of proposed changes to California's access standards (CCR Title 24, Part 2 (California Building Code).
- Some disability advocates have raised major concerns and opposition to the proposed amendments that they claim will undo critical rights of people with disabilities and seniors to access to public accommodations.
- The Division of the State Architect (DSA) develops accessibility regulations for State and local government facilities and properties that are privately funded, owned, and operated within California.
- After public comments, hearings, and adoption by the California Building Standards Commission (BSC), the proposed regulations become part of the California Building Code (CBC).
- The Brown Administration contends that California's accessibility regulations must meet or exceed the requirements of the federal Americans with Disabilities Act (ADA) – a position that most disability advocates agree with. Those regulations may also contain additional requirements to assure access and usability for persons with disabilities.
- Beginning March 15, 2012, the 2010 ADA Standards are required nationwide; and the California regulations must be updated for consistency and to maintain existing provisions that provide greater accessibility.
- In preparation for that update, the Division of the State Architect said it evaluated three options for the format and organization of the accessibility provisions. The options included 1) the current California provisions, 2) the International Building Code, and 3) the 2010 Americans with Disability Act (ADA) Standards.
- The Division of the State Architect requested input and comments from interested individuals, organizations, affected parties and stakeholders on their preference for the model code format. They

reported that the preferences were 65% for the 2010 ADA Standards, 21% for the International Building Code and 14% for the Current California Provisions. Based upon its staff review and input from stakeholders, DSA selected the 2010 ADA Standards as the model code for the 2013 accessibility regulations. Some disability advocates have strongly criticized the process as unfair and the proposed regulations that they contend will significantly undermine access to public accommodations for thousands of people with disabilities and seniors across California.

- For more information go to the Division of the State Architect webpage at: http://www.dgs.ca.gov/dsa/programs/progAccess/access2013.aspx

The following are several documents including the proposed regulations and other supporting documents on the Division of the State Architect website:

- Final Express Terms for Proposed Building Standards of the Division of the State Architect (Dsa-Ac) Regarding the California Building Code, California Code Of Regulations, Title 24, Part 2 - 2013 California Building Code (336 pages): http://www.documents.dgs.ca.gov/dsa/access/Pt2_Final-ExpressTerms.pdf
- Final Statement of Reasons for Proposed Regulatory Changes (61 Pages): http://www.documents.dgs.ca.gov/dsa/access/Pt2_Final-SOR.pdf
- Comparative Analysis of the 2010 Americans with Disabilities Act Standards and the 2010 California Building Code - Chapter 11B Accessibility Standards (462 Pages): http://www.documents.dgs.ca.gov/dsa/access/2010ADA_CBC_Comparison.pdf
- Cross Reference Guide - 2013 Building Code Update for Accessibility (108 Pages): http://www.documents.dgs.ca.gov/dsa/access/CrossRef_01-18-13.pdf

SENATE BUDGET COMMITTEE WILL HOLD HEARING JAN 24th

- The Governor's "State of the State" will be followed by the Senate Budget and Fiscal Review Committee's overview of the Governor's proposed 2013-2014 State Budget, at 09:30 AM or upon adjournment of the Senate floor session, at the State Capitol in Room 4203.
- The informational hearing will be televised live on CalChannel (check local cable listings) and also streamed live on CalChannel website at www.calchannel.com)
- No action or public testimony is taken at these overview hearings. A representative from the Governor's Department of Finance usually provides an overview of the Governor's proposed budget plan, followed by an overview by the Legislative Analyst Office (LAO). That office is a non-partisan legislative office that reviews budget and other fiscal issues for the Legislature.
- The Senate Budget and Fiscal Review Committee has also scheduled three informational hearings focusing on the higher education, health and K-12 education proposed budgets: February 14 with an overview of the higher education proposed budget; February 21 with an overview of the health proposed budget and February 28th with an overview of the K-12 education proposed budget.
- The Assembly Budget Committee will hold its overview hearing on the budget January 31st, Thursday, upon adjournment of the Assembly floor session, at the State Capitol in Room 4202. No other hearings of the full Assembly Budget Committee have been scheduled.
- No budget subcommittee hearings in either house have been scheduled yet

GOVERNOR RELEASED 2013-2014 BUDGET PLAN JANUARY 10th

- The Governor released on January 10th his proposed budget for the 2013-2014 State Budget year that begins July 1, 2013. While the spending plan did not contain any major cuts to the health and human services budget – the first time in over 10 years – it did contain provisions to continue implementation of several sweeping policy changes to major programs including Medi-Cal, Healthy Families, mental health and In-Home Supportive Services (IHSS).

- The Legislature will begin budget subcommittee hearings on the Governor's spending plan beginning as early as late next month and continuing through May.
- The Governor submits to the Legislature a revised version of his budget plan in early May – referred to as the "May Revise" or "May Revision" that contains new proposals and other changes to the budget plan he submitted in January, based on the latest actual state spending and revenue numbers – and any changes in funding and policies coming from the federal government that impact California.
- The Legislature will then hold a final round of budget subcommittee and then full committee hearings in May, possibly followed by budget conference committee hearings held through early June (the Legislature did not convene a budget conference committee in 2012).
- The Legislature will approve a budget plan by late June and send it to the Governor, along with several budget related bills called "trailer bills" that contain changes in state law to implement certain policy changes in the budget, including those required by federal law.

CDCAN CALENDAR OF HEARINGS AND MEETINGS

Meetings and hearings are listed in date order.
Some events to note:

- Budget Committee Hearings (State Capitol) – Jan 24th, Feb 14, Feb 21st, Feb 28th (Senate) and Jan 31st (Assembly)
- California Building Standards Commission meeting regarding disability access related regulations (in Sacramento) – Jan 23rd and Jan 24th
- Developmental Disabilities Briefing (State Capitol) – Jan 23rd
- John Lonberg Memorial Service (Riverside) – Feb 09th

JANUARY 23, 2013 – WEDNESDAY

01:00 PM (continues on January 24th, Thursday 09:00 AM()
California Building Standards Commission
Physical Meeting Location:
California Department of Consumer Affairs
1625 North Market Blvd.
First Floor Hearing Room
Sacramento, CA 95833
Note: this is located in the North Natomas area

To Participate by Telephone:
Teleconference Phone Number: **(866) 650-3044**
Participant Code# **657517**
Note: The Commission advises that people should call in to the teleconference from a land-line using the telephone handset only. This enhances the Commission ability to hear your comments clearly. Calling from a speaker phone or cell phone reduces the quality of the audio and makes it much harder for your comments to be heard clearly.
Teleconference instructions:

- All callers begin in "Listen Only" mode.
- When it is time to take comments on a specific agenda item from persons on the phone, callers will hear, "This conference is now in Question and Answer mode.
- To alert the speaker that you have a question, press 1 and 0. Each question will be answered in the order it was received."
- If a caller presses 1 and 0, they will hear, "You will be notified when the speaker is ready for your

question."

- Note: Please refrain from pressing 1 and 0 multiple times. Doing this toggles your position in and out of the call queue. Press 1 and 0 only once and wait for your notification to speak.
- The callers whose turn it is to comment will hear: "Please ask your question after the tone." A tone will sound and the caller is now in "Talk" mode.
- After each caller has commented, they will be placed back into "Listen Only" mode.
- When the last caller has commented, the comment period for that item is over and the "Question and Answer" mode will be switched back to "Listen Only" mode.
- The meeting will proceed to the next agenda item.

JANUARY 23, 2013 – WEDNESDAY
02:00 PM (to 04:00 PM)
Capitol Briefing Day: An Overview of California's Developmental Services System
State Capitol – Room 112

JANUARY 24, 2013 – THURSDAY
09:00 AM - CALIFORNIA BUILDING STANDARDS COMMISSION
(continued from January 23rd meeting)
Physical Meeting Location:
California Department of Consumer Affairs
1625 North Market Blvd.
First Floor Hearing Room
Sacramento, CA 95833
Note: this is located in the North Natomas area

To Participate by Telephone:
Teleconference Phone Number: **(866) 650-3044**
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- After each caller has commented, they will be placed back into "Listen Only" mode.
- When the last caller has commented, the comment period for that item is over and the "Question and Answer" mode will be switched back to "Listen Only" mode.
- The meeting will proceed to the next agenda item.

JANUARY 24, 2013 - THURSDAY
09:30 AM** – SENATE BUDGET AND FISCAL REVIEW COMMITTEE
** or upon adjournment of the Senate floor session
State Capitol – Room 4203
Informational Hearing: Overview of Governor's 2013-2014 Budget

JANUARY 29, 2013 - TUESDAY
09:00 AM - JOINT HEARING SENATE AND ASSEMBLY PUBLIC SAFETY COMMITTEES
State Capitol – Room 4203
Informational Hearing: Gun Violence and Fircarms Law in California
Note: scheduled to meet until 12 noon.

JANUARY 29, 2013 - TUESDAY
1:30 PM - ASSEMBLY HEALTH COMMITTEE
State Capitol - Room 4202
Informational Hearing: Improving Outcomes through the Patient Centered Medical Homes
Note: this hearing scheduled until 4:00 PM

JANUARY 31, 2013 - THURSDAY
Upon Adjournment of Assembly Floor Session – ASSEMBLY BUDGET COMMITTEE
State Capitol - Room 4202
Informational Hearing: Overview of the Governor's Proposed 2013 - 2014 State Budget

FEBRUARY 09, 2013 – SATURDAY
05:00 PM – JOHN LONBERG MEMORIAL SERVICE
La Sierra University Seventh Day Adventist Church
4937 Sierra Vista Avenue
Riverside, CA 92505
Church Phone: (951) 354-7095
Reception will follow at Alumni Center (across the street from church) at 15000 Pierce Street, Riverside, CA 92505
CDCAN Note: John Lonberg, a longtime respected disability rights advocate passed away on December 27, 2012.
His daughter, Gaydene Emmrich wrote on the California Disability Rights (CDR) list serve that "…as you may know, John has had some great health struggles in the past few years. Yet, he always remained upbeat about the future. He will be missed by many."
She invited people to his memorial and reception. Persons having any questions about this event can contact Gaydene Emmrich at John Lonberg's email: jlonberg@earthlink.net

FEBRUARY 14, 2013 - THURSDAY
09:30 AM** - SENATE BUDGET AND FISCAL REVIEW COMMITTEE
State Capitol – Room 4203
Informational hearing: Overview of 2013-2014 Higher Education Budget
** - or meets upon adjournment of the Senate floor session.

FEBRUARY 21, 2013 - THURSDAY
09:30 AM** - SENATE BUDGET AND FISCAL REVIEW COMMITTEE
State Capitol – Room 4203
Informational hearing: Overview of 2013-2014 Health Care Budget
** - or meets upon adjournment of the Senate floor session.

FEBRUARY 28, 2013 - THURSDAY
09:30 AM** - SENATE BUDGET AND FISCAL REVIEW COMMITTEE
State Capitol – Room 4203
Informational hearing: Overview of 2013-2014 K-12 Education Budget
** - or meets upon adjournment of the Senate floor session.

MARCH 12, 2013 - TUESDAY
1:30 PM - JOINT HEARING SENATE AND ASSEMBLY HUMAN SERVICES COMMITTEES
State Capitol - Room 3191
Informational Hearing: The Real Face of California's Poor: Interpreting the New Federal Poverty Measure

FEBRUARY 19, 2013 - TUESDAY
02:00 PM – ASSEMBLY AGING AND LONG–TERM CARE COMMITTEE
State Capitol - Room 126 (note room change)
Informational Hearing: A Matter of Life and Death, What Are the Choices?

VERY URGENT!!!!!!

January 22, 2013

PLEASE HELP CDCAN CONTINUE ITS WORK

WE MAY NOT BE ABLE TO CONTINUE!!!

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CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833
[replaces 1225 8th Street Suite 480, Sacramento, CA 95814]
NEW Phone: 916-757-9549 (replaces 916-212-0237)

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

Attachment #5

Tri-Counties Regional Center
SAN LUIS OBISPO • SANTA BARBARA • VENTURA

520 E. Montecito Street
Santa Barbara, CA 93103
T/ 800.322.6994
F/ 805.884.7229
www.tri-counties.org

May 31, 2012

Dear Parent,

These are exciting times of change in California and we are writing to let you know about a new law that will help you obtain behavioral intervention treatment, including applied behavioral analysis (ABA) for your child or adult loved one with autism or pervasive developmental disorder (PDD).

On July 1, 2012, Senate Bill 946 becomes law, making California the 28th state in the nation to pass an Autism Insurance Mandate. This new law requires California private insurance companies to contract with Qualified Autism Services Providers and cover behavioral intervention. **Families with Medi-Cal only are not affected by this new law.** More information about this new law is enclosed.

Tri-Counties Regional Center (TCRC) will be holding information sessions in each office during the month of June to help families understand the law and how TCRC will be working with families and providing assistance to you during the transition. In the event that the Planning Team is unable to agree on the transition steps or the transition to insurance is unsatisfactory, the Lanterman Fair Hearing procedures remain available to persons served and their families.

Please join us to learn more. RSVP as soon as possible by calling your local TCRC office. Spanish translation will be available. Please request Spanish translation when calling to RSVP.

Autism Insurance Training Schedule

All Sessions will be held from 6:00pm -7:30pm

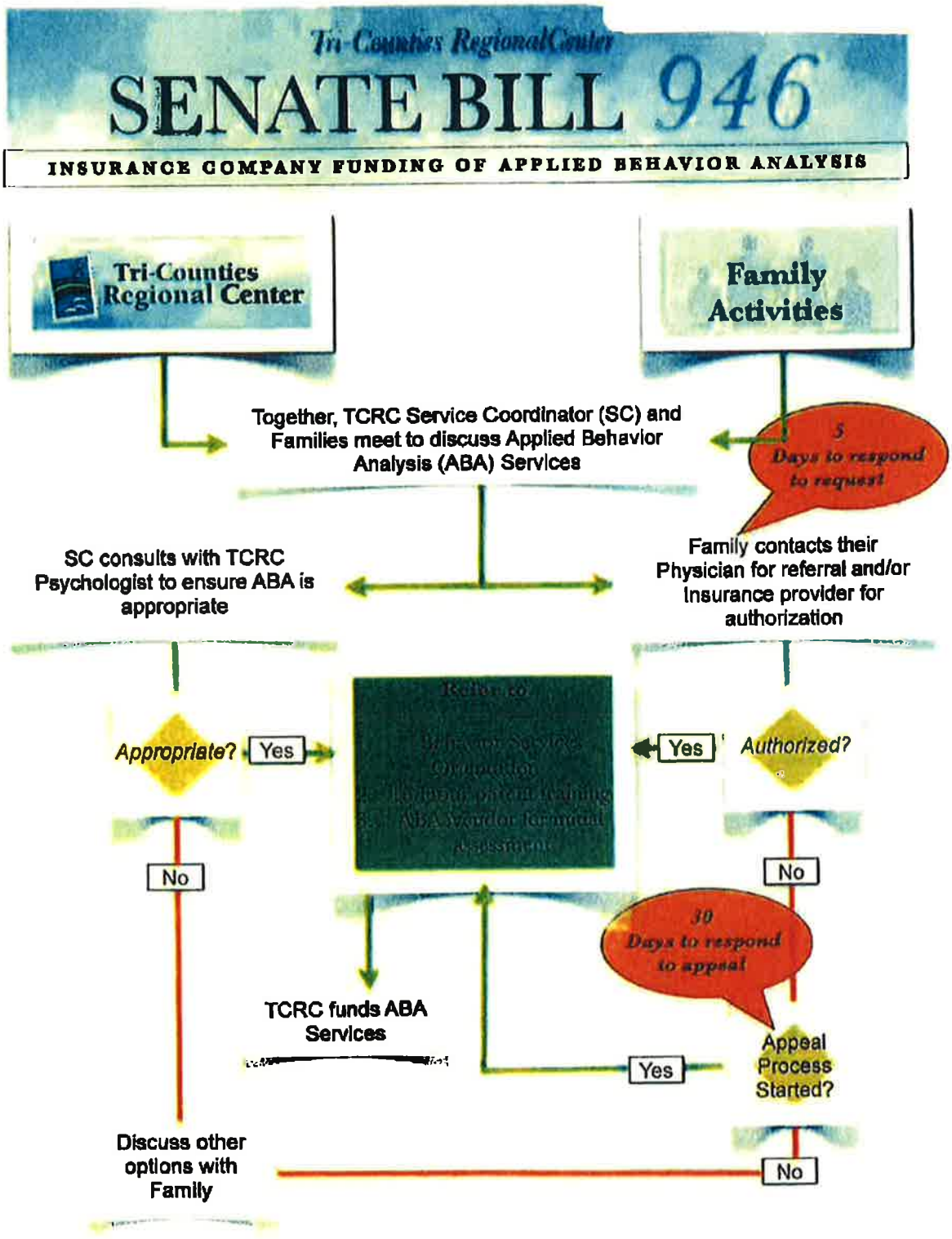
Wednesday	June 6	Atascadero	(805) 461-7402
Thursday	June 7	San Luis Obispo	(805) 543-2833
Wednesday	June 13	Santa Maria	(805) 922-4640
Wednesday	June 20	Simi Valley	(805) 522-8030
Thursday	June 21	Santa Barbara	(805) 962-7881
Thursday	June 27	Oxnard	(805) 485-3177

Senate Bill 946 is Good News for California and brings families a new opportunity to receive essential services. TCRC looks forward to working with you and the health insurance providers to implement this historic change.

Sincerely,

Omar Noorzad, Ph.D.
Executive Director

Attachment #6



Attachment #7

Tri-Counties Regional Center

SB 946 – Autism Health Insurance Plan Mandate
INSURANCE CO-PAYMENTS

August 2012

A. GENERAL GUIDELINES

1. **TCRC will pay co-payment amounts ("co-pays") for Applied Behavior Analysis ("ABA") sessions provided to persons served and their families who are covered by private insurance up to $45 per day.**
2. TCRC will not require any financial justification from families to approve co-pays.
3. TCRC will pay the ABA service provider directly for family co-pays.
4. TCRC will not reimburse families directly for insurance co-pays. This eliminates any potential IRS income penalties for the family.
5. TCRC will only reimburse co-pays for ABA treatments at this time. (OT, PT, SLP or other medically necessary services are not included in this reimbursement procedure).
6. Early Start services and insurance reimbursement are regulated differently; contact the Service Coordinator or the Early Start Manager in the local TCRC office if there are questions about insurance funded services for children 0-3.
7. ABA service providers may waive the co-pay requirement if direct reimbursement from TCRC violates any of the health plan or business procedures of the ABA service provider.
8. Health Plans may also waive co-pays. Information will be provided to Service Coordinators and Managers as provided by the Health Plans.
9. TCRC will reimburse co-pays using Medicaid Waiver billable service codes.
10. Families who are on the Medicaid Waiver and have private insurance will need to use private insurance as the primary funding source.
11. Families receiving Medi-Cal only and who do not have private insurance are not affected by SB 946 and ABA services will be fully funded by TCRC.
12. Information on participating Health Plans and ABA Providers is available on TCRC's website.

Attachment #8

FAQs Regarding Insurance Funding for Behavioral Health Treatment for Autism and PDD
September 28, 2012

Please note that this document provides information about a situation that continues to evolve. As such, ARCA anticipates that changes will be made to it as updated information becomes available.

1. **Which insurance plans are required to provide funding for behavioral health treatments for autism and PDD?**

Every privately-funded health insurance plan that provides hospital, medical or surgical coverage in addition to behavioral and health services is impacted with the exception of employer self-funded plans is responsible for coverage of these services as of July 1, 2012 as a result of Senate Bill 946. Additionally, the Department of Managed Health Care has indicated that as of this same date this responsibility also applies to plans funded by Healthy Families as well as certain plans funded by CalPERS under Assembly Bill 88 (Mental Health Parity). TRICARE has been funding for ABA services for active duty family members, but was recently ordered by a federal court to begin providing the service to all members. It may be some time before TRICARE expands coverage to all members.

2. **Which CalPERS plans are required to fund behavioral health treatments for individuals with autism or PDD?**

The three CalPERS HMO plans (Blue Shield of California Net Value, Blue Shield Access+ and Kaiser Permanente) are required to fund these services. CalPERS PPO plans (PERS Select, PERS Choice and PERSCare) are self-funded and are not required to offer these services.

3. **Do different standards apply to plans funded by CalPERS and Healthy Families?**

Yes. As of September 6, 2012 there is an emergency regulation in place that applies to plans funded by CalPERS and Healthy Families. Essentially, the regulation establishes that CalPERS and Healthy Families plans must provide "medically necessary" treatment for Autism and PDD under existing mental health parity law. This means that services provided under those plans must be provided by licensed mental health professionals rather than by unlicensed BCBAs and paraprofessionals. CalPERS funded Blue Shield plans and Healthy Families funded Blue Cross plans are permitted to utilize the services of unlicensed professionals under a settlement agreement with DMHC. ARCA will provide updates as this situation continues to evolve.

4. Are any self-funded plans providing coverage for behavioral health treatments for individuals with autism or PDD?

Self-funded plans are not required to provide funding for these services under California law. Some are, however, opting to provide this as a benefit to their members. At least one regional center is requiring that families in self-funded plans provide evidence that their plan is self-funded as well as an indication from their insurers whether this is a covered benefit.

5. When do the funding requirements go into effect?

Most insurance carriers were required to comply no later than July 1, 2012. TRICARE was already providing services as were some insurance companies that were part of a settlement agreement on this issue last year.

6. What is the process for requesting funding for behavioral health treatments for individuals with health care service plans based in other states?

Thirty states have mandates of one kind or another that require health insurers to fund behavioral health treatment for individuals with autism. For a list of those states, please visit http://www.autismspeaks.org/advocacy/states. If the state has a mandate, the referral process would be initiated by contacting the insurer. If problems arise in with these referrals, the regulatory agency overseeing health insurers in that state can be contacted for assistance (http://www.naic.org/documents/members_membershiplist.pdf).

7. As children now served by Healthy Families will be transitioning into Medi-Cal, what should regional centers do with those children in the meantime?

Healthy Families provides private HMO coverage through contracted insurance providers to income-eligible children. As a part of the 2012-2013 state budget, there was agreement to transition children served by Healthy Families into Medi-Cal. The timeline for termination of Healthy Families outlined in trailer bill language is very preliminary and dependent upon approval to changes in Medi-Cal. Funding for behavioral health treatments through insurers funded by Healthy Families remains available in the meantime. As such, regional centers should pursue funding for these services through those insurers.

8. What should regional centers do with children who are receiving behavioral health treatment services and are institutionally deemed?

As with other clients, check to ascertain whether they have health insurance in addition to Medi-Cal and pursue funding for behavioral health treatment through that insurance provider.

9. Will insurance companies implement these requirements consistently from one provider to the next?

No. Insurance companies have broad latitude in the implementation of the requirements. Insurance plans can choose what providers to contract with and what rates to pay. They will also individually determine what copayments will be charged for the services provided.

10. Will authorizations for these services be handled similarly to those for medical services that insurance companies authorize?

There are a couple of important distinctions to be aware of. First, some insurance plans contract out their behavioral health services to other providers such as Magellan or Optum Behavioral Health, so individuals may be redirected to call a different phone number once it is apparent that the request is for behavioral health treatment. Some insurance cards have a distinct phone number on the back for the behavioral health provider, but this is not necessarily the case. Second, some insurers that are anticipating a high volume of referrals for these services have established special units to address concerns related to these specific services. For information regarding how to best access these services from many health providers, please see the document titled "Behavioral Health Treatment Insurance Referral Processes" that ARCA has developed.

11. What types of treatments are required to be covered?

The statute states that funding will be provided for ABA services in addition to "evidence-based behavior intervention programs". There is a lot of ongoing discussion about what other therapies would be considered "evidence-based" and those that would not.

12. What efforts are in place to try to increase consistency?

Senate Bill 946 also required the creation of an Autism Advisory Task Force overseen by the Department of Managed Health Care that is exploring best practices related to evidence-based treatment options, duration of therapy as well as the qualifications of providers among other topics. This group will finish its work by the end of 2012 and must present a report to the Legislature at that time.

13. How will this change impact service provision for regional center clients in need of behavioral health treatment?

Under Welfare and Institutions Code Section 4659 (a)(2) regional centers are required to access funding from "private entities to the maximum extent they are liable for the cost of services, aid, insurance, or

medical assistance to the consumer." As such, individuals and family members need to access available funding from insurance companies for behavioral health treatment associated with autism and pervasive developmental disorder before the regional center can offer funding for these services.

14. How can regional centers facilitate a referral for behavioral health treatment to an individual's health insurer?

The procedure for each plan differs a bit. The larger plans have developed a distinct referral process for this transition. In general, the plans are requesting that either the current behavioral provider or regional center contact the plan and be able to provide at a minimum:

- Individual's date of birth
- Individual's health member identification number
- Diagnostic assessment confirming the diagnosis of autism or PDD
- Current behavioral treatment plan that includes:
    - Measurable goals
    - Current symptomalogy
    - Background of the individual
    - Number of hours of service requested delineated by service level (i.e., BCBA and paraprofessional)

ARCA has developed detailed procedures for specific health plans on their preferred processes for transition. As noted in the following question, it is important to realize that different timelines for approval or denial of funding requests apply depending upon who initiates contact with the health plan. As additional plan contact information becomes available, ARCA will continue to expand the information provided related to accessing services through specific health plans.

15. Once a health plan receives a request for services, how long does the plan have to determine if funding for the service will be granted?

This depends upon whether the request for services is initiated by a provider or another entity. If a provider (in-network or not) requests authorization to provide a service, the plan has five business days to determine whether to fund it, deny the request or request additional information necessary to make a decision. If a family requests the service, there are no firm timelines, but a health plan must initiate its internal grievance procedure if an enrollee or representative expresses dissatisfaction with the actions of the plan. The internal grievance procedure can take no longer than thirty calendar days. If either the five day or thirty day timelines pose an "imminent and serious threat to the health of the enrollee", plans must issue an expedited decision within three calendar days.

16. Should regional centers refer only those clients with a firm diagnosis of autism or PDD to health plans, or should others be referred as well?

The statute stemming from Senate Bill 946 refers back to the statute that established mental health parity in the state of California. Per regulation, mental health parity requires services be provided to those with a "preliminary or initial diagnosis" until a final diagnosis can be made. If a health plan questions the validity or strength of the diagnosis of autism of PDD, it would then be incumbent upon the plan to seek further diagnostic clarity at its expense while providing medically necessary services to treat the condition. Most health plans follow the American Academy of Pediatrics screening guidelines for Autism and PDD and complete screening of toddlers at ages 18 and 24 months and full diagnostic assessments if indicated at that time.

17. Once a health plan has approved funding for behavioral health treatments, how long may an individual wait before services begin?

The health plan is responsible to offer an appointment to begin services within a specified period of time depending on the services being offered. This offer of an appointment may not work with the individual's schedule and services may be delayed for that reason. Non-physician mental health provider appointments must be offered within 10 business days. An appointment must be offered for an occupational therapist, speech therapist or specialty physician (i.e., a psychiatrist) within 15 business days. Generally, these requirements are considered for the plan as a whole rather than in individual cases as it is a measurement of overall network adequacy.

18. If a regional center is currently funding a behavioral health treatment for a client, how can it discontinue funding for that service as a result of availability of funding for similar services through the individual's health insurance?

As with other changes to the Individual Program Plan, this change requires the consent of the planning team. If agreement cannot be reached, the regional center will need to issue a notice of proposed action at least thirty days prior to discontinuing funding. Many regional centers have found that having personal conversations with impacted clients and families prior to sending written notification of the change is an important first step to take. Clients and their families will have an opportunity to appeal that decision.

19. How do regional centers and the people they serve know which providers have contracted with which insurance companies?

Families and regional centers should access the health plan's on-line provider list. Since the providers change frequently, a printed listing would be quickly out of date. One regional center has indicated they have asked behavioral treatment vendors to provide this information so that they can match families with insurance to vendors that are contracted with their health plans. Lastly, regional centers and

health plans have been asked to provide liaison contact information to troubleshoot issues such as this as they arise. ARCA has provided regional centers with the insurance liaison contact information that has been received. If contact information for a specific plan is needed, please let Amy Westling in the ARCA office know so that efforts can be made to get that information for you.

20. Are all regional center vendors being accepted by health insurers into their network?

No. As long as an insurer can show that it has an adequate network of providers to serve various geographic areas as well as the volume of those needing services, it can contract with as few providers or as many as it would like. Some insurers have indicated a plan only to contract with providers associated with licensed professionals (i.e., psychologists or LMFTs) rather than those overseen by BCBAs. This is permissible, and in response, many providers have recently associated themselves with licensed professionals that the insurance companies are willing to contract with.

21. What are the options if an individual or family is currently receiving services from a provider that is not contracted with their health provider and would like to continue with that same provider?

This depends a bit upon the type of health plan involved. If the coverage is provided through an HMO, the provider can request a "single case agreement" or to be paid as an out-of-network provider if there is a strong justification to not change providers. HMOs have wide discretion on whether to approve such requests or not. In a PPO plan, contracted providers are in the network and those meeting necessary qualifications that have not contracted with the PPO are not. Individuals and families may choose to utilize a non-network provider and pay a higher coinsurance for the service. As regional centers are the payers of last resort, ongoing funding of alternative providers at family request may not be permissible.

22. What should a regional center do with new requests for behavioral health treatment for this population?

As health insurance funding for these services began on July 1, 2012, regional centers should assist families to pursue funding for these services through their private insurance before making funding commitments. This will ensure the smoothest access to services for individuals and their families.

23. How do health care service plans determine the amount of service they will fund?

In most cases, the plan determines the number of service hours that it believes is medically necessary. A few health plans (Blue Shield and Blue Cross included) entered into settlement agreements last year that

resulted in the granting of hours without considering medical necessity. In some areas of the state, it has been reported that the number of hours that a health care services plan has granted exceeds the service level that the regional center would have authorized, which may be related to the settlement agreements.

24. What if insurance companies deny funding for these services?

Most impacted health plans are licensed by the Department of Managed Health Care. That department provided a webinar training about the internal grievance procedures for plans as well as further appeal processes to regional center staff on June 14, 2012. This was intended to enable regional center staff to assist individuals and their families with walking through the insurance appeal process. DMHC archived this webinar for future regional center training use. It is available for viewing at https://dmhc.webex.com/dmhc/ldr.php?AT=pb&SP=MC&rID=66226517&rKey=db1a63e163e38fdd or for download at https://dmhc.webex.com/dmhc/lsr.php?AT=dw&SP=MC&rID=66226517&rKey=2f9baf31be70da14.

The Department of Managed Health Care (DMHC) needs specific information about problems that have arisen to be reported to their Help Center at 1-888-466-2219 in order to be able to intervene with health providers on a case-by-case as well as systemic basis. DMHC has four complaint processes, including:

- **Quick Resolution – Routine matters that can be resolved within a couple of days via telephone with the health plan.**
- **Urgent Complaints – Issues that cannot wait thirty days for resolution such as prescriptions and delays in obtaining appointments.**
- **Standard Complaint Resolution – Coverage disputes and concerns about the quality of care (i.e., a plan indicates it does not cover ABA).**
- **Independent Medical Review – Medical necessity for a covered benefit (i.e., a plan covers ABA but indicates a belief that the client does not need it).**

Regional centers can act as an authorized representative for the individual and family in the complaint and Independent Medical Review process through completion and submission of forms available on the DMHC website.

25. There have been reports that some families are seeking a denial from their health plan rather than funding for services in order to approach regional centers for continued funding. Is it permissible for an insurance company to deny services at the request of the family?

No. A health plan must evaluate a request for services on the merits of the claim. The plan must first determine whether the requested treatment is a covered benefit under the plan. If it is, the plan must determine medical necessity for the service and issue the correct decision related to funding based on the facts of the individual case. Health plans may only issue denials if the requested service is either not a covered benefit or if it is found not to be medically necessary for the individual.

26. Do insurance companies provide aid paid pending during the appeal process if they decide not to support ongoing authorization for services?

No. Services are authorized for a specified period of time. Before the authorization ends, the insurer makes a decision as to whether to authorize additional service hours for another period of time. If the decision is not to authorize additional services that are being requested, the individual or family of a minor child is notified in writing and given the opportunity to appeal.

27. Is the expectation that regional centers will fund ongoing services while a funding decision is being appealed through the insurance carrier?

It is incumbent upon the regional center to make an independent decision about whether to support funding of a service that an insurance company denies. Part of making this decision would likely mean requesting records about interventions that the individual has received via health insurance funding. Once regional centers begin providing funding, they are likely responsible for aid paid pending should an appeal stem from a decision to discontinue it at a later date.

28. How is information exchanged between regional centers and health care service plans related to an individual's diagnosis, treatment and progress?

Both health care service plans and regional centers are subject to the requirements of HIPAA. Regional centers have additional requirements related to their practice outlined in Welfare and Institutions Code Section 4514. Section 4514 (c) allows for an exception to normal confidentiality of regional center records "to the extent necessary for a claim, or for a claim or application to be made on behalf of a person with a developmental disability for aid, insurance, government benefit, or medical assistance to which he or she may be entitled." Some regional centers have indicated a plan to err on the side of caution on this issue and to obtain signed releases from families before disclosing specific information to health insurers.

29. Is there a means for regional centers to recover funds from health care service plans for services funded during periods that individuals or their families are appealing a decision by a health care service plan?

The Department of Managed Health Care cannot require insurers to reimburse regional centers or any third parties that provide funding even when the funding decision by the health care service plan is overturned on appeal. There is a provision in Welfare and Institutions Code Section 4659.11 that

appears to allow for regional centers to submit claims to health care service plan in this instance. ARCA is working to get clarification related to the mechanics of this process.

30. What are regional centers doing relative to requests for assistance with funding of the copayments associated with behavioral health treatments funded by health care service plans?

ARCA's attempts to have the insurance copayment issue legislatively addressed were not successful. Regional centers are in the process of developing practices for their individual centers around this issue. In some instances, centers are planning to pay the copayments to providers directly under the service code that they are already vendored for. There is a commitment to ensuring that there remains access to needed services.

31. Has ARCA requested a legal opinion related to the responsibility of regional centers to fund copayments?

Yes. ARCA requested a legal opinion from Enright and Ocheltree on the issue of regional centers' ability to fund copayments for behavioral health treatments that are being funded by health care plans. Each regional center Executive Director received a copy of this opinion. This legal opinion was inadvertently released and was distributed online between various groups. ARCA maintains that this document remains a protected document as its initial release was unintentional. One regional center recently argued that point in a fair hearing and was able to exclude the document from evidence.

32. Are providers permitted to accept third-party (i.e., regional center) payments for copayments?

Yes. Providers can accept third-party payments for copayments if they choose to.

33. How do families know when they've reached their annual copayment maximum?

ARCA has heard reports that health insurers are less consistent at tracking copayments for behavioral health than for medical services. Families should be encouraged to keep track of copayment amounts paid in order to avoid an overpayment of copayments. Some insurers provide information about copayment expenditures on their websites to make this simpler to follow.

34. Is it permissible for a BHT provider to accept a contracted rate from a health care plan and subsequently bill the regional center or family for the difference between the provider's typical rate and the contracted rate?

No. This is known as "balance billing" and is not allowed. Providers are expected to charge copayments and coinsurance consistent with the terms of the health plan, but an in-network provider in an HMO plan should not be engaging in this practice.

35. How does the implementation of the Affordable Care Act impact the future of health care funding for behavioral health treatment for those diagnosed with Autism or PDD?

The California Legislature passed two bills last week which outlined the "essential health benefits" that many health plans will have to provide after January 1, 2014. One included benefit is behavioral health treatment for individuals diagnosed with Autism or PDD. These requirements apply to new plans issued to individuals or small employers after January 1, 2014. Additionally, Medi-Cal will be required to provide some form of behavioral health treatment but the exact parameters of that are unclear at this time.

36. What can regional centers do as more issues arise?

ARCA remains committed to helping regional centers to navigate through the implementation of insurance funding for behavioral health services. ARCA is meeting with the Departments of Managed Health Care, Insurance and Developmental Services as well as the California Association of Health Plans to discuss and resolve Senate Bill 946 implementation issues. Please contact Amy Westling (awestling@arcanet.org) in the ARCA office for additional assistance or guidance on implementation concerns and issues.

Attachment #9

TRI-COUNTIES REGIONAL CENTER

Enhancing the Quality of Life for Persons with Developmental Disabilities

Policies & Guidelines

Policies and Guidelines - 10601

SERVICE POLICY GUIDELINES

Behavior Intervention Services

Tri-Counties Regional Center enhances the quality of life for persons with developmental disabilities by working with individuals and their families to secure assessment and treatment supports and services that maximize their opportunities and choices for living, learning, working, and pursuing recreational activities in their community.

Tri-Counties Regional Center will coordinate, support and advocate for individuals to obtain appropriate behavior intervention services in their community. Tri-Counties Regional Center works with and advocates within the communities it serves to develop and identify appropriate behavior intervention services provided by professionals experienced with and sensitive to the needs of individuals with developmental disabilities. Such services maximize the potential for individuals to develop, and/or prevent deterioration, in areas of their development.

Behavior intervention services are prescribed assessments or treatments provided directly by, or under the supervision of, a qualified licensed or certified professional trained in behavior management. This service is intended to assist persons served and parents or care givers when the individual exhibits maladaptive, harmful, socially unacceptable, or developmentally unacceptable behaviors. Behavior intervention services use specialized methods of teaching important social and adaptive skills and of training family members, or primary care givers, in the effective use of positive behavior management skills. All parents or care givers will be expected to attend a brief orientation to behavior intervention services by Tri-Counties Regional Center staff before services commence. Tri-Counties Regional Center endorses only the use of non-aversive behavior intervention techniques which are evidence-based.

Access to specialized behavior intervention services directly related to the developmental disability of the individual may be necessary for the functional ability of some individuals. Tri-Counties Regional Center may authorize funding for behavior intervention services when an individual exhibits maladaptive, harmful, socially unacceptable, or developmentally unacceptable behaviors that constitute a danger or have a significant adverse effect on their participation in school or work, on family functioning, or on residential options.

The period, frequency and total amount of behavior intervention services is determined by the Planning Team, including a Tri-Counties Regional Center psychologist or physician and service provider. The provision of behavior intervention services is based on the needs of the individual or family as determined by an initial or follow up behavioral assessment. Typically, the behavior intervention service is time limited to achieve both behavioral goals for the individual and training goals for the family or care givers. In addition, the Planning Team may determine that periodic support is needed on a consultative basis to ensure the continued success of past intervention services. The intent for provision of such consultative services is to offer guidance and preventive intervention.

In some situations, intensive family support provided in the form of behavior intervention services may be required to address persistent aberrant behaviors of their children. These behavior intervention services may be offered when the parent or care giver participates as the primary agent of change. The intent for provision of such behavior intervention services is for the parent or care giver to be provided with technical supervision

and support. Before intensive behavior intervention services begin, the parent or care giver is expected to attend a group parent training program that explains intensive behavior intervention, expectations of service provision, and the parent participation necessary for the intensive services to be successful. Review of the intensive behavior intervention services is expected to take place at least every six months through the planning team process involving the parent, Tri-Counties Regional Center service coordinator and clinician, and the service provider. The purpose of the review is to assure the satisfaction of the parent, the quality assurance of the service provision, and the effectiveness of the behavior program.

When the need is directly related to, or is the direct result of, a developmental disability and all generic and private resources, including private medical insurance, deny a necessary service, Tri-Counties Regional Center may authorize funding for the purchase of specialized behavior intervention services recommended by the Planning Team. For persons with a diagnosis of Autism or Pervasive Developmental Disorder (PDD), SB 946, effective July 1, 2012, requires privately funded health insurance plans to cover behavioral intervention treatment, including applied behavioral analysis (ABA). Tri-Counties Regional Center staff will support the person and family through their insurance company's process for accessing SB 946 services. When the insurance company approves services, the Tri-Counties Regional Center service coordinator will work with the family to request that the health plan waive any co-payments. If this is not possible, Tri-Counties Regional Center will offer to pay any co-payments for SB 946 services directly to the provider, using a service code that maximizes federal funding. Co-payments will be capped at a level that assures cost-effectiveness.

For persons in public school programs and individuals who reside in Level 4 behavior facilities or in health care facilities, behavior intervention services are expected to be provided as part of the individual's program, rather than as a separately funded service. Tri-Counties Regional Center service coordinators will actively advocate with local education agencies and health care facility providers to ensure the delivery of required and mandated services.

Services for children that the Tri-counties Regional Center clinical team suspect of having autism should begin as soon as eligibility for regional center services has been determined and the IFSP or IPP has been developed. The IFSP or IPP may include the need for intensive services. Tri-Counties Regional Center will coordinate services and supports with other public agencies, including the schools, which have a legal responsibility to serve children with autism or other developmental disabilities. Services for children with autism should be systematically planned and involve developmentally appropriate activities that target specific objectives. They should also have a strong and continuous parent training component.

Children up to three years of age suspected of having autism, served under the California Early Intervention Services Act's Early Start program, should receive a total of up to 25 hours per week of intervention. Included in this total are services from all agencies, including Tri-Counties Regional Center as necessary, that address the core deficits associated with autism. It does not include services that address other needs which are not specific to autism, such as physical therapy and California Children Services (CCS) services.

Starting at three years of age, preschool children eligible for regional center services with a diagnosis of autism under the Lanterman Act should have the school as their primary program of educational intervention. Up to 15 hours per week of Tri-counties Regional Center funded services that address the core deficits associated with autism may be used to supplement the school program. This does not include services that address other needs which are not specific to autism, such as physicial therapy and CCS services.

By seven years of age, children with autism should be enrolled in a school program with approximately 30 hours per week of educational instruction. Up to 10 hours per week of Tri-Counties Regional Center funded services that address the core deficits associated with autism may be used to supplement the school program. This does not include services that address other needs which are not specific to autism, such as physical therapy and CCS services.

Tri-Counties Regional Center will advocate for and work with individuals and their family members to ensure that generic and private service providers discharge their obligations to meet the needs of persons with developmental disabilities. It is the financial responsibility of individuals or their families to pay premiums and meet any required deductible amount or co-payment liabilities, except as noted above for SB 946 services, as determined by generic resources and/or private insurance carriers. Except as legally prohibited by the terms of a Special Needs Trust, trust funds established for the care or benefit of a person served are considered a private resource, and therefore it is expected that this source of funds be used prior to regional center funds.

If a generic or private resource initially denies a required behavior intervention service that Tri-Counties Regional Center has determined to be their responsibility, that denial will be considered for appeal and/or referral to the Department of Managed Health Care for an independent medical review. Tri-Counties Regional Center may authorize funding for a behavior intervention service while the individual or family member pursues coverage or appeals a denial of service by a generic or private resource, including private health insurance, under the following circumstances:

- The Planning Team will make the determination that the service is required to protect the individual's health and safety, or that a prolonged wait for the service will have an irreversible impact on the individual's health and safety; and
- The Planning Team will consider the individual's risk for regression and the capacity of the individual to regain any loss of function or ability if the service is not provided in a timely manner.

Tri-Counties Regional Center will not authorize funding of any behavior intervention service that is considered experimental, optional or elective in nature. The expected result from the provision of a behavior intervention service must meet measurable outcomes as stated on the person's Individual Program Plan. The provision of behavior intervention service must be both clinically and fiscally an effective use of public funds.

Exception Policy:
Tri-Counties Regional Center recognizes that some individual needs are so unique that they may not be addressed in this Service Policy and may require an exception. Such requests for an exception to a Service Policy will be made through the Planning Team process.

Tri-Counties Regional Center

Attachment #10

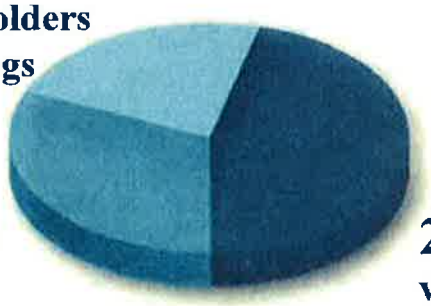
SB 946 Implementation & Outreach

June 2012 - January 2013

By the numbers

488 stakeholders received face-to-face training

95 General Stakeholders via Regional Meetings



132 TCRC & FRC Staff

257 New Parents via Orientations

91 Live Events

30 of these events...
are Behavioral Services Orientations held once a month at most offices. Includes personal Health Insurance Q&A.

700 Email & Phone Responses

Current Insurance Workgroup Projects

- Guidelines established for payment of co-insurance
- Exception criteria established for payment of deductibles
- Completion of baseline insurance information for agency wide tracking
- New worksheet for staff analysis of family out of pocket costs
- Revisions reflecting new understanding of co insurance and deductibles
- Revised information for parents and guidelines for Service Coordinators supporting families
- Billing procedures for vendors
- Vendorization guidelines for New ABA Providers in Insurance Networks
- Health Plan Provider network update

What's Next?

- Notice to parents of complaint/appeal expectations
- Scheduling workshops to assist parent to complete appeals
- Staff training in worksheet cost analysis for family out of pocket costs

SB 946 Implementation Report

During the month of December, TCRC's Autism Coordinator scheduled evening information sessions for parents and providers in each office which were attended by 14 individuals. Face to face meetings with TCRC Children's Service Coordinators and Parents Helping Parents Family Resource Center staff were held in Atascadero & SLO during December and in January with the Simi Early Start Team. These meetings continue to be scheduled on an on-going basis in addition to individual consultation with staff, parents, providers, community groups and other interested parties who have a need to understand SB 946.

All new families requesting behavioral support receive information on accessing insurance through attendance at monthly Behavioral Services Orientations conducted by the Autism Coordinator.

TCRC also provides information on SB 946 and resources to help access private insurance at local community events, including the Autism Speaks Walk in Santa Barbara and the Ventura County Conference on Autism Across the Lifespan, and will be participating in several upcoming events providing outreach materials. The Autism Coordinator is also working with Area Board to share implementation issues.

Many of the plans are not required to comply with SB 946 because they are self funded, federal, military, or out of state. This has been a difficult verification process, and continues to change as new regulations are passed. All families who have Medi-Cal will continue to be funded by TCRC, which is approximately half of ABA authorizations TCRC is currently funding.

TCRC has established guidelines and accounting codes for payment of co-insurance (a percentage of the ABA vendor's contracted rate with health plan which families are expected to pay). Unlike fixed daily co-pays, the co-insurance rates are billed hourly and vary with each ABA vendor and each health plan.

The Insurance Workgroup is also developing guidelines for consideration of payment of the portion of the deductible allocated to the ABA treatment; these are reviewed individually, by exception and require limited financial hardship information from the family to establish the justification for TCRC assistance with deductible. All out of pocket costs are paid directly to the ABA vendor on behalf of the family.

An authorization must be in place from the insurance provider before approval of TCRC funding of any costs. This

SB 946 Implementation Report

ensures the out of pocket costs are being counted toward the family annual maximum payment for healthcare services from their health plan.
In most of the cases analyzed thus far, TCRC will incur significant cost savings and families will often meet the annual out of pocket maximum in the first 2 or 3 months of services and TCRC's financial contribution ends.

TCRC has completed the vendorization of ABA providers for co-pay & co-insurance costs. This limited vendorization agreement continues to be available for any ABA provider contracted with health plans in the TCRC catchment area to enable families to utilize the providers in their health plan network and also access assistance from TCRC.

Over the coming weeks, staff will be following up with families who have private insurance to verify their attempts to access ABA services via insurance.

Families are being encouraged to file complaints with the Department of Managed Health Care or CA Department of Insurance if they encounter delays, denials or other barriers to timely access of insurance. Some health plans are implementing services relatively smoothly, while others continue to have limited network availability, confusing diagnostic reporting requirements, low reimbursement rates, and delays in service approval. Currently, many of the local families with Kaiser are still waiting for services to begin, due to staffing shortages, corporate transitions with Easter Seals, and other difficulties.

TCRC's Insurance Workgroup will be finalizing guidelines and training staff on use of a new worksheet to analyze family out of pocket costs and completing work on documents to inform families and providers of procedures for co-insurance and deductibles.

Attachment #11

Association of Regional Center Agencies

2013-15 Strategic Plan

Kinetic Flow
January 2013

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Introduction

In 2000-01, the Association for Regional Center Agencies' (ARCA or the Association) Strategic Planning Committee developed a three-year strategic plan titled, "2002-05 Strategic Plan for the Regional Center System." The development process included an Environmental Scan and Strategic Thinking by the Strategic Planning Committee with review of the plan by the ARCA Board of Directors and participation in development of the actions and plan implementation by ARCA's Committees. As a final step, the ARCA staff assessed the success of the plan. After the 2002-05 Strategic Plan became outdated in July 2005, no new Strategic Plan was developed or enacted.

In 2008, ARCA members expressed interest in developing a new strategic plan to guide the priorities and actions of the Association. ARCA formed the Strategic Planning Committee (the Committee) with seven members and chaired by Omar Noorzad. In designing the new strategic planning process, the Committee expressed interest and expanding the breadth and depth of the development process. To this end, the Committee, in 2008 issued a competitive RFP that outlined the steps and tasks the Committee wanted implemented. Kinetic Flow was awarded the contractor to assist ARCA with this plan. Later in 2008, the strategic planning process was halted due to funding and the Strategic Planning Committee was suspended for the interim.

In 2012, ARCA revived the Strategic Planning effort guided by the Strategic Planning Committee co-chaired by Omar Noorzad and James Shorter, along with the new members of the Strategic Planning Committee. The revised 2012 Strategic Planning Process aimed at achieving the same goals and objectives as in 2008 though utilizing a streamlined process that maximizes the outcomes for ARCA while honoring the limited resources available to ARCA and for this project.

As the Association had been without a Strategic Plan since 2005, the 2013-15 Strategic Planning Process included extensive review of the Vision, Mission, and Values of the organization, and an organizational assessment, as well as an environmental scan and SWAT analysis. Further, as the Board of Directors had limited meeting time to discuss strategic issues, the 2013-15 Strategic Planning Process utilized a number of facilitation modalities. At each step in this process, the Strategic Planning Committee, Executive Committee, and often the Board of Directors were provided opportunity for input and feedback.

This document presents the 2013-15 Strategic Plan for the Association of Regional Center Agencies as completed to date: January 2013.

Strategic Planning Process

The Association's 2012-15 Strategic Planning Process included:

Board of Directors Strategic Thinking Survey. In preparation for the Strategic Planning session, the ARCA Board of Directors participated in the Strategic Thinking Survey. This 22 question survey solicited feedback from all Board members on their perception of ARCA as it stands today, strengths, weaknesses, necessary changes, including review of the Vision, Mission and Values statements. The Strategic Thinking Survey was conducted via the Internet and completed by 36 of the 42 representatives of the Board of Directors.

Board of Directors Retreat. On October 19th, 2012 the ARCA Board of Directors and ARCA Staff participated in a facilitated discussion of the Vision, Mission and Values Statements for inclusion in, and use in the formulation of, the new Strategic Plan. The Board of Directors reviewed and discussed the environmental scan, SWAT analysis and top priority focus areas for the next three years. The Board also began to define the priority areas, the strategic issues surrounding the areas and the associated outcome measures.

---Process Steps below are either in progress or will be initiated in the next three months.---

Board of Directors Organizational Assessment. One of the critical components to ARCA's achievement of the priority areas is the cohesiveness and actions of the Board of Directors as individuals within this larger group. The complexity and nature of the Board structure serves as a strength for ARCA, though it can also present challenges; the Organizational Assessment addresses these issues and looks at general governance of the ARCA Board and its operations.

Committee Survey. The Committee Survey provides each Committee a chance to review ARCA's Priority Areas and provide strategies and tasks, as well as outcome measures, the Committee can undertake within the committee's own focal area, to help effect change in the Priority Areas and ARCA's goals.

Regional Center Feedback. To provide each member of ARCA (the 21 regional centers) an opportunity to review the revised ARCA Vision, Mission, and Value Statements and Priority Areas with their regional center Board of Directors and provide feedback, each regional center was provided an eight week time period within which to comment on the Strategic Plan.

One-On-One Interviews. The Strategic Planning Committee Co-Chairs and the ARCA Executive Director will review the draft Strategic Plan with Directors of key stakeholder groups in California, including the Department of Developmental Services, Disability Rights, Inc., the State Council on Developmental Disabilities, Legislative Members and Budget Committee Members, as well as other possible stakeholders for insights.

Review and Amendment of Draft Strategic Plan. The Strategic Planning Committee, the Executive Committee and the Board of Directors review, edit and amended the Strategic Plan.

Vision, Mission, Values

Vision

A strong regional center system that effectively carries out its responsibilities to support Californians with developmental disabilities.

Mission

The mission of the Association of Regional Center Agencies (ARCA) is to represent the individual regional centers to support and preserve, the Lanterman Developmental Disabilities Services Act through advocacy, training, education, and legislative action.

Values

The Values Statement of the Association includes:

- ARCA recognizes that California's regional center system supports the needs of individuals with developmental disabilities and their families and values the fundamental right of individuals to equal treatment, community inclusion, and personal choice;
- ARCA values its role as a bold leader in the field of developmental disabilities that passionately advocates on behalf of California's twenty-one regional centers and the individuals they serve;
- ARCA conducts itself with integrity and transparency and believes that open and honest communication is the cornerstone of productive relationships; and
- ARCA respects differences in opinion and recognizes that healthy and open debate fosters innovation, collaboration, and commitment to a common vision.

Priority Area: Funding

Descriptive Statement:

ARCA believes additional financial resources are required to ensure that the developmental services system can continue to meet the needs of individuals with developmental disabilities while securing federal financial participation for the State. Regional centers also require greater assurance that allocated funds will be dispersed in a timely manner that allows them to meet their financial obligations to fund vendored services and operational expenses.

Strategic Issues:

ARCA has determined that reforms to regional center purchase-of-service and operations funding are essential to ensure a sustainable developmental services system for California. Specific factors contributing to this need include:

- The current provider rate structure (i.e., freezes, inadequate median rates, etc.) impacts service quality and limits innovation;
- In recent years, start-up funds have only been available for programs targeting individuals exiting developmental centers;
- DDS has indicated that a new POS allocation methodology will be forthcoming that will be based on individual client needs;
- Salaries in the core staffing formula, which drive regional center operations allocations, have not been systematically updated since 1991, limiting regional centers' ability to maintain federally mandated service coordinator to client ratios;
- High caseloads lead to unmet client and family needs as well as jeopardize federal funding;
- Rent allocations need to meet current regional center lease requirements;
- Regional center and DDS estimates regarding the sufficiency of purchase of service allocations to meet client needs vary widely;
- Regional center advances and contract amendments need to be released by DDS within contractual timelines; and
- Regional center invoices to DDS need to be paid in a timely manner.

Desired Outcomes:

ARCA envisions an updated financial structure that allows regional centers to confidently meet their financial obligations while continuing the State's eligibility for federal financial participation through:

- An updated rate-setting methodology that allows for innovation while remaining cognizant of fiscal realities;
- The authority to develop new programs with the aid of start-up funds aimed at individuals who have not been placed in developmental centers;
- Development of a POS allocation methodology in conjunction with DDS that accurately anticipates POS requirements in light of individual client needs;

- Comprehensive updates to the core staffing formula salaries that will allow regional centers to pay competitive wages in order to retain staff as well as a commitment to periodic adjustment of these salaries to ensure ongoing suitability;
- Agreement between regional centers and DDS on budget estimate methodology in order to provide greater financial security; and
- A renewed commitment from DDS for timely and complete disbursements to regional centers.

Existing Resources in this Direction and Potential Strategies:

- Explore methods to divert funds from developmental centers to regional centers as the population of developmental centers declines (i.e., unified budget);
- Work in conjunction with provider groups and DDS to develop a rate-setting methodology that is responsive to client needs;
- Explore state and federal support issues in collaboration with DDS;
- Revisit the regional center allocation budget methodology;
- Explore permanent funding sources, including options for other funding streams for regional centers (i.e., private fundraising);
- Identify elements necessary for sustainable financial support for purchase of service and operations which is sufficient to meet the needs of the system; and
- Explore the mechanisms that other states use to fund their developmental services systems.

Strategies and Tasks	Outcome Measures
...to be completed by the Committee Survey	

Priority Area: Quality Assurance: Effective Systems of Service and Systems Outcomes

Descriptive Statement:

ARCA believes the regional center system must have the ability to measure/assess services across the system using standardized metrics for:

- Quality Outcomes;
- Cost; and
- Individual / Family Impact.

Quality Assurance within the regional center system should promote system improvements through standardized measurement, and provide for:

- Informed decision-making by stakeholders (i.e., people with developmental disabilities and their families, regional centers, service providers, ARCA, the Department of Developmental Services, the Legislature, etc.);
- Establishment of the "worth" of the system to stakeholders; and
- Service and system-wide transparency and accountability.

Strategic Issues:

ARCA has determined that a comprehensive quality assurance system is essential for providing for an efficient, effective regional center system for California. Many factors contribute to the need for an effective and efficient quality assurance system, including:

- The regional center system is a performance-based system with no standardized performance assessments;
- California's developmental services budget is $4 billion annually, which needs to be justified to the Legislature and community;
- Choices are made daily that impact the lives of individuals with developmental disabilities, but systematic data-driven decision making is not currently possible;
- Regional centers believe that variation in quality and performance exists across providers, but there is no data-supported evidence of this;
- The need for an effective, efficient quality management system for California has been well-documented by more than 40 reports since 1980, and numerous Legislative Senate and Assembly bills, and in lawsuits against the State; and
- Many categories of services do not have consistent statewide service standards against which service quality can be effectively measured.

Desired Outcomes:

ARCA envisions a quality assurance system in which:

- Standardized information is available to:
  - Empower people;
  - Monitor services: and
  - Improve the quality of services and systems and peoples' quality of life.

- Further, that data is available to use for:
  - Service Choice;
  - Service Development;
  - Legislative advocacy; and
  - Community outreach.

Existing Resources in this Direction and Potential Strategies:

- Explore pilots and initiatives that have successfully implemented enhancements to the quality assurance system. Review those initiatives to assess their impact, outcomes, potential cost-savings and effectiveness. Projects that should be explored include:
  - Performance Contract Pilot Project;
  - Service Delivery Reform;
  - ARCA's Unified Plan;
  - Movers Study;
  - CMS Crosswalk for California;
  - Bay Area Quality Management System;
  - Golden Gate Regional Center Provider Group Documents;
  - Golden Gate Regional Center Board of Directors Document, "A Consolidated Developmental Services Quality Management System: Achieving Comprehensive Efficiency and Effectiveness;
  - Golden Gate Regional Center: The Quality Roadmap Proposal;
  - TCRC Services and Supports Survey / Satisfaction Studies;
  - OCRC Integration of National Core Indicators;
  - OCRC Virtual Charts;
  - RCRC Vision Statement Review (by Multiple Perspectives)
  - SCDD Report on Quality Assurances in the Delivery of Services for Persons with Developmental Disabilities; and
  - CADDIS.
- Consult with individual regional centers that may have additional key quality assurance metrics.

Strategies and Tasks	Outcome Measures
...to be completed by the Committee Survey	

Priority Area: Long-Term System Sustainability

Descriptive Statement:

ARCA believes that California's developmental services system must creatively respond to the diverse needs of current and future Californian's with developmental disabilities throughout their lifetime.

Strategic Issues:

ARCA has determined that systemic reforms are essential in order for California's developmental services system to continue to be responsive to changing environments and client needs. Specific factors contributing to this need include:

- Reduced reliance on developmental centers and other restrictive settings necessitates greater development of community resources to meet challenging service needs;
- Changing demographics of individuals with developmental disabilities and their families (i.e., autism rates, aging caregivers, aging clients, racial/ethnic diversity, etc.) require focused resource development; and
- Other states are implementing alternative service delivery models such as managed care and receiving federal financial participation.

Desired Outcomes:

ARCA envisions a regional center system that remains responsive to changing environments and needs through:

- Development of new service models to meet the needs of the changing demographics of individuals with developmental disabilities being served in the regional center system;
- System responsiveness to changing requirements at the Federal level; and
- Sustainability of the regional center system in ever-changing economic, political, and demographic environments.

Existing Resources in this Direction and Potential Strategies:

- Explore the feasibility of conducting a Medicaid Waiver eligible pilot of self-directed services;
- Explore ways in which the Way Forward project can work collaboratively with ARCA to examine needed system changes;
- Review the Lanterman Act to ensure that recent additions in response to budgetary limitations do not infringe on the service entitlement guaranteed in each Individual Program Plan; and
- Examine the practices other states are employing to meet the needs of individuals with developmental disabilities that are eligible for federal financial participation.

Strategies and Tasks	Outcome Measures
...to be completed by the Committee Survey	

Focus Area: Operational Goals and Systemic Maintenance

In addition to the Priority Areas detailed above, there are a number of operational focus areas that require the attention of ARCA's Board of Directors, Committees and Staff to maintain and further the regional center system. While these focus areas, and the committees that address these areas, are not highlighted in the three prioritized focus areas, they are no less vital to ARCA and the regional center system. Additionally, as part of the 2013-15 Strategic Planning Process, the Organizational Assessment identified the following internal issues that ARCA will be addressing in this Strategic Plan.

Attachment #12

Department of Developmental Services Withdraws Four Living Units at Sonoma Developmental Center from Federal Certification

The Department of Developmental Services (DDS informed the Centers for Medicaid and Medicare (CMS) today that due to ongoing deficiencies at Sonoma Developmental Center (SDC) Intermediate Care Facility (ICF), the Department is voluntarily withdrawing four living units from federal certification effective immediately. The withdrawal will allow SDC to maintain certification and receive federal funding for the remaining residences. The action is in response to a federal notice in December from CMS that initiated a decertification action for this program at Sonoma.

"The well-being of our residents at Sonoma Developmental Center (SDC) is a top priority and the Department has made critical improvements in the ICF, but significant work still needs to be done," said DDS Director Terri Delgadillo. "The Department is committed to correcting the problems on all ICF living units and will expeditiously pursue recertification of the four residences as the reforms are implemented."

DDS has already made numerous changes in the leadership and culture at SDC to ensure clients receive the level of care that they deserve. Both the Executive Director and the Clinical Director at SDC have been removed. DDS has launched a nationwide search for a new Executive Director. Several other employees have been terminated or disciplined and investigations continue which could result in additional actions. In addition to these steps, DDS has hired additional direct care staff and has established a Corrective Action and Quality Assurance Team, consisting of state and national experts, who have been reviewing the entire SDC system to implement immediate and ongoing improvements.

The Office of Protective Services continues to undergo substantial changes as well, including the appointment of an interim commander on loan from the California Highway Patrol to help foster the necessary staff and skills for an effective law enforcement department.

DDS has engaged an external consultant who is a nationally-recognized expert and trainer in regulatory compliance for Intermediate Care Facility/Developmental Disability programs to conduct onsite monitoring of the changes at the facility and provide immediate feedback to DDS management, facility management and staff regarding areas of concern. Frequent unannounced onsite reviews, focused mock surveys, additional reporting requirements, and the provision of technical assistance and training are also key components of the plan of correction.

Delgadillo said DDS will continue to work with state and federal partners on long-term solutions to regain certification. "We will continue to work with families, the Legislature, staff, and their union representatives on further actions that will be taken to ensure that residents are receiving the care they deserve."

Attachment #13

Omar Noorzad - Fwd: California Watch Panel in Sonoma on 1/30/13

From: Omar Noorzad
To: Directors Team Directors Team
Date: 1/24/2013 2:42 PM
Subject: Fwd: California Watch Panel in Sonoma on 1/30/13

I'll be in Sacramento on Wednesday for a meeting of the ARCA Exec. Comm. with Terri Delgadillo on Thursday morning to address issues between ARCA and DDS. I will most likely also attend this event below as it could set the tone for the closure of Sonoma as well as the remaining DCs save Porterville. FYI, I am taking a personal day on Tue to attend to a family matter. Hence, I will be away from the office Tue-Thur of next week. Thanx

Omar

>>> Amy Westling <AWestling@arcanet.org> 1/22/2013 09:57 AM >>>
Per our discussion at Friday's Board of Directors meeting, following is information regarding the California Watch session that will be held in Sonoma on January 30, 2013 regarding the future of California's developmental centers.

Join us for a panel discussion highlighting the work of reporter Ryan Gabrielson.

Is this email not displaying correctly? View it in your browser.

CALIFORNIA WATCH

Join us in Sonoma for a panel discussion on the future of developmental centers in California

Co-presented by the Sonoma Index-Tribune

Wednesday, Jan. 30 at 6p.m.

This event is free, but space is limited and registration is required.

RSVP here

On Dec. 12, the state Department of Public Health announced that the Sonoma Developmental Center, California's largest board-and-care facility for the severely disabled, would lose its primary license to operate, depriving the center of millions of dollars in federal support. The sanction came after an investigation by California Watch revealed the center's management and police force had failed to adequately investigate significant evidence of patient abuse.

Patients at the center are among the state's most vulnerable, suffering from cerebral palsy, severe autism and other mental, intellectual and physical disabilities. Additionally, the center employs more than 1,000 people, many of them Sonoma residents.

What does this new development mean for the city of

Sonoma, the developmental center and the people who live in surrounding communities?

Highlighting the work of California Watch reporter Ryan Gabrielson, we will also feature a panel discussion with community members and experts in the field moderated by Phil Bronstein, executive chairman of the Center for Investigative Reporting.

When: Wednesday Jan. 30 at 6 p.m.

Where: Ramekins: 450 W. Spain St., Sonoma

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