SUBCOMMITTEE 3
FINAL ACTION REPORT

INCLUDING INTRODUCTION TO FINAL ACTION REPORT, TRAILER BILL LIST AND GOVERNOR'S VETOES AND SIGNING MESSAGES

Senate Budget and Fiscal Review Committee

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is proceeding through the Legislature to establish a Medi-Cal Managed Care Plan tax which would provide support to the Healthy Families Program, as well as the Medi-Cal Program. This pending legislation would also provide adjustments to the premiums paid by families for enrollment of their children, as well as other cost-saving adjustments.

In addition, as proposed by the Governor, payments made to certified application assistors to facilitate enrollment of children into the HFP were eliminated for a reduction of $2.7 million (GF).

- **Access for Infants and Mothers (AIM) Program.** Adopted the Governor's May Revision to cap new enrollment into AIM as of January 1, 2010, due to a reduction in the transfer from the Cigarette and Tobacco Surtax Revenues (i.e., Proposition 99 Funds) to the Perinatal Insurance Fund. The reduction of $33.4 million results in an annual enrollment decrease of 56 percent or 5,900 pregnant women.

4300 Department of Developmental Services

Summary of Reduction. In January, the Governor proposed to reduce the state's support for community-based services provided through the Regional Centers by $334 million (GF). In lieu of the Administration's proposal, the Legislature enacted a $100 million (GF) reduction as part of the February budget package and adopted trailer bill language to require the DDS to submit a plan to the Legislature to achieve this reduction. A key aspect of the legislation was to direct the DDS to use a comprehensive "stakeholder process" to include statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations, to craft the components of the plan.

At May Revise, with the economy still soft and statewide voter rejection of $6 billion in various budget solutions, the additional $224 million (GF) reduction as proposed by the Governor was enacted as part of the budget revision in July. While members of the stakeholder process may not support the budget reduction, the final package reflects the valuable input of the workgroup.

Each of the adjustments to achieve the $334 million (GF) reduction are discussed below. It should be noted that these adjustments do not change the Individualized Program Plan process, nor do they change existing appeal rights and processes which are available to clients and their families.

- **New Federal Funds to Offset General Fund Expenditures.** Identified a total of $79.6 million in new federal funds, to backfill for General Fund support, is assumed through five actions as follows:
    - Receipt of $60 million is assumed through an amendment to the state's Medi-Cal State Plan (i.e., a 1915(i) amendment) which will enable California to receive federal funds for services to DDS clients who are enrolled in Medi-Cal but are not eligible for the DDS' Home and Community-Based Waiver.

- Receipt of $13 million is assumed by adding certain services, such as day care, to DDS' existing Home and Community-Based Waiver.
- Receipt of $4.6 million by having the DDS become an Organized Health Care Delivery System which relates to Intermediate Care Facilities for the Developmentally Disabled (ICF-DD facilities) and the provision of certain services, such as transportation.
- Receipt of $2 million by having 30 existing residents at Porterville Developmental Center entered into a specialized treatment area where their services will be eligible for federal financial participation.
- Enactment of legislation which directs Regional Centers to not newly vendor any licensed Community Care Facilities (CCFs) with a capacity of 16 or more beds which do not qualify for federal financial participation commencing as of July 1, 2012.

- **Transportation Reform.** Reduced by $16.9 million (GF) from this service category by requiring Regional Center's to pursue lower cost transportation services as follows:
  - If a client can use public transportation, they will be assisted to do so, rather than purchase special transportation;
  - While still meeting the consumer's need, the least expensive transportation option will be used;
  - Regional Centers will purchase services near the client's home to save transportation costs when such service meets the client's needs as identified on their Individual Program Plan; and
  - When feasible, families will provide transportation for their children.
- **Establishment of General Standards for Authorizing Services.** Reduced by a total of $45.9 million (GF) through a series of changes which pertain to the purchase of services as follows:
  - The Lanterman Act requires Regional Centers to utilize "generic services", such as Medi-Cal and In-Home Supportive Services, prior to purchasing a specialized service. Now if a client or family chooses not to access available generic services as identified on an Individual Program Plan, Regional Centers will not be able to pay for the service.
  - Medical and dental services covered by generic services, health plans or private insurance will not be purchased by Regional Centers for applicable clients aged three and over without proof of denial from the insurance provider. Services can be provided pending approval, initiation or denial of service.
  - Regional Centers shall not purchase experimental treatments, therapeutic services or devices that have not been clinically determined or scientifically proven to be effective or safe.

- Regional Centers will provide information to clients or applicable representative about the type and costs of services provided each year to the consumer.
- The cost of providing services by different service vendors, if available, shall be reviewed and the least costly vendor who is able to meet the consumer's needs as identified on the IPP shall be selected.

- **Holiday Schedule.** Reduced by $16.3 million (GF) by standardizing the holiday schedule for day programs, look-alike day programs and work activity programs and increased the total number of holidays to 14. These programs will now have the same 14 holidays. The statute does provide flexibility to the Department of Developmental Services to make adjustments to this schedule when applicable.
- **Behavioral Services.** Reduced by $19.3 million (GF) and established specific standards for Regional Centers to purchase behavioral services. Key aspects of these standards are as follows:
  - Regional Centers can purchase Applied Behavior Analysis or Intensive Behavior Intervention services if the service provider uses evidence-based practices and the services promote positive social behaviors and help address issues with learning and social interactions.
  - Parents of children receiving these services must participate, as specified, in the established intervention plan.
  - These services may not be used for purposes of providing respite, day care, or school services, or solely as emergency crisis services.
  - Regional Centers will discontinue purchasing services once a client's treatment goals as identified in their IPP are met. The IPP team must review progress regularly and change the service if it is not effective.
  - Regional Centers will evaluate these services for each client receiving them at least every six months.
- **Group Training for Parents on Behavior Intervention Techniques.** Saved $6.4 million (GF) by requiring Regional Centers to consider, based on the IPP, proving group training to parents in lieu of proving some or all of the in-home parent training component of the behavior intervention services.
- **Use of Generic Service—In Home Supportive Services.** Required Supportive Living Providers to assist clients to obtain In Home Supportive Services within five days of moving into supported living. While the client is waiting for IHSS services, the Supported Living Provider will be paid the IHSS rate for IHSS type services provided to the consumer. This does not change the IPP process.

- **Supported Living Services.** Reduced by $6.9 million (GF) expenditures for Supported Living Services through the following actions:
    - Regional Centers will strive to have clients who share a home use the same Supported Living Services provider to be more cost effective as long as it meets the clients' needs as identified.
    - Regional Center's will no longer pay a client's rent unless needed to implement a client's IPP in specified limited and unique circumstances.
    - Administrative costs for Supported Living Services must be reasonable and the rates of payment for services must be cost effective as specified.
- **Custom Endeavors Option.** Reduced by $12.7 million (GF) by requiring existing Day Programs and work activity programs to offer a new "custom endeavor option" as a component of their current program design. This option would be provided based upon an IPP. The Custom Endeavors Option is less costly than Day Programs and work activity programs.
- **New Service for Seniors.** Reduced by $1 million (GF) by requiring existing Day Programs to offer a senior component to their current program design for aging consumers who desire a less intensive Day Program structure. This option would be based upon an IPP.
- **Utilization of Neighborhood Preschools.** Recognized savings of $8.9 million (GF) by using local neighborhood preschools in lieu of segregated infant development programs when applicable with the Regional Centers providing necessary supports.
- **Use of Private Insurance—Under 3 Years of Age.** Reduced by $6.5 million (GF) by requiring parents of children under 3, where applicable, to ask their private insurance or health care service plan to pay for medical services covered by the insurance or health plan. Intake and assessment services provided by Regional Centers will still remain free of charge.
- **Early Start Program Changes.** A total of $35 million (GF) was reduced from this program through a series of eligibility and services changes as follows:
    - **Eligibility.**
        1. Toddlers aged 24 months or greater with a delay currently can enter the program with a delay of 33 percent or greater in or of the five domains (i.e., cognitive, self-help, physical, communication and social-emotional). Beginning July 1, 2009, they will need to have a delay of 50 percent or greater in one domain or 33 percent or greater in two domains.
        2. As of October 1, 2009, infants and toddlers who are "at risk" will no longer be eligible for the Early Start Program. However, these infants and toddlers will be eligible for services in a new prevention program.

- **Services.**

  1. Effective October 1, 2009, discontinue provision of services in the Early Start Program that are not required by the federal government, with the exception of durable medical equipment. The services not to be included are child care, diapers, dentistry, interpreters, translators, genetic counseling, music therapy, and respite services not related to the developmental delay of the infant or toddler.

  2. As of July 1, 2009, families will be required to use their private insurance for medical services. Regional Centers will continue to pay for medical services that are required for the infant or toddler for those without insurance or for those services insurance does not cover.

- **Children's Services—Governor's Veto. The Governor vetoed $50 million (GF) from the Regional Centers for services provided to infants, toddlers, and children from birth to five years of age.** The Governor contends that the First Five Commission has funds to provide to the Regional Centers for this purpose; however at this time, no action has been taken by the Administration or the Commission to obtain or provide this funding to the DDS for this purpose.

- **In-Home Respite Agency Worker Duties.** Recognized a reduction of $3 million (GF) by allowing respite workers to assist clients with colostomies, catheters, and gastrostomies, consistent with the abilities of trained program staff. The respite worker must be trained by a licensed professional and will receive an increase in compensation for the time performing these duties.

- **Wellness Projects**. Suspended the Wellness projects and physician training programs for a reduction of $1.3 million (GF).

- **Triennial Quality Assurance Reviews.** Eliminated these reviews conducted by Regional Centers for a savings of $1 million (GF).

- **Reduction to Regional Center Operations.** A total of $10.5 million (GF) was reduced from Regional Center Operations allocation directly. Of this amount, $3.5 million pertains to one-time only costs and the remaining $7 million pertains to case management and related expenditures.

- **Reduction to Developmental Centers.** In addition to employee furloughs and staff reductions, a total of $25.2 million (GF) was reduced from the state-operated Developmental Centers and Community Facilities by taking the following actions:

  - Sierra Vista Community Facility will be closed effective as of December 2009 and the residents will relocate to living options based upon their needs for a savings of $2 million (GF).

  - Elimination of about $23 million (GF) by deleting certain capital outlay projects.

- **Parental Fee Program.** Obtained savings of $900,000 (GF) by increasing the fee paid by parents of children under the age of 18 living in any out-of-home care arrangement (such as a community care facility). These fees had not been updated since 1989, except for an increase in the maximum fee amount in 2003. Parents with income below the current federal poverty level will not be assessed a fee. The fee increase for the maximum fee would increase from $662 to $1,875 per month for the highest income families.

- **Individual Choice Budget.** ABX4 9 provided a framework for a new service delivery model for the DDS, in consultation with stakeholders, to develop an "individual choice budget". This new model will provide individuals with resources to obtain quality services and supports within a defined budget, while providing choice and flexibility that, in total, saves money in purchase of services expenditures. At such time as this model is implemented and is deemed by the DDS to be achieving specific levels of savings, some or all of the cost saving strategies in certain areas will sunset.

- **Respite Program—Temporary Service Standards Pending Individual Choice Budget.** Reduced by $4.8 million (GF) by implementing standards to be used by Regional Centers in authorizing respite services as follows:

    - Regional Centers may purchase respite services when the needs of a client are greater than that of an individual of the same age without developmental disabilities. Exemptions to this rule can be provided under certain circumstances.

    - Consistent with the need for respite services established in an IPP, no more than 90 hours of in-home respite services in a three-month period, or no more than 21 days of out-of-home respite services in a fiscal year, may be purchased by a Regional Center. Exemptions to this rule can be provided under certain circumstances.

    - Day care services cannot be used in-lieu of respite services.

  These respite program standards will be lifted upon certification of the Director of the DDS that the Individual Choice Budget has been implemented as specified.

- **Temporarily Suspend Certain Services.** Reduced by $27.4 million (GF) by temporarily suspending certain services pending implementation of the Individual Choice Budget model. The services to be temporarily suspended include: camping services; educational services for minor, school-aged children, non-medical therapies (such as art and dance); and social/recreation activities, except those vendored as community-based day programs.

- **Quality Assurance Consolidation.** Reduced by $2 million (GF) to reflect changes pertaining to the quality assurance system used in the community to be implemented in January 2010.

- **Payments to Providers in the Community.** Reduced by three percent, as proposed by the Governor in January, certain payments for services delivered from February 1, 2009 to June 30, 2010. This reduction results in a reduction of $40.4 million ($24.1 million General Fund) in

2008-09 and $100.8 million ($60.2 million General Fund) in 2009-10. This reduction is in addition to the $334 million (GF) that was enacted in July.

- **Medi-Cal Optional Benefits.** Increased funding to provide Medi-Cal Optional Benefits to all individuals with developmental disabilities receiving services through the Regional Centers and are enrolled in Medi-Cal.

4440 Department of Mental Health

Community-Based Services

- **Early and Periodic Screening, Diagnosis and Treatment Program.** Adopted the Governor's May Revision for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program to provide a total of $1.038 billion ($364.8 million General Fund and $674.1 million federal reimbursements). This reflects a net reduction of $14.6 million (GF) as compared to the 2008-09, and includes the following adjustments:
    - Reduced by $53.4 million (GF) to reflect elimination of state support for county programs developed using Mental Health Services Act (MHSA) funds that the department contends increased services within the EPSDT Program.
    - Increased by $226.7 million (GF) to reflect the lack of passage of Proposition 1E and use of MHSA funds.
    - Increased by $19 million (GF) to reflect Emily Q court order requiring the department to implement a nine point plan regarding certain services.
    - Decreased by $4.9 million (GF) to reflect revised caseload and expenditures.
    - Decreased by $122.1 million (GF) to reflect enhanced federal funds under the federal American Recovery & Reinvestment Act.
- **Deferral of Payment for EPSDT.** Deferred $15.8 million (GF) in payments to counties to reimburse prior year cost settlement claims for the EPSDT Program. These claims are to be paid in future years.
- **Mental Health Managed Care Program.** Adopted the Governor's May Revision to reduce by $113.4 million (GF) the Mental Health Managed Care Program. This reduction includes the following adjustments:
    - Reduced by $64 million (GF) the amount of state support to reflect the level of state funding not being claimed under federal financial participation as identified by the department.
    - Provided an increase of $9.2 million ($4.1 million GF) for increases to patient caseload.