DEPARTMENT OF DEVELOPMENTAL SERVICES
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DATE: **July 12, 2013**

TO: **REGIONAL CENTER DIRECTORS AND BOARD PRESIDENTS**

SUBJECT: **JUNE 2013 TRAILER BILL LANGUAGE AFFECTING REGIONAL CENTERS**

The purpose of this correspondence is to transmit a summary of the recently enacted Developmental Services Budget Trailer Bill, AB 89 (Chapter 25, Statutes of 2013), and other statutory changes that directly affect regional centers or the developmental services system. AB 89 contains an urgency clause, and was therefore effective immediately upon enactment, June 27, 2013. Changes effected by AB 89 include the following:

- Establishment of a closure date for Lanterman Developmental Center (LDC).
- Deletion of the time limitation on use of Department of Developmental Services (Department) employees under the Community State Staff Program.
- Further restrictions on the use of Institutions for Mental Disease (IMDs) and a requirement that regional centers complete a comprehensive assessment for any consumer residing in an IMD as of July 1, 2013.
- Specification of the conditions under which regional centers may fund IMD services for consumers under 21 years of age.
- Requirements that notification is provided to the Clients' Rights Advocate (CRA) of the appropriate regional center when:
    - A consumer is admitted to an IMD;
    - There is a request for extended stay of a consumer under 21 years of age in an IMD;
    - A consumer files a petition for writ of habeas corpus; or,
    - The comprehensive assessment results for a consumer residing in a developmental center will be discussed at an individual program planning (IPP) meeting.
- Authorization for the CRA of the appropriate regional center to participate in IPP meetings related to actions the CRA is notified of, as specified above, unless a consumer objects, and to attend any hearing related to a petition for writ of habeas corpus.
- When a consumer residing in a developmental center or IMD files a petition for writ of habeas corpus, a requirement that regional centers submit to specified entities a copy of the consumer's most recent comprehensive assessment within two days of the regional center receiving notice of the filing.

- Authorization for regional centers to pay copayments and coinsurance associated with health care service plans and health insurance policies, under specified conditions.
- Requirements that regional centers notify the Department of public meetings regarding disparities data 30 days prior to the date of the meeting; post a notice on its Internet Web site 30 days prior to the date of the meeting; and, send the notice to individual stakeholders and groups representing underserved communities in a timely manner.
- Elimination of the sunset date for the Annual Family Program Fee.

The following changes in law did not require Trailer Bill language (TBL), since each provision contained a sunset date.

- Restoration of the 1.25 percent regional center Operations and service provider payment reductions.
- Elimination of statutory provisions that:
    - Authorized regional centers to modify personnel requirements, functions, or qualifications, or staff training requirements for providers, except for licensed or certified residential providers, whose payments were reduced by 1.25 percent.
    - Relieved vendored residential service providers, whose payments were reduced by 1.25 percent, from requirements to complete quarterly and semiannual progress reports pursuant to Title 17, California Code of Regulations (Cal. Code Regs., tit. 17) section 56026(b) and (c).
    - Suspended requirements described in Cal. Code Regs., tit. 17 sections 56732 and 56800, that community-based day programs and in-home respite agencies conduct annual reviews and submit written reports to vendoring regional centers, user regional centers, and the Department.
- Reinstatement of statutory provisions requiring that:
    - Regional centers maintain specific service coordinator caseload ratios for consumers who have not moved from the developmental centers to the community since April 14, 1993, are three years of age and older, and are not enrolled in the Home and Community-Based Services (HCBS) Waiver program.
    - Contracts between the Department and regional centers require the regional center to have or contract for specialized expertise.

While this correspondence provides a high level summary of AB 89, a complete and thorough review of the bill is imperative for regional centers' statutory compliance.[1] Clarifying information regarding implementation of AB 89 is included in several areas below. Regional centers should continue to educate their communities regarding these legislative changes.

[1] Go to the June 11, 2013, amended version of the bill at http://leginfo.legislature.ca.gov to see the changes in statute made by AB 89.

LDC Closure

Section 13: AB 89 requires the Department to complete closure of LDC by the fall of 2014, and no later than December 31, 2014. The closure shall be completed pursuant to the plan developed in accordance with Section 4474.1 of the Welfare and Institutions Code[2].

Section 2: Section 4474.2 was amended to eliminate the time limitation (i.e., two years following the transfer of the last resident from LDC) on use of Department employees, working at LDC, to work in the community with former LDC residents while remaining state employees (also known as the "Community State Staff Program").

Comprehensive Assessments of Developmental Center Residents

Section 1: Section 4418.25 was amended, specifying that comprehensive assessments of developmental center residents conducted pursuant to this section shall *identify the types of community-based services and supports available to the consumer that would enable the consumer to move to a community setting*. Necessary services and supports not currently available in the community setting shall be considered for development pursuant to regional center community placement plans and associated funding.

Additionally, Section 4418.25 was amended, requiring regional centers to provide, to the extent appropriate, when updating a comprehensive assessment (i.e., annually, as part of the IPP process), relevant information from the statewide specialized resource service (SSRS) established pursuant to Section 4418.25(b). The CRA for the regional center shall be notified of each IPP meeting that includes discussion of the assessment results and may participate in the IPP meeting unless the consumer objects on his or her own behalf.

Utilization of IMDs

Section 5: Section 4648 was amended to specify that, effective July 1, 2012, regional centers shall not place a consumer in an IMD for which federal Medicaid funding is not available unless there is an emergency circumstance, as outlined in Section 4648(a)(9)(C)(ii). Effective July 1, 2013, the prohibition on placement in, and purchase of new residential services from, an IMD applies regardless of the availability of federal funding. Prior to any emergency IMD admission, regional centers shall consider, to the extent feasible, resource options identified by the SSRS. The CRA for the regional center shall be notified of each emergency admission and IPP meeting pursuant to Section 4648(a)(9)(C), and may participate in all IPP meetings unless the consumer objects on his or her own behalf.

[2] All citations are to the Welfare and Institutions Code unless otherwise stated.

Regional centers shall complete a comprehensive assessment for any consumer residing in an IMD as of July 1, 2013, prior to the individual's next scheduled IPP meeting.

Section 6: Section 4648.01 was added, authorizing a consumer who is under 21 years of age to be placed in an IMD for a period that exceeds 180 days if all of the following conditions are satisfied prior to the end of the 180-day period or, if the consumer was placed in the institution prior to July 1, 2013, if the conditions are satisfied within 30 days of the consumer's placement reaching 180 days or by July 31, 2013, whichever is later:

1. The regional center has conducted an updated comprehensive assessment and based on that assessment the IPP team determines that due to the nature and extent of the consumer's disability, he or she requires the services provided at the IMD and there is no less restrictive setting currently available for the consumer.
2. The IPP team has developed a plan that identifies the specific services and supports necessary to transition the consumer into the community, and the plan includes a timeline to obtain or develop those services and supports.

A consumer described in Section 4648.01 shall not be placed in an IMD for a period that exceeds one year unless the regional center demonstrates significant progress toward implementing the plan to transition the consumer into the community, and extraordinary circumstances that are beyond the regional center's control have prevented the regional center from obtaining necessary services and supports within the timeline established in the plan. In this case, the regional center may request, and the Department may approve, an additional extension of the placement for a period not to exceed 30 days. The CRA for the regional center shall be notified of any proposed extension and the IPP meeting to consider the extension, and may participate in the IPP meeting unless the consumer objects on his or her own behalf.

Section 4648.01 requires the Department and regional centers to work together to identify services and supports needed to serve individuals under 21 years of age with both developmental and mental health disabilities, facilitate the development of a community-based statewide network of crisis stabilization resources for children, and, if appropriate, target the use of community placement plan funds for these consumers. Section 4648.01 shall become inoperative on July 1, 2014, and as of January 1, 2015, is repealed, unless a later enacted statute that is enacted before January 1, 2015, deletes or extends the dates on which it comes inoperative and is repealed.

Implementation: The Department will work with the Association of Regional Center Agencies (ARCA) Community Placement Plan Committee and Difficult to Serve Task Force in fulfillment of this statutory requirement. When purchasing IMD and mental

health rehabilitation center services, regional centers are required to adhere to the timelines contained in AB 1472 (Chapter 25, Statutes of 2012). In correspondence dated March 1, 2013, the Department provided guidance to regional centers regarding the statutory timelines and requirements when purchasing services from facilities ineligible for federal financial participation, which may only occur under emergency circumstances.

Writ of Habeas Corpus

Section 9: Section 4801 was amended, requiring the clerk of the appropriate superior court to transmit to the CRA of the appropriate regional center, a copy of any petition for writ of habeas corpus filed on behalf of a consumer pursuant to Section 4800. The petition shall be transmitted at the time it is filed together with notification regarding the time and place of an evidentiary hearing in the matter. The CRA may attend any hearing pursuant to this section to assist in protecting the person's rights.

If the person seeking release, or for whom release is sought, resides in a developmental center or IMD, the regional center director or designee shall submit to the court, the person's attorney, and all parties required to be noticed pursuant to Section 4801(b), a copy of the most recent completed assessment required by Section 4418.25(c), 4418.7(e), or 4648(a)(9). The regional center shall submit copies of these assessments within two working days of receiving the notice required pursuant to Section 4801(b).

Section 10: Section 4806 was added, specifying that Sections 4800-4805 (Chapter 10 of Division 4.5) shall be construed in a manner that affords the adult requesting release all rights under Section 4502, including the right to treatment and habilitation services and supports in the least restrictive environment, and the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.), including the right to receive services in the most integrated setting appropriate.

Copayments and Coinsurance Associated with Health Care Service Plans and Health Insurance Policies

Section 7: Section 4659.1 was added, authorizing regional centers to, when necessary to ensure that a consumer receives a service or support pursuant to his or her IPP or individualized family service plan (IFSP), pay any applicable copayment or coinsurance associated with the service or support for which a parent, guardian, or caregiver is responsible if all of the following conditions are met:

1. The service or support is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent, guardian, or caregiver.
2. The consumer is covered by his or her parent's, guardian's, or caregiver's health care service plan or health insurance policy.
3. The family has an annual gross income that does not exceed 400 percent of the federal poverty level.

4. There is no other third party having liability for the cost of the service or support, as provided in Section 4659(a) and Article 2.6 (commencing with Section 4659.10).

For consumers 18 years of age or older, regional centers may, when necessary to ensure that a consumer receives a service or support pursuant to his or her IPP, pay any applicable copayment or coinsurance associated with the service or support for which a consumer is responsible if the following conditions are met:

1. The service or support is paid for, in whole or in part, by the consumer's health care service plan or health insurance policy.
2. The consumer has an annual gross income that does not exceed 400 percent of the federal poverty level.
3. There is no other third party having liability for the cost of the service or support, as provided in Section 4659(a) and Article 2.6 (commencing with Section 4659.10).

Regional centers may pay a copayment or coinsurance for a service or support provided pursuant to a consumer's IPP or IFSP if the family's or consumer's income exceeds 400 percent of the federal poverty level, the service or support is necessary to successfully maintain the child at home or the adult consumer in the least-restrictive setting, and the parents or consumer demonstrate one or more of the following:

1. The existence of an extraordinary event that impacts the ability of the parent, guardian, or caregiver to meet the care and supervision needs of the child or impacts the ability of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy, to pay the copayment or coinsurance.
2. The existence of catastrophic loss that temporarily limits the ability of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy, to pay and creates a direct economic impact on the family or adult consumer. For purposes of this paragraph, catastrophic loss may include, but is not limited to, natural disasters and accidents involving major injuries to an immediate family member.
3. Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

The parent, guardian, or caregiver of a consumer or an adult consumer with a health care service plan or health insurance policy shall self-certify the family's gross annual income to the regional center by providing copies of W-2 Wage Earners Statements, payroll stubs, a copy of the prior year's state income tax return, or other documents and proof of other income. The parent, guardian, or caregiver of a consumer or an adult consumer with a health care service plan or health insurance policy is responsible for notifying the regional center when a change in income occurs that would result in a change in eligibility for coverage of the health care service plan or health insurance

policy copayments or coinsurance. Documentation submitted pursuant to this section shall be considered records obtained in the course of providing intake, assessment, and services and shall be confidential pursuant to Section 4514.

This section shall not be implemented in a manner that is inconsistent with the requirements of Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1431 et seq.).

Note: Regional centers shall not pay health care service plan or health insurance policy deductibles.

Implementation: Regional centers must ensure that purchases for health insurance copayments or coinsurance are authorized only if the family (or adult consumer) either 1) has an annual gross income that does not exceed 400 percent of the federal poverty level or 2) demonstrates the existence of an extraordinary event, catastrophic loss or significant unreimbursed medical costs as defined. Compliance with this section of TBL will be monitored through the Department's fiscal audits of regional centers.

For consumers 18 years of age or older, if the consumer is either the health insurance policy holder or identified as eligible under a policy held by another, purchases for co-payments or coinsurance may be authorized if the consumer meets either the income or other criteria.

Section 4: Section 4519.6 was added, requiring the Department and regional centers to annually collaborate to determine the most appropriate methods to collect and compile meaningful data in a uniform manner, as specified in Section 4519.5, related to the payment of copayments and coinsurance by each regional center.

Implementation: Based on an informal survey of regional centers conducted by ARCA and discussion with a number of regional center representatives, it was apparent that the use of service sub codes was the most appropriate method to identify purchases for copayment or coinsurance. However, a uniform method, which could be applied statewide, does not currently exist. Therefore, regional centers must use the following service sub codes for copayment or coinsurance.

Copayments: sub code must begin with 'ICP'
Coinsurance: sub code must begin with 'ICI'

Additionally, to ensure purchases are eligible for federal reimbursement, copayments and coinsurance purchases must be made using the service code appropriate for the type of service/provider. For example, a copayment for a service provided by a Behavior Analyst must be made using service code 612 and a sub code that begins with 'ICP'. Effective July 1, 2013, all copayment and coinsurance purchases must use these service/sub code combinations.

Disparities Data – Notification of Public Meetings

Section 3: Section 4519.5(e) was amended, requiring regional centers to inform the Department of public meetings regarding disparities data, scheduled pursuant to this section[3], 30 days prior to the date of the meeting. Additionally, regional centers shall post a meeting notice on its Internet Web site 30 days prior to the meeting and send the notice to individual stakeholders and groups representing underserved communities in a timely manner. The Department is required to post notice of any regional center stakeholder meetings on its Internet Web site.

Implementation: Since regional centers are required to post meeting notices on their Internet Web sites 30 days prior to the meeting, regional centers may, at that time, provide the Department with a link to their Internet Web site posting in fulfillment of this requirement.

Annual Family Program Fee

Section 8: Section 4785 was amended, lifting the sunset date for the Annual Family Program Fee.

Implementation: In FY 2013-14, the Department will work with ARCA and regional centers to resolve issues associated with implementation of the Annual Family Program Fee.

Technical Changes Clarifying Court Ordered Commitments

Sections 11 and 12: Sections 6500 and 6509 were amended to clarify that a person with a developmental disability *may* be committed to the Department for residential placement (e.g., a licensed community care facility or health facility) other than in a developmental center or state-operated community facility if he or she is found to be a danger to himself, herself, or others. Any order of commitment for residential placement other than in a state developmental center or state-operated community facility [made pursuant to Section 6500(b)(1)] shall expire automatically one year after the order of commitment is made. Subsequent petitions for additional periods of commitment may be filed by any party enumerated in Section 6502. In the event subsequent petitions are filed, the procedures followed shall be the same as with the initial petition for commitment.

Developmental Centers Master Plan

Section 14: The California Health and Human Services Agency (Agency) shall, on or before November 15, 2013, submit to the appropriate policy and fiscal committees of the Legislature a master plan for the future of developmental centers. In the preparation of this plan, Agency shall consult with a cross-section of consumers, family members, regional centers, consumer advocates, community service providers, organized labor, the Department, and representatives of the Legislature.

[3] Section 4519.5(e) requires regional centers to meet with stakeholders in a public meeting within three months of compiling the data with the Department.

Agency shall, on or before January 10, 2014, submit to the appropriate policy and fiscal committees of the Legislature a report regarding Agency's plans to address:

- The service needs of all developmental center residents;
- The fiscal and budget implications of the declining developmental center population and the aging infrastructure, staffing, and resource constraints;
- The availability of community resources to meet the specialized needs of residents now living in the developmental centers;
- A timeline for future closures; and,
- The statutory and regulatory changes that may be needed to ensure the delivery of cost-effective, integrated, quality services for this population.

Additional Statutory Changes

The following changes in law did not require TBL, since each provision contained a sunset date.

Restoration of the 1.25 Percent Operations & Purchase of Service Funding Reduction

The Governor's Fiscal Year (FY) 2013-14 Budget contains funding to restore the 1.25 percent regional center Operations and service provider payment reductions.

Caseload Ratios & Regional Center Expertise

Section 4640.6 contained provisions, which sunsetted on June 30, 2013. Section 4640.6(j), states, "From July 1, 2010, until June 30, 2013, the following shall not apply:

- The service coordinator–to–consumer ratio requirements of paragraph (1), and subparagraph (C) of paragraph (3), of subdivision (c)…"

  Therefore, the following caseload ratio requirements resumed, effective July 1, 2013:
  - An average service coordinator-to-consumer ratio of 1 to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.
  - All consumers who have not moved from the developmental centers to the community since April 14, 1993, and who are not described in subparagraph (A), an average service coordinator–to–consumer ratio of 1 to 66. [The individuals described in subparagraph (A), are all consumers three years of age and younger and consumers enrolled in the HCBS Waiver program for persons with developmental disabilities.]

- …The requirements of paragraphs (1) to (6), inclusive, of subdivision (g)." This reinstated statutory provision requires that contracts between the Department and regional centers shall require the regional center to have, or contract for, all of the following areas:
    (1) Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.
    (2) Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.
    (3) Family support expertise to assist the regional center in maximizing the effectiveness of support and services provided to families.
    (4) Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supportive living arrangements.
    (5) Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.
    (6) Quality assurance expertise, to assist the regional center to provide the necessary coordination and cooperation with the area board in conducting quality–of–life assessments and coordinating the regional center quality assurance efforts.

<u>Temporary Service Provider Relief</u>
Section 4791 contained a provision which sunsetted on June 30, 2013. This section states, "Notwithstanding any other provision of law or regulation, from July 1, 2010, until June 30, 2013, regional centers may temporarily modify personnel requirements, functions, or qualifications, or staff training requirements for providers, except for licensed or certified residential providers, whose payments are reduced by 1.25 percent pursuant to the amendments to Section 10 of Chapter 13 of the Third Extraordinary Session of the Statutes of 2009, as amended by the act amending this section…

…(d) Notwithstanding any other provision of law or regulation, the department shall suspend, from July 1, 2010, until June 30, 2013, the requirements described in Sections 56732 and 56800 of Title 17 of the California Code of Regulations requiring community–based day programs and in–home respite agencies to conduct annual reviews and to submit written reports to vendoring regional centers, user regional centers, and the department.
(e) Notwithstanding any other provision of law or regulation, from July 1, 2010, until June 30, 2013, a residential service provider, vendored by a regional center and whose payment is reduced by 1.25 percent pursuant to the amendments to Section 10 of Chapter 13 of the Third Extraordinary Session of the Statutes of 2009, as amended by the act amending this section, shall not be required to complete quarterly and

semiannual progress reports required in subdivisions (b) and (c) of Section 56026 of Title 17 of the California Code of Regulations. During program review, the provider shall inform the regional center case manager of the consumer's progress and any barrier to the implementation of the individual program plan for each consumer residing in the residence."

If you have any questions regarding this correspondence, please contact Brian Winfield, at (916) 654-1569.

Sincerely,

Original Signed by

NANCY BARGMANN
Deputy Director
Community Services Division

cc: Eileen Richey, ARCA
Mark Hutchinson, DDS