



**LEGISLATION AND PUBLIC POLICY  
COMMITTEE (LPPC)  
MEETING NOTICE/AGENDA**

Posted at [www.scdd.ca.gov](http://www.scdd.ca.gov)

**DATE:** October 23, 2014

**TIME:** 10:00 a.m. – 3:00 p.m.

**LOCATION:** State Council on Developmental Disabilities  
1507 21<sup>st</sup> Street, Suite 210  
Sacramento, CA 95811  
916/322-8481

**TELECONFERENCE SITE:**

**Area Board 7**  
2580 North First Street, Suite 240  
San Jose, CA 95131  
(408) 324-2106

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1. <b>CALL TO ORDER</b>	J. Lewis
2. <b>ESTABLISHMENT OF QUORUM</b>	J. Lewis
3. <b>WELCOME AND INTRODUCTIONS</b>	J. Lewis

4. **APPROVAL OF SEPTEMBER 4, 2014 MINUTES** J. Lewis **3**

5. **PUBLIC COMMENTS**

*This item is for members of the public to comment and/or present information to the Council. Each person will be afforded up to three minutes to speak. Written requests, if any, will be considered first. The Council will also provide a public comment period, not to exceed a total of seven minutes, for public comment prior to action on each agenda item.*

6. **LEGISLATION** A. Bacigalupo

A. Final outcome of bills tracked by the LPPC/State Council **11**

B. Legislative priorities for next legislative term **19**

7. **AUTISM BEHAVIORAL SERVICES/Medi-Cal COVERAGE** J. Lewis **41**

8. **SPECIAL EDUCATION** F. Almaliti

9. **TASK FORCE UPDATES** **61**

A. Developmental Center Task Force/Workgroups Updates J. Lewis

B. Developmental Services Task Force C. Lapin

10. **DEPARTMENT OF LABOR/OVERTIME AND MINIMUM WAGE ISSUES** A. Bacigalupo **77**

11. **SENATE BILL 577 EMPLOYMENT PILOT PROGRAMS** V. Smith

12. **NEW CENTER FOR MEDICARE AND MEDICAID RULES** R. Newton **91**

13. **SELF DETERMINATION** C. Lapin

14. **VISION FOR COUNCIL'S FUTURE** All **117**

15. **ADJOURNMENT** J. Lewis

# Legislative and Public Policy Committee Meeting

MINUTES

09/04/2014

SACRAMENTO, CA

<b>MEETING CALLED BY</b>	Janelle Lewis, Chair
<b>TYPE OF MEETING</b>	State Council Committee Meeting
<b>FACILITATOR</b>	Janelle Lewis
<b>NOTE TAKER</b>	Anastasia Bacigalupo
<b>COMMITTEE MEMBER ATTENDEES</b>	Janelle Lewis, Jennifer Allen, Lisa Davidson, Connie Lapin, David Forderer, April Lopez,
<b>COMMITTEE MEMBERS NOT IN ATTENDANCE</b>	Tho Vinh and Feda Almaliti.
<b>SCDD STAFF ATTENDEES</b>	Mark Polit, Bob Phillips, Janet Fernandez, Karim Alipourfard, Anastasia Bacigalupo
<b>PUBLIC</b>	Stacy Sisson

## Agenda Topics

### CALL TO ORDER

<b>CONCLUSIONS</b>	Meeting called to order at 10:07 AM by Ms. Lewis.
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### APPROVAL OF MEETING MINUTES

<b>DISCUSSION</b>	Committee did not receive the May meeting minutes for approval. Committee received the June meeting minutes for approval.		
<b>CONCLUSIONS</b>	Committee tabled approval of May meeting minutes for the October meeting. The committee requested the following edits: David Forder was in attendance and deletions on page 3 (Lewis for Polit under Report on Legislation- discussion and delete second sentence under Report on Parental Fee and Self Determination- discussion). Motion for approval of June meeting minutes made by Mrs. Lapin and seconded by Mr. Forderer. Motion passes and Mrs. Lopez abstains.		
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>	
Approve May meeting minutes.	LPPC Members	10/23/2014	

### PUBLIC COMMENT ON MATTERS NOT ON THE AGENDA

<b>DISCUSSION</b>	No public comment offered.
<b>CONCLUSIONS</b>	No public comment offered.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
None at this time.	N/A	N/A

## MEMBERS REPORTS

<b>DISCUSSION</b>	<p>Mrs. Lapin handed out a flyer about a conference in Los Angeles about Self Determination. She reported that the trip to the developmental center (DC) organized by Mr. Ceragioli was great. She is concerned about the wage issues affecting care providers in the state.</p> <p>Mrs. Davidson reported that the DC trip was excellent and that Area Board 10 has committee that works on Self Determination. Westside Regional Center is starting to educate the public about Self Determination.</p> <p>Mrs. Lopez reported that she and her family just returned from a down syndrome family camp in northern California.</p> <p>Mr. Forderer expressed his concerns about how Assembly Bill 1595 will change Area Board offices throughout the state. He asked for support from committee members to bring up these concerns at the next State Council meeting. He reported that Area Board 7 is doing many presentations about Self Determination in the community.</p> <p>Mrs. Lewis reported that she will be going to a stakeholder meeting later that day regarding Medi-Cal covering behavioral services for people with autism.</p>	
<b>CONCLUSIONS</b>	Committee members and staff asked Mrs. Lopez for information about the camp.	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Share information about the down syndrome camp with committee members and staff.	April Lopez	10/23/2014

## REPORT ON THE STATE BUDGET

<b>DISCUSSION</b>	<p>The committee was provided with information in the LPPC packet and handouts at the meeting about the state budget. Mr. Polit shared that the trailer bills included some important changes to regional center services- restoration of early start eligibility criteria and regional centers now permitted to pay deductibles for autism related services.</p> <p>10% rate increase bills failed (SB 935 and SB 1626). The provider community will have to begin again with the legislative advocacy. Mr. Polit recommended that providers engage DDS, Secretary Dooley and the Governor's office.</p>	
<b>CONCLUSIONS</b>	No action requested by committee members.	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>

N/A

N/A

N/A

### REPORT ON INSURANCE COPAY, AB 2299 AND MEDI-CAL

<b>DISCUSSION</b>	<p>As previously mentioned, regional centers are now permitted to pay deductibles for autism related behavioral services; however, the same conditions apply (annual income is below 400% FPL or extraordinary/catastrophic event).          AB2299 is dead but is likely to be resurrected by the various autism advocacy groups (Autism Speaks, Autism Deserves Equal Treatment).          Medi-Cal will cover autism related services for children and adults up to age 21 who have full scope and emergency Medi-Cal. This coverage should be available within the next couple of weeks. Issues bubbling up are Medi-Cal provider rates are typically significantly lower than the industry standard. This will likely impact provider choice and availability. Another issue is continuity of care- for those families who will have to access Medi-Cal services there are questions as to how the transition will occur.          New CMS rules- the state of California will be submitting a plan to the federal government for new waiver services. Concerns over how the transition to compliance with the new waiver requirements will occur.</p>	
<b>CONCLUSIONS</b>	LPPC members inquired as to how the new CMS rules will impact EPSDT.	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Develop 1 page fact sheet in English/Spanish and in plain language about Medi-Cal coverage of autism behavioral services.	Anastasia Bacigalupo	10/23/2014
Research the impact of the new CMS rules on EPDST.	Anastasia Bacigalupo	10/23/2014

### REPORT ON LEGISLATION

MARK POLIT

<b>DISCUSSION</b>	<p>LPPC members reviewed the handouts provided by Mr. Polit. Mr. Polit asked members to determine which bills they believe the State Council should work towards resurrecting.          Mr. Polit presented to the group on the Military Children with DD Act- as a means to afford military families more access to autism behavioral services where military health insurance plans have been able to avoid state laws covering co-pays and allowing for co-insurance and deductibles to be paid.          LPPC members reviewed the various legislative tracking tools provided by staff- overview by Mr. Polit, print outs from Capitol Track and online chart by Ms. Bacigalupo.</p>	
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<b>CONCLUSIONS</b>	LPPC members requested that they each review dead bills and bring to next meeting their recommendations for bills to be resurrected. LPPC members agreed on reviewing AB 1753, AB 2041, SB 579, AB 2299, AB 1626, SB 1160 and SB 391. Mrs. Davidson motioned that the LPPC recommended that the State Council support the Military Children with DD Act and Ms. Allen seconded the motion. Motion approved- unanimous vote in favor. LPPC members requested that they continue to receive all of the tools for tracking legislation.
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ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Review dead bills and determine which bills the State Council should advocate to be resurrected for the next legislative term.	LPPC Members	10/23/2014
Present recommendation for support of the federal Military Children with DD Act.	Janelle Lewis	09/16/2014

**REPORT ON DEVELOPMENTAL CENTERS TASK FORCE**

<b>DISCUSSION</b>	Task force work group meetings are happening in Fresno (August), Los Angeles (September 3 <sup>rd</sup> /4 <sup>th</sup> ) and Sacramento (October 10 <sup>th</sup> /11 <sup>th</sup> ). Mr. Phillips discussed issues around delayed ingress and secured parameter homes.
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<b>CONCLUSIONS</b>	Mrs. Lewis will attend the Sacramento task force work group meeting. LPPC members asked Mr. Phillips to get clarification on delayed ingress and secured parameter homes.
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ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Attend Sacramento meeting on behalf of LPPC/SCDD.	Janelle Lewis	10/10 & 10/11
Research and provide additional information on delayed ingress and secured parameter homes.	Robert Phillips	10/23/2014

**REPORT ON DEVELOPMENTAL SERVICES TASK FORCE**

<b>DISCUSSION</b>	Mrs. Lapin provided a history of the task force and its new name. She is seeking more representation of parents and consumers on the task force- currently she is the only parent/representative of a consumer. She suggested that there be parents of school aged children and parents of early start children appointed to the task force.
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<b>CONCLUSIONS</b>	LPPC members will encourage community members to seek appointment from Secretary Dooley.
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ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
N/A	N/A	N/A

**SELF DETERMINATION AND FORMATION OF WORKGROUP**

<b>DISCUSSION</b>	Mrs. Lewis told the group that the LPPC cannot form a Self Determination subcommittee all by itself. SCDD's bylaws state that the LPPC would have to get SCDD vote approval. LPPC members requested that Area Board executive directors be invited to join the Self Determination work group.	
<b>CONCLUSIONS</b>	LPPC members asked Mrs. Lewis to discuss this with Ms. Bocanegra (counsel for SCDD).	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Discuss how to create a LPPC workgroup to work on Self Determination.	Janelle Lewis	10/23/2014

**IMPACT OF DOL OVERTIME RULE CHANGE ON SUPPORTED LIVING SERVICES**

<b>DISCUSSION</b>	LPPC members received a presentation from Stacy Sisson, a local provider (Strategies To Empower People- "STEP") representing the California Supported Living Network (CSLN). Ms. Sisson stated that there are several issues with the overtime rule change and how they impact IHSS workers, SLS providers and respite providers. Issues are: (1) not permitting more 8 hours per day and 40 hours per week or the worker is owed overtime. The problem this creates is that the flexibility that consumers and families enjoyed with the care providers is now effectively gone. (2) Agencies cannot afford to pay overtime and are discouraging workers from working more than 8 hours in a day or 40 hours in a week. (3) Passive shifts (overnight shifts) are being counted as a shift for calculating daily hours worked or weekly hours worked. (4) The careprovider's hours are being pooled between their employment with IHSS and the SLS agency. This is called "joint employers" where two or more agencies employ the same person and all of the person's hours worked are counted together. CLSN requested a written request from the Department of Labor (DOL) on these 4 issues. The DOL anticipates responding by October 15 <sup>th</sup> .	
<b>CONCLUSIONS</b>	LPPC members requested that Ms. Sasson provide written materials about the advocacy efforts of CSLN at the federal and state levels. Specifically letters sent to the Department of Labor.	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Follow up with Stacy Sasson and share materials sent with LPPC members.	SCDD Staff	10/23/2014

**PLANNING FOR NEXT MEETING**

<b>DISCUSSION</b>	Agenda items discussed.
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<b>CONCLUSIONS</b>	Agenda items for next meeting: -Review and approval of May meeting minutes -Priorities and Recommendations for SCDD to focus on for the next legislative term.
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<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Develop agenda and materials for next meeting.	Janelle Lewis and SCDD Staff	10/13/2014

**ADJOURNMENT**

<b>CONCLUSIONS</b>	Meeting adjourned at 3:05 pm by Ms. Lewis.
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# LEGISLATION





## LPPC List of Tracked Bills by Outcome October 2014 (2013-2014 Session)

### Assembly Bills- CHAPTERED

#### AB 420

**(Dickinson D) Pupil discipline: suspensions and expulsions: willful defiance.**

**Chapter Number:** 660

**Introduced:** 2/15/2013

**Last Amend:** 8/13/2014

**Status:** 9/27/2014-Chaptered by Secretary of State - Chapter 660, Statutes of 2014.

**Summary:** Would eliminate the authority to suspend a pupil enrolled in kindergarten or any of grades 1 to 3, inclusive, and the authority to recommend for expulsion a pupil enrolled in kindergarten or any of grades 1 to 12, inclusive, for disrupting school activities or otherwise willfully defying the valid authority of those school personnel engaged in the performance of their duties. The bill would make the restrictions inoperative on July 1, 2018.

**Laws:** An act to amend Section 48900 of the Education Code, relating to pupil discipline.

Position :Support

#### AB 1089

**(Calderon, Ian D) Foster care.**

**Chapter Number:** 761

**Introduced:** 2/22/2013

**Last Amend:** 8/4/2014

**Status:** 9/29/2014-Chaptered by Secretary of State - Chapter 761, Statutes of 2014.

**Summary:** Would specify the transfer procedures that would apply when a consumer of regional center services who has an order for foster care, is awaiting foster care placement, or is placed in out-of-home care transfers between regional centers. The bill would establish specific timelines and procedures for making these transfers. By imposing new duties and a higher level of service on county employees, the bill would impose a state-mandated local program.

**Laws:** An act to amend Section 95014 of the Government Code and to amend Section 4643.5 of the Welfare and Institution Code relating to foster care.

Position :Support

#### AB 1595

**(Chesbro D) State Council on Developmental Disabilities.**

**Chapter Number:** 409

**Introduced:** 2/3/2014

**Last Amend:** 8/22/2014

**Status:** 9/18/2014-Chaptered by Secretary of State - Chapter 409, Statutes of 2014.

**Summary:** Would revise the activities the State Council on Developmental Disabilities is authorized to conduct

to include, among other things, encouraging and assisting in the establishment or strengthening of self-advocacy organizations led by individuals with developmental disabilities and appoint an authorized representative for persons with developmental disabilities, as specified. The bill would make additional changes relating to the activities of the council. This bill contains other related provisions and other existing laws.

Position  
Support

**AB 1687**    **(Conway R) Persons with Developmental Disabilities Bill of Rights.**

**Chapter Number:** 178

**Introduced:** 2/13/2014

**Last Amend:** 3/26/2014

**Status:** 7/23/2014-Chaptered by Secretary of State - Chapter 178, Statutes of 2014.

**Summary:** Current law grants specified rights to a person with developmental disabilities who has been admitted or committed to a state hospital, community care facility, or health facility, including the right to have access to individual storage space for private use and a right to see visitors each day. Current law requires a developmental center to immediately report resident deaths and certain serious injuries, including a sexual assault, to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located. This bill would recast those rights as the Persons with Developmental Disabilities Bill of Rights.

Position  
Support

**AB 1806**    **(Bloom D) Pupil Services: homeless children or youth.**

**Chapter Number:** 767

**Introduced:** 2/18/2014

**Status:** 9/29/2014-Chaptered by Secretary of State - Chapter 767, Statutes of 2014.

**Summary:** Would, if an individual with exceptional needs is a homeless child or youth, as defined, and the local educational agency has proposed a change of placement due to an act for which a decision to recommend expulsion is at the discretion of the principal or the district superintendent of schools, require the designated local educational agency liaison for homeless children and youth to be invited to participate in the individualized education program team meeting that makes a manifestation determination, as specified. This bill contains other related provisions and other existing laws.

Position  
Support

**AB 1900**    **(Quirk D) Victims of Sex crimes: testimony: video recording.**

**Chapter Number:** 160

**Introduced:** 2/19/2014

**Last Amend:** 3/27/2014

**Status:** 7/21/2014-Chaptered by Secretary of State - Chapter 160, Statutes of 2014.

**Summary:** Current law provides that when a defendant has been charged with certain sex crimes, including rape and sodomy, and the victim is a person 15 years of age or less or is developmentally disabled as a result of an intellectual disability, when the defendant has been charged with spousal rape or corporal injury resulting in a traumatic condition upon certain persons, or when the defendant is charged with certain sex crimes, including rape and sodomy, that are committed with or upon a person with a disability, the prosecution may apply for an order that the victim's testimony at the preliminary hearing be recorded and preserved on videotape. This bill would allow a court to use any means of video recording to comply with these recording and preservation requirements.

**Laws:** An act to amend Sections 1346, 1346.1, 1347, 1347.5 of the Penal Code relating to testimony.

Position

Watch

**Senate Bills-CHAPTERED**

**SB 577 (Pavley D) Autism and other developmental disabilities: Employment.**

**Chapter Number:** 431

**Introduced:** 2/22/2013

**Last Amend:** 8/21/2014

**Status:** 9/18/2014-Chaptered by Secretary of State - Chapter 431, Statutes of 2014.

**Summary:** Would require the State Department of Developmental Services, contingent upon receiving federal financial participation, to conduct a 4-year demonstration project to determine whether community-based vocational development services will increase employment outcomes for consumers and reduce purchase of service costs for working age adults, as specified. The bill would require the development and semiannual review of a plan, as specified, if community-based vocational development services, as defined, are determined to be a necessary step to achieve a supported employment outcome.

**Laws:** An act to add and repeal Section 4850.3 of the Welfare and Institution Code, relating to developmental disabilities.

Position

Support

**SB 1093 (Liu D) Developmental services: regional centers: culturally and linguistically competent services.**

**Chapter Number:** 402

**Introduced:** 2/19/2014

**Last Amend:** 6/10/2014

**Status:** 9/18/2014-Chaptered by Secretary of State - Chapter 402, Statutes of 2014.

**Summary:** Would require regional centers to provide independent living skills services to an adult consumer, consistent with a consumer's individual program plan, that provide the consumer with functional skills training that enables him or her to acquire or maintain skills to live independently in his or her own home, or to achieve greater independence while living in the home of a parent, family member, or other person. This bill contains other related provisions and other existing laws.

**Laws:** An act to amend Section 4519.5 and 4629 and to add Section 4688.05 to, the Welfare and Institutions Code, relating to developmental services.

Position

Support

**SB 1127 (Torres D) Emergency services: individuals with developmental disabilities and cognitive impairments.**

**Chapter Number:** 440

**Introduced:** 2/19/2014

**Last Amend:** 6/15/2014

**Status:** 9/18/2014-Chaptered by Secretary of State - Chapter 440, Statutes of 2014.

**Summary:** Would include a missing person who is developmentally disabled or cognitively impaired among the persons who may be the subject of a Silver Alert. This bill would also delete the repeal date, thereby extending the operation of these provisions indefinitely.

**LAWS:** An act to amend Section 8594.10 of the Government Code, relating to emergency services.

Position:  
Watch

## Assembly Bills-DEAD

**AB 1335** **(Maienschein R) Sex offenses: disabled victims.**

**Introduced:** 2/22/2013

**Last Amend:** 5/20/2014

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was S. APPR. SUSPENSE FILE on 8/14/2014)

**Summary:** Proposition 83, the Sexual Predator Punishment and Control Act (Jessica's Law), provides that the Legislature may amend the provisions of the act to expand the scope of their application or increase the punishment or penalties by a statute passed by a majority vote of each house. This bill would add the crimes of rape, sexual penetration, sodomy, and oral copulation, perpetrated against a person who is incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, to the above provisions, if the victim is developmentally disabled, as defined.

Position  
Watch

**AB 1626** **(Maienschein R) Developmental services: habilitation.**

**Introduced:** 2/10/2014

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was S. APPR. SUSPENSE FILE on 8/14/2014)

**Summary:** Current law requires providers of individualized or group-supported employment services to be paid at an hourly rate of \$30.82, and requires an interim program provider to be paid a fee of \$360 or \$720, as specified. This bill would increase the hourly rate paid to providers of individualized and group-supported employment services to \$34.24, and increase the fees paid to interim program providers to \$400 and \$800, respectively.

Position  
Support

**AB 2041** **(Jones R) Developmental services: regional centers: behavioral health treatment.**

**Introduced:** 2/20/2014

**Last Amend:** 6/26/2014

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was S. APPR. SUSPENSE FILE on 8/14/2014)

**Summary:** Would require that a regional center classify a vendor as a behavior management consultant or behavior management assistant if the vendor designs or implements evidence-based behavioral health treatment, has a specified amount of experience in designing or implementing that treatment, and meets other licensure and education requirements. The bill would require the department to amend its regulations as necessary to implement the provisions of the bill.

Position: Support

**AB 2057** **(Bonilla D) Pupil assessment: alternate performance assessments.**

**Introduced:** 2/20/2014

**Last Amend:** 8/22/2014

**Status:** 8/31/2014-**Failed Deadline** pursuant to Rule 61(b)(17). (Last location was S. RLS. on 8/25/2014)

**Summary:** Would require the CAASPP to include an alternate performance assessment, as specified, in grades 3 to 8, inclusive, and grade 11 in English language arts and mathematics. The bill would require the CAASPP to include the California Alternate Performance Assessment being administered in grades 5, 8, and 10 in science, until successor assessments for that subject matter are implemented, as specified. Position:

Position: Support

**AB 2299**

**(Nazarian D)** Developmental Services: health insurance copayments, coinsurance, and deductibles.

**Introduced:** 2/21/2014

**Last Amend:** 8/4/2014

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was S. APPR. SUSPENSE FILE on 8/14/2014)

**Summary:** Would authorize a regional center to pay any applicable copayment, coinsurance, or deductible for a service or support required by a consumer's individual program plan if the service or support is paid for by the health care service plan or health insurance policy of the consumer or his or her parent, guardian, or caregiver and, among other things, the family or the person with a health care service plan or health insurance policy, as applicable, has an annual adjusted gross income that does not exceed 400% of the federal poverty level. This bill contains other related provisions and other existing laws.

Position

Support

**AJR 36**

**(Gonzalez D)** Special Minimum Wage Certificate Program.

**Introduced:** 2/19/2014

**Last Amend:** 8/5/2014

**Status:** 8/31/2014-**Failed Deadline** pursuant to Rule 61(b)(17). (Last location was S. THIRD READING on 8/18/2014)

**Summary:** This measure would urge the United States Congress to phase out the use of the Special Minimum Wage Certificate provision and eventually repeal Section 14(c) of the 1938 Fair Labor Standards Act.

Position

Support

**Senate Bills-DEAD**

**SB 231**

**(Correa D)** Bullying: California Bullying Prevention Clearinghouse.

**Introduced:** 2/11/2013

**Last Amend:** 8/5/2013

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2013)

**Summary:** Would enact the Michael Joseph Berry Peer Abuse Prevention and Awareness Act of 2013, pursuant to which the California Bullying Prevention Clearinghouse would be established, to be administered by the State Department of Education. The bill would require the Superintendent of Public Instruction to appoint members to a clearinghouse, California Bullying Prevention Advisory Council which would include individuals who have experience in specified areas, including, among others, hotline telephone services, social media, and behavioral health services. This bill contains other related provisions.

Position : Watch

**SB 391**

**(DeSaulnier D) California Homes and Jobs Act of 2013.**

**Introduced:** 2/20/2013

**Last Amend:** 8/8/2013

**Status:** 8/31/2014-**Failed Deadline** pursuant to Rule 61(b)(17). (Last location was A. APPR. SUSPENSE FILE on 8/30/2013)

**Summary:** Would enact the California Homes and Jobs Act of 2013. The bill would make legislative findings and declarations relating to the need for establishing permanent, ongoing sources of funding dedicated to affordable housing development. The bill would impose a fee, except as provided, of \$75 to be paid at the time of the recording of every real estate instrument, paper, or notice required or permitted by law to be recorded. By imposing new duties on counties with respect to the imposition of the recording fee, the bill would create a state-mandated local program. This bill contains other related provisions and other existing laws.

Position

Support

**SB 579**

**(Berryhill R) Developmental Services: Commission on Oversight Efficiency and Quality Enhancement Models.**

**Introduced:** 2/22/2013

**Last Amend:** 6/11/2014

**Status:** 6/27/2014-**Failed Deadline** pursuant to Rule 61(b)(13). (Last location was A. HUM. S. on 6/11/2014)

**Summary:** Would establish the Commission on Oversight Efficiency and Quality Enhancement Models to investigate methods of implementing a unified and consistent oversight and quality enhancement process that ensures the welfare, community participation, health, and safety of individuals with developmental disabilities who are served in programs licensed by the Community Care Licensing Division of the State Department of Social Services. The bill would require the process to also enhance accountability and quality review processes for the services directly provided by regional centers.

Position

Support

**SB 922**

**(Knight R) Sex Offenses: disabled victims.**

**Introduced:** 1/29/2014

**Last Amend:** 5/7/2014

**Status:** 6/27/2014-**Failed Deadline** pursuant to Rule 61(b)(13). (Last location was A. PUB. S. on 6/24/2014)

**Summary:** Would make specified sex crimes, if committed against a person who has a mental disorder or developmental or physical disability, and the person committing the act knows or reasonably should know that the victim has the disorder or disability, by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury, punishable by imprisonment in the state prison for 9, 11, or 13 years in the case of rape or an act of sodomy, and 8, 10, or 12 years in the case of oral copulation or sexual penetration. By creating new crimes, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

Position : Watch

**SB 935**

**(Leno D) Minimum Wage: annual adjustment.**

**Introduced:** 2/3/2014

**Last Amend:** 5/27/2014

**Status:** 6/27/2014-**Failed Deadline** pursuant to Rule 61(b)(13). (Last location was A. L. & E. on 6/26/2014)

**Summary:** Would increase the minimum wage, on and after January 1, 2015, to not less than \$11 per hour, on and after January 1, 2016, to not less than \$12 per hour, and on and after January 1, 2017, to not less than \$13 per hour. The bill would require the automatic adjustment of the minimum wage annually thereafter, to maintain

employee purchasing power diminished by the rate of inflation during the previous year.

Position

Watch

**SB 1160** **(Beall D) Developmental services: employment.**

**Introduced:** 2/20/2014

**Last Amend:** 8/4/2014

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was A. APPR. on 8/14/2014)

**Summary:** Would require, for group services provided by a regional center, a job coach-to-consumer ratio of not less than 1 to 2 nor more than 1 to 8 where services to a minimum of 2 consumers are funded by the regional center or the Department of Rehabilitation. The bill would recast the definition of "individualized services" to provide, in part, job coaching and other supported employment services that decrease over time, consistent with the consumer's individual program plan and abilities with the goal of achieving stabilization, when possible. This bill contains other related provisions.

Position: Support

**SB 1176** **(Steinberg D) Health care coverage: cost sharing: monitoring.**

**Introduced:** 2/20/2014

**Last Amend:** 6/24/2014

**Status:** 8/31/2014-**Failed Deadline** pursuant to Rule 61(b)(17). (Last location was A. INACTIVE FILE on 8/21/2014)

**Summary:** Would require a health care service plan or health insurer to be responsible for monitoring the accrual of out-of-pocket costs toward the annual out-of-pocket limit. The bill would require a health care service plan or health insurer, for cost sharing attributed to in-network providers, including contracted vendors, that count toward the annual limit on out-of-pocket costs, to be solely responsible for monitoring the accrual of out-of-pocket costs and prohibit the health care service plan or health insurer from requiring the consumer to track or monitor the accumulation of cost sharing for covered essential health benefits attributed to in-network providers, including contracted vendors.

Position: Support

**SB 1396** **(Hancock D) School Climate: multi-tiered intervention and support program.**

**Introduced:** 2/21/2014

**Last Amend:** 4/23/2014

**Status:** 8/15/2014-**Failed Deadline** pursuant to Rule 61(b)(14). (Last location was A. APPR. on 8/14/2014)

**Summary:** Would establish a multi-tiered intervention and support program. The bill, to the extent that one-time funding is made available in the Budget Act of 2014, would require the State Department of Education to apportion funds to a designated county office of education, selected from applicant county offices of education that would be the fiduciary agent for the program. The bill would require the designated county office of education to consult with specified organizations and target the funding towards a statewide professional development effort that would provide training in multi-tiered intervention and support to school personnel. This bill contains other related provisions.

Position: Support

**SB 1** **(Steinberg D) Sustainable Communities Investment Authority.**

**Introduced:** 12/3/2012

**Last Amend:** 9/3/2013

**Status:** 8/31/2014-**Failed Deadline** pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 9/12/2013)

**Summary:** Would authorize certain public entities of a Sustainable Communities Investment Area to form a Sustainable Communities Investment Authority (authority) to carry out the Community Redevelopment Law in a

specified manner. The bill would require the authority to adopt a Sustainable Communities Investment Plan for a Sustainable Communities Investment Area and authorize the authority to include in that plan a provision for the receipt of tax increment funds provided that certain economic development and planning requirements are met. This bill contains other related provisions and other existing laws.

Position: Support

**SCA 10** **(Wolk D) Legislative procedure.**

**Introduced:** 1/22/2013

**Status:** 8/31/2014-**Failed Deadline** pursuant to Rule 61(b)(17). (Last location was S. RLS. on 1/31/2013)

**Summary:** The California Constitution prohibits a bill other than the Budget Bill from being heard or acted on by a committee or either house of the Legislature until the 31st day after the bill is introduced, unless the house dispenses with this requirement by roll call vote entered in the journal, 3/4 of the membership concurring. This measure would add an additional exception to this 31-day waiting period by authorizing a committee to hear or act on a bill if the bill, in the form to be considered by the committee, has been in print and published on the Internet for at least 15 days. This bill contains other related provisions and other existing laws.

Position: Watch

**VETOED by Governor Brown**

**SB 1046** **(Beall D) Insurance: mental illness: developmental disabilities: coverage: penalties.**

**Introduced:** 2/18/2014

**Last Amend:** 4/8/2014

**Status:** 8/19/2014-**Vetoed by the Governor**

**Summary:** Current law requires health insurance policies to provide benefits for specified conditions, including coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism, as specified. This bill would give the Insurance Commissioner the authority to assess administrative penalties for any violations of the above provisions, including any rules or orders adopted or issued based on violations of those provisions. The penalties would not exceed \$2,500 for each violation, or for an ongoing and continuous violation, the penalty would not exceed \$2,500 per day for as long as the violation continues.

**Governor's Message:** I am returning SB 1046 without my signature. This bill would give the Insurance Commissioner additional authority to penalize health insurers up to \$2,500 per person, per day, for each violation of the Mental Health Parity Act, in addition to any other penalties or remedies allowed by law. The Insurance Commissioner already has broad penalty authority under the Unfair Insurances Practices Act. The scope of this existing authority is currently at issue in the courts. Until this matter is resolved, it would be premature to conclude what changes, if any, should be made to the Commissioner's broad statutory powers. Sincerely, Edmund G. Brown Jr.

Position: Support

**Summary:** Chaptered: ABs: 6 SBs: 3 Total: 9

Dead: ABs: 6 SBs: 10 Total: 16

Vetoed: SB: 1

Total Measures: 26



**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
<b>AB 1335</b> <i>Mainschein</i> <b>Senate- 2 year</b> <b>dead</b>	<b>Sex Offenses: disabled victims</b> This bill would add the crimes of rape, sexual penetration, sodomy, and oral copulation, perpetrated against a person who is incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, to the above provisions. By applying the above enhancements to these crimes, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.	ARCA support with amendments	Watch	Watch
<b>AB 1626</b> <i>Maienschein</i> <b>Senate- 2 year</b> <b>dead</b>	<b>Developmental services: habilitation</b> This bill would increase the hourly rate paid to providers of individualized and group-supported employment services to \$34.24, and increase the fees paid to interim program providers to \$400 and \$800, respectively.	ARCA Support (letter)	Recommends support	Support (letter sent)
<b>AB 1688</b> <i>Conway</i> <b>Assembly- 2 year</b> <b>dead</b>	<b>Developmental centers: crime</b> Existing law requires, upon the filing of a claim for reimbursement, a city, county, or superior court to be reimbursed for reasonable and necessary costs connected with state prisons or prisoners in connection with certain circumstances, including with any crime committed in a prison, with any hearing on any return of a writ of habeas corpus prosecuted by or on behalf of a prisoner, or with any costs incurred by a coroner in connection with the death of a prisoner. This bill would similarly require that, upon the filing of a claim for reimbursement, a city or county be reimbursed for reasonable and necessary costs related to the investigation or prosecution of a crime committed by a developmental center employee against a developmental center resident. This bill contains other related provisions and other existing laws.		Watch	Watch
<b>AB 1753</b> <i>Holden</i> <b>Assembly- 2 year</b> <b>dead</b>	<b>Developmental services: regional centers: vendorization</b> This bill would, if a consumer, or his or her parents, legal guardian, conservator, or authorized representative, requests that a service specified in the consumer's individual program plan be provided by a service vendor that has been vendored by another regional center, authorize the service vendor to provide services to the consumer under the same contractual terms as the vendoring regional center if certain requirements are satisfied, including that the service vendor is in good standing with the vendoring regional center and		Recommends support	Support (letter sent)



**SCDD STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
	that the service provider provides services at no additional costs to the consumer or the consumer's regional center.			
<p><b>AB 2041</b> <i>Jones</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p><b>Developmental services: regional centers: behavioral treatment</b> This bill would require that a regional center classify a vendor as a behavior management consultant or behavior management assistant if the vendor designs or implements behavioral health treatment, has a specified amount of experience in designing or implementing that treatment, and meets other licensure and education requirements. This bill contains other related provisions and other existing laws.</p>	ARCA opposes	Recommends support	Support (letter sent)
<p><b>AB 2057</b> <i>Bonilla</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p><b>Pupil assessment: alternate performance assessments</b> This bill would require the California Assessment of Student Performance and Progress (CAASPP) to include an alternate performance assessment, as specified, in grades 3 to 8, inclusive, and grade 11 in English language arts and mathematics. The bill would require the CAASPP to include the California Alternate Performance Assessment being administered in grades 5, 8, and 10 in science, until successor assessments for that subject matter are implemented, as specified. The bill would require the state board to adopt an alternate performance assessment, as specified, in English language arts and mathematics for full implementation in the 2015-16 school year unless the state board determines that the assessments cannot be implemented. The bill also would require the State Department of Education to submit, no later than February 1, 2015, a report to the appropriate committees of the Legislature, the state board, school districts, county offices of education, and charter schools on the status of the successor alternate assessments in English language arts and mathematics and science, as specified, and the field tests that measure specified content standards. The bill would require the department to submit, no later than October 1, 2015, a specified report to the appropriate committees of the Legislature, the state board, school districts, county offices of education, and charter schools on the alternate performance assessments and the field tests that measure specified content standards. The bill, for the 2014-15 school year, would require each local educational agency</p>		Recommends support	Support (letter sent)



## STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
<p><b>AB 2299</b> <i>Nazarian</i> <a href="#">SCDD Co-Sponsor</a> <b>Senate- 2 year</b> <b>dead</b></p>	<p>to administer the field tests that measure specified content standards in a manner determined by the department in consultation with the president or executive director of the state board, as specified. The bill would require specified field tests in English language arts and mathematics to qualify as the alternate performance assessment for the 2014-15 school year. The bill would require the department, with the approval of the state board and the Director of Finance, to amend the assessment contract, as appropriate, to accommodate the field testing and to allow for any necessary studies using information collected from the field tests. The bill would require the department to apply for a specified waiver from the United States Department of Education.</p> <p><b>Developmental services: health insurance copayments</b> This bill would delete the prohibition against payment of deductibles and would require a regional center, without regard to the family's or consumer's annual gross income, to pay any applicable copayment, coinsurance, or deductible for a service or support required by a consumer's individual program plan if the support or service is paid for by the health care service plan or health insurance policy of the consumer or his or her parent, guardian, or caregiver.</p>		<p>Recommends support</p>	<p>Support (letter sent)</p>
<p><b>AB 2349</b> <i>Yamada</i> <b>Assembly- 2 year</b> <b>dead</b></p>	<p><b>Developmental services: Sonoma developmental center</b> This bill would establish the Office of Community Care Coordination within the State Department of Developmental Services, and would require the office to develop a plan, on or before January 1, 2016, that addresses, among other things, the operation of at least 2 acute crisis clinics, as specified. The bill would also require the office to identify which modifications are necessary to enable the Sonoma Developmental Center to operate as a placement of last resort and as an acute crisis clinic.</p>		<p>Watch</p>	<p>Watch</p>
<p><b>AJR 36</b> <i>Gonzalez</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p><b>Special Minimum Wage Certificate</b> This measure would urge the United States Congress to phase out the use of the Special Minimum Wage Certificate provision and eventually repeal Section 14(c) of the 1938 Fair Labor Standards Act.</p>	<p>ARCA support (letter)</p>	<p>Recommends support</p>	<p>Support (letter sent)</p>

**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
<b>SB 1</b> <i>Steinberg</i> <b>Senate- 2 year</b> <b>dead</b>	<b>Sustainable Communities Investment Authority</b> This bill would authorize certain public entities of a Sustainable Communities Investment Area, as described, to form a Sustainable Communities Investment Authority (authority) to carry out the Community Redevelopment Law in a specified manner. The bill would require the authority to adopt a Sustainable Communities Investment Plan for a Sustainable Communities Investment Area and authorize the authority to include in that plan a provision for the receipt of tax increment funds provided that certain economic development and planning requirements are met. The bill would authorize the legislative body of a city or county forming an authority to dedicate any portion of its net available revenue, as defined, to the authority through its Sustainable Communities Investment Plan. The bill would require the authority to contract for an independent financial and performance audit every 5 years. This bill contains other related provisions and other existing laws.		Recommends support	Support (letter sent)
<b>SB 231</b> <i>Correa</i> <b>Assembly- 2 year</b> <b>dead</b>	<b>Bullying: California Bullying Prevention Clearinghouse</b> This bill would enact the Michael Joseph Berry Peer Abuse Prevention and Awareness Act of 2013, pursuant to which the California Bullying Prevention Clearinghouse would be established, to be administered by the State Department of Education. The bill would require the Superintendent of Public Instruction to appoint members to a clearinghouse, California Bullying Prevention Advisory Council which would include individuals who have experience in specified areas, including, among others, hotline telephone services, social media, and behavioral health services. This bill contains other related provisions.		Watch	Watch
<b>SB 391</b> <i>DeSaulnier</i> <b>Assembly- 2 year</b> <b>dead</b>	<b>California Homes and Jobs Act of 2013</b> This bill would enact the California Homes and Jobs Act of 2013. The bill would make legislative findings and declarations relating to the need for establishing permanent, ongoing sources of funding dedicated to affordable housing development. The bill would impose a fee, except as provided, of \$75 to be paid at the time of the recording of every real estate instrument, paper, or notice required or permitted by law to be recorded. By imposing new du-	ARCA support (letter)	Recommends support	Support (letter sent)



**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
	<p>ties on counties with respect to the imposition of the recording fee, the bill would create a state-mandated local program. The bill would require that revenues from this fee be sent quarterly to the Department of Housing and Community Development for deposit in the California Homes and Jobs Trust Fund, which the bill would create within the State Treasury. The bill would provide that moneys in the fund may be expended for supporting affordable housing, administering housing programs, and the cost of periodic audits, as specified. The bill would impose certain auditing and reporting requirements. This bill contains other related provisions and other existing laws.</p>			
<p><b>SB 579</b> <i>Berryhill</i> <b>Assembly- 2 year</b> <b>dead</b></p>	<p><b>Developmental services: Commission on Oversight Efficiency and Quality Enhancement Models</b> Would establish the Commission on Oversight Efficiency and Quality Enhancement Models to investigate methods of implementing a unified and consistent oversight and quality enhancement process that ensures the welfare, community participation, health, and safety of individuals with developmental disabilities who are served in programs licensed by the Community Care Licensing Division of the State Department of Social Services. The bill would require the process to also enhance accountability and quality review processes for the services directly provided by regional centers. This bill contains other related provisions and other existing laws. *Support with amendments: seeking more representation of people served and family members on the commission.</p>	<p>Sponsors: -ACRA</p>	<p>*Support with amendments</p>	<p>*Support with amendments; letter sent</p>
<p><b>SB 663</b> <i>Lara</i> <b>Assembly- 2 year</b> <b>dead</b></p>	<p><b>Crimes: persons with developmental and intellectual disabilities</b> This bill would make those provisions applicable to a case involving a crime against a person with a developmental disability. This bill contains other related provisions and other existing laws.</p>	<p>ARCA support (letter)</p>	<p>Recommends support</p>	<p>Support (letter sent)</p>
<p><b>SB 840</b> <i>Lara</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p><b>Educational equity: local educational agency policies against bullying</b> This bill would require each local educational agency to develop and implement a policy against bullying, as specified, which includes, at a minimum, a procedure for referring victims of bullying to counseling, mental health, or other health services as appropriate, mandatory training for certificated em-</p>		<p>Watch</p>	<p>Watch</p>

## STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
	<p>ployees on the prevention, and addressing, of bullying, and a procedure for the documentation of all incidents of bullying that take place within the local educational agency as well as the responsive actions taken, if any. The bill would require the local educational agency to forward the documentation of the bullying incidents to the State Department of Education.</p>			
<p><b>SB 922</b> <i>Knight</i> <b>Assembly- 2 year</b> <b>dead</b></p>	<p><b>Sex offenses: disabled victims</b> This bill would make these crimes, if committed against a person who has a mental disorder or developmental or physical disability, and the person committing the act knows or reasonably should know that the victim has the disorder or disability, by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury, punishable by imprisonment in the state prison for 9, 11, or 13 years in the case of rape or an act of sodomy, and 8, 10, or 12 years in the case of oral copulation or sexual penetration. By creating new crimes, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.</p>		Watch	Watch
<p><b>SB 935</b> <i>Leno</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p><b>Minimum wage: annual adjustment</b> The bill would require the automatic adjustment of the minimum wage annually thereafter, to maintain employee purchasing power diminished by the rate of inflation during the previous year. The adjustment would be calculated using the California Consumer Price Index, as specified. The bill would prohibit the Industrial Welfare Commission (IWC) from reducing the minimum wage and from adjusting the minimum wage if the average percentage of inflation for the previous year was negative. The bill would require the IWC to publicize the automatically adjusted minimum wage. This bill contains other related provisions.</p>		Watch	Watch
<p><b>SB 1046</b> <i>Beall</i> <b>Senate; Vetoed</b> <b>by Governor</b> <b>Brown.</b></p>	<p><b>Insurance: mental illness: developmental disabilities: coverage penalties</b> This bill would give the Insurance Commissioner the authority to assess administrative penalties for any violations of the above provisions, including any rules or orders adopted or issued based on violations of those provisions. The bill would also give the commissioner authority to assess a penalty for each patient harmed by a violation of the above provisions, including any rules or</p>	ACRA support (letter)	Recommends support	Support (letter sent)



**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
<p><b>SB 1109</b> <i>Hueso</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p>orders adopted or issued based on violations of those provisions, as a separate and distinct violation. The penalties would not exceed \$2,500 for each violation, or for an ongoing and continuous violation, the penalty would not exceed \$2,500 per day for as long as the violation continues.</p> <p><b>Public contracts: integrated employment</b> This bill would state the intent of the Legislature to enact legislation to provide that the state serve as a model for employers in California in increasing competitive integrated employment for individuals with disabilities by prohibiting the entering into of contracts by the state with organizations that pay employees with disabilities less than the minimum wage.</p>		Watch	Watch
<p><b>SB 1160</b> <i>Beall</i> <b>Assembly- 2 year</b> <b>dead</b></p>	<p><b>Developmental services: employment</b> The Lanterman Act defines "group services" for these purposes to mean job coaching in a group supported employment placement at a job coach-to-consumer ratio of not less than 1 to 3 nor more than 1 to 8 where services to a minimum of 3 consumers are funded by the regional center or the Department of Rehabilitation. Existing law defines "individualized services" to mean job coaching and other supported employment services for regional center-funded consumers in a supported employment placement at a job coach-to-consumer ratio of 1 to 1, and that decrease over time until stabilization is achieved. This bill would require, for group services, a job coach-to-consumer ratio of not less than 1 to 2 nor more than 1 to 8 where services to a minimum of 2 consumers are funded by the regional center or the Department of Rehabilitation. The bill would recast the definition of "individualized services" to provide, in part, job coaching and other supported employment services that decrease over time, consistent with the consumer's individual program plan and abilities with the goal of achieving stabilization, when possible. This bill contains other related provisions.</p>		Recommends support	Support (letter sent)
<p><b>SB 1176</b> <i>Steinberg</i> <b>Assembly- 2 year</b> <b>dead</b></p>	<p><b>Health care coverage: cost sharing: monitoring</b> This bill would require a health care service plan or health insurer to be responsible for monitoring the accrual of out-of-pocket costs toward the annual out-of-pocket limit. The bill would require a health care service plan or health</p>		Recommends support	Support (letter sent)

**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
	<p>insurer, for cost sharing attributed to in-network providers, including contracted vendors, that count toward the annual limit on out-of-pocket costs, to be solely responsible for monitoring the accrual of out-of-pocket costs and prohibit the health care service plan or health insurer from requiring the consumer to track or monitor the accumulation of cost sharing for covered essential health benefits attributed to in-network providers, including contracted vendors. The bill would require a health care service plan or health insurer to accept claims from the provider or information from the consumer with respect to cost sharing for out-of-network providers who are providing certain emergency services or otherwise providing covered benefits arranged by the health care service plan or health insurer subject to the annual limit on out-of-pocket expenses. The bill would also require the health care service plan or health insurer, if the cost sharing for covered essential health benefits attributable to an enrollee or insured exceeds the maximum annual out-of-pocket limits, to reimburse the enrollee or insured no later than 5 working days after the health care service plan or health insurer is required to reimburse the claim or notify the claimant that the claim is contested or denied. The bill would require that the enrollee or insured have the opportunity to review the accrual of cost sharing and provide additional information regarding cost sharing that should be accrued to the out-of-pocket limit. Because a willful violation of the bill's provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.</p>			
<b>SB 1178</b> <i>Correa</i> <b>Senate- 2 year</b> <b>dead</b>	<p><b>Individuals with developmental disabilities</b>          Would state the intent of the Legislature to enact legislation that would require the Department of Housing and Community Development to report to the Legislature on the status of the housing needs of individuals with developmental delays.</p>	<p>Sponsors:          -ACRA</p>	<p>Recommends support</p>	<p>Support          (letter sent)</p>
<b>SB 1396</b> <i>Hancock</i> <b>Assembly- 2 year</b>	<p><b>School climate: School wide Positive Behavior Intervention and Support program</b>          This bill would establish the School wide Positive Behavior Intervention and</p>		<p>Recommends support</p>	<p>Support          (letter sent)</p>



**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES/ LPPC PENDING LEGISLATION**

Bill Info.	Description	Support/ Opposition	LPPC Status	SCDD Status
<b>dead</b>	<p>Support program. The bill, to the extent that one-time funding is made available in the Budget Act of 2014, would require the State Department of Education to apportion funds to a designated county office of education, selected from applicant county offices of education that would be the fiduciary agent for the program. The bill would require the designated county office of education to consult with specified organizations and target the funding towards a statewide professional development effort that would provide training in school wide positive behavior and support to school personnel.</p>			
<p><b>SB 1428</b> <i>Evans</i> <b>Senate- 2 year</b> <b>dead</b></p>	<p><b>Sonoma Developmental Center: Land use</b> This bill would require that, prior to the development of any plan for, or implementation of, any sale, lease, transfer, or major change of use of any portion of the Sonoma Developmental Center, the department and the Department of General Services confer and cooperate with public and private entities in the development of an improvement and redevelopment plan for the center. The bill would authorize the plan to contain specified elements, including plans for the development of new or improved public or private core resident care facilities on the site, the permanent protection, maintenance, operation, and potential expansion of the wildlife habitat corridor the creation of public recreational facilities, and potential expansion of water supply facilities consistent with natural resource protection.</p>		<p>Support if amended.</p>	<p>Support if amended.</p>
<p><b>SCA 10</b> <i>Wolk</i> <b>Seante- 2 year</b> <b>dead</b></p>	<p><b>Legislative procedure</b> The California Constitution prohibits a bill other than the Budget Bill from being heard or acted on by a committee or either house of the Legislature until the 31st day after the bill is introduced, unless the house dispenses with this requirement by roll call vote entered in the journal, 3/4 of the membership concurring. This measure would add an additional exception to this 31-day waiting period by authorizing a committee to hear or act on a bill if the bill, in the form to be considered by the committee, has been in print and published on the Internet for at least 15 days. This bill contains other related provisions and other existing laws.</p>		<p>Watch</p>	<p>Watch</p>





Draft

LEGISLATIVE  
and Public Policy  
Platform

Approved 2014

## About the Council

The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 establishes State Councils on Developmental Disabilities in each of the 56 states and territories to promote self-determination, independence, productivity, integration, and inclusion in all aspects of community life for people with intellectual and developmental disabilities (IDD) and their families. The Lanterman Act establishes the California State Council on Developmental Disabilities (Council) to fulfill those obligations through advocacy, capacity building, and systems change.

To that end, the Council develops and implements goals, objectives, and strategies designed to improve and enhance the availability and quality of services and supports.

The Council is comprised of 31 members appointed by the Governor, including individuals with disabilities and their families, and representatives from Disability Rights California, the University Centers for Excellence in Developmental Disabilities, and state agencies.

In addition to the Council's Sacramento headquarters, 13 regional offices support individuals with IDD and their families through activities such as advocacy, training, monitoring, and public information. The Council strives to ensure that appropriate laws, regulations, and policies pertaining to the rights of individuals are observed and protected.

This document conveys the Council's position on major policy issues that affect individuals with IDD and their families.

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## SELF-DETERMINATION

Individuals with IDD and their families must be given the option to control their service dollars and their services through Self-Determination. With the support of those they choose and trust, people with IDD and their families are best suited to understand their own unique needs, develop their own life goals, and construct those services and supports most appropriate to reach their full potential. Self-Determination gives individuals the tools and the basic human right to pursue life, liberty, and happiness in the ways that they choose.



## EMPLOYMENT

A regular job with competitive pay gives people an opportunity to contribute and be valued at a work site; it gives them a chance to build relationships with co-workers, be a part of their communities, and contribute to their local economies. It reduces poverty and reliance on state support, and it provides a life of greater dignity.

Integrated competitive employment is the priority outcome for working age individuals with IDD, regardless of the severity of their disability. Policies and practices must set expectations for employment, promote collaboration between state agencies, and remove barriers to integrated competitive employment through access to information, benefits counseling, job training, postsecondary education, and appropriate provider rates that incentivize quality employment outcomes.

## TRANSPORTATION

Access to transportation is essential to the education, employment, and inclusion of individuals with disabilities. Individuals with IDD must be a part of transportation planning and policymaking to assure their needs and perspectives are heard and addressed. Mobility training must be a standard program among public transportation providers to increase the use of public transportation and reduce reliance on more costly segregated systems.



## HEALTH CARE

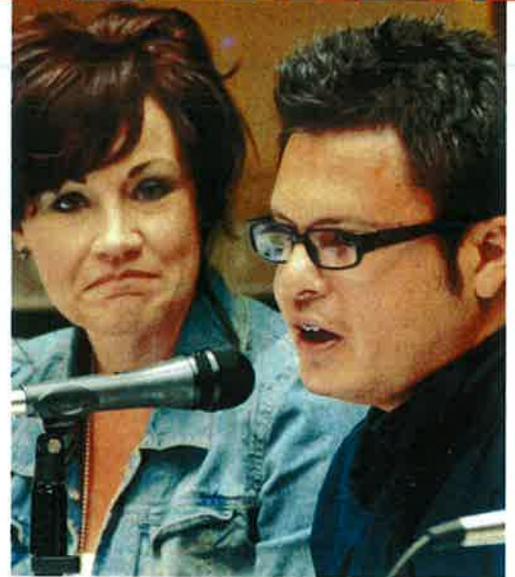
Individuals must be reimbursed for insurance co-pays, co-insurance, and deductibles, when their health insurance covers therapies that are on their IPPs.

California has an obligation to assure that individuals with disabilities have continuity of care, a full continuum of health care services and equipment, and access to plain language information and supports to make informed decisions about their health care options.

California has an obligation to support the health care of individuals with IDD. This includes people with multiple health care needs, those who require routine preventative care, mental health treatment, dental care, durable medical equipment, and those with gender specific health issues.

## EQUITY

Regional center services and supports must be distributed equitably so that individuals receive culturally and linguistically competent services and supports that meet their needs, regardless of their race, ethnicity, or income. Disparities in services can result in severe health, economic, and quality of life consequences.



## EDUCATION

Schools must implement the goals of the Individuals with Disabilities Education Act (IDEA) to provide children with disabilities with free appropriate public education and prepare them for post-secondary education, employment, and independent living. Students with disabilities will be educated alongside their non-disabled peers in the least restrictive environment. School districts and other educational authorities need to be held accountable for implementing the letter and the intent of IDEA, in all aspects, including measureable post-secondary goals.

## HOUSING

Community integrated living options for individuals with IDD must be increased and enhanced through access to housing subsidy programs and neighborhood education to reduce discrimination. Permanent, affordable, accessible, and sustained housing options must be continually developed to meet both current and future needs.

## SELF-ADVOCACY

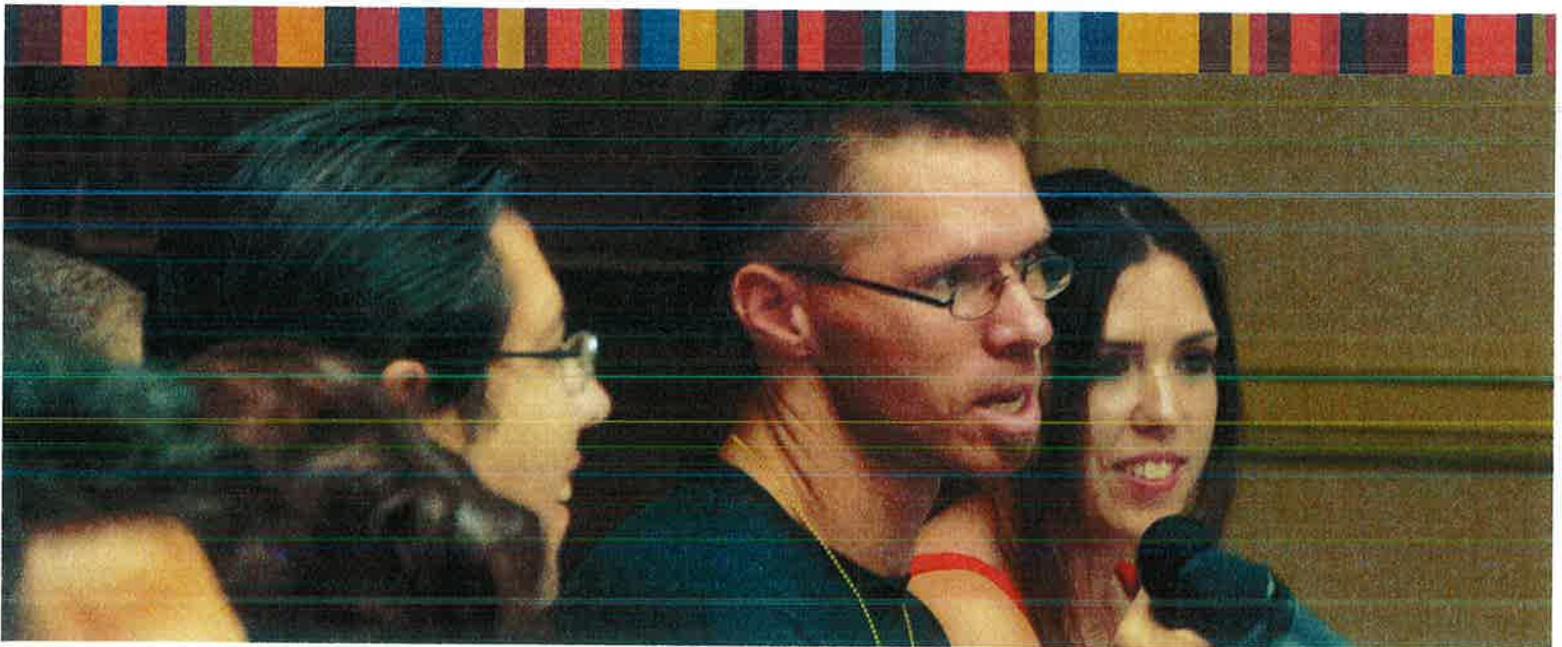
Individuals with IDD must be supported to exert maximum control over their lives. They must be provided the opportunity and support to assume their rightful leadership in the service system and society, including voting and other civic responsibilities. Self-advocates must have access to enhanced training, plain language materials, and policy making opportunities.

## COMMUNITY PARTICIPATION

Individuals with IDD must have access to and be supported to participate in their communities, with their non-disabled peers, through opportunities such as education, employment, recreation, organizational affiliations, spiritual development, and civic responsibilities.

## TRANSITION TO ADULT LIFE

Education, rehabilitation, and regional center services must support students to transition to integrated competitive employment or post-secondary educational opportunities that will lead to employment. Successful strategies include starting career exploration at age 14, coordination among systems, youth empowerment in their education and service planning, integrated work experiences, family engagement, and a seamless transition to post-secondary work or education.



## RATES FOR SERVICES

The state must restore rates to adequately support the availability of quality services for people with all disabilities in all the systems that serve them. A planned and systematic approach to rate adjustments must prioritize and incentivize services and supports that best promotes self-determination, independence, employment, and inclusion in all aspects of community life.

## VICTIMS OF CRIME

All people have a right to be safe; however, individuals with IDD experience a much greater rate of victimization, and a far lower rate of prosecution for crimes against them, than does the general public. The same level of due process protections must be provided to all people. Individuals with IDD need to be trained in personal safety, how to protect themselves against becoming victims of crime, and how their participation in identification and prosecution can make a difference. Law enforcement personnel must be trained in how to work with people with IDD who they interact with during the course of their duties, including those who are victims of crimes.



## QUALITY OF SERVICES AND SUPPORTS

The State of California must ensure that funding is used to achieve positive outcomes for individuals with IDD and their families. The state must streamline burdensome and duplicative regulations and processes that do not lead to positive outcomes for people with IDD and their families. Quality assessment and oversight must be provided by the state; it must measure what matters, be administered in a culturally competent manner, and the results made public and used to improve the system of services and supports.



## Promise of the Lanterman Act

The Lanterman Act promises to honor the needs and choices of individuals with IDD by establishing an array of quality services throughout the state. Services shall support people to live integrated, productive lives in their home communities, in the least restrictive environment. Access to needed services and supports must not be undermined through categorical service elimination, service caps, means testing, or family cost participation fees and other financial barriers. California must not impose artificial limitations or reductions in community-based services and supports that would compromise the health and safety of persons with IDD.



# California State Council Regional Office

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Draft



**AUTISM BEHAVIORAL  
SERVICES/  
Medi-Cal COVERAGE**



# Update on Autism Behavioral Services

State Council on Developmental Disabilities/LPPC

October 2014

## Recent Changes to California Law

With the close of this legislative term, there are changes to how children and adults with autism can access behavioral services through their regional center. Last year the law went into effect that allowed regional centers to pay copayments or coinsurance for an autism-related behavioral service or support written into a consumer's individual program plan (IPP) only if certain requirements were met. Also, regional centers were not allowed to pay deductibles for an autism-related behavioral service or support written into a consumer's IPP.

As of September 2014, the law changed. The new law says that regional centers are allowed to pay copayments, coinsurance, **or a deductible** for an autism-related behavioral service or support written into a consumer's individual program plan (IPP) only if:

- The service or support is paid for by a health care service plan or health insurance policy of the consumer, their parent or care provider, and,
- The consumer's yearly family income was less than 400% of the federal poverty level, or
- The consumer's yearly family income was more than 400% of the federal poverty level but they were facing some sort of significant event or financial burden (for example, loss of their home or high medical bills).

## Medi-Cal Coverage of Autism Behavioral Services

As of September 15<sup>th</sup>, Medi-Cal will start covering behavioral services for children and adults (up to age 21) with autism. Applied Behavioral Analysis (ABA) is one of the services that Medi-Cal will cover with this change in benefits.

Right now Medi-Cal can cover autism behavioral services for a consumer if they have Medi-Cal as their main or secondary health insurance. Since this is all very new, many parts of this new Medi-Cal benefit may change over the next year. The LPPC will be tracking this important new benefit for consumers who have autism.

**co-payment:** an amount of money that your insurance plan may require you pay in order to get a medical service or medication.

**co-insurance:** a type of health insurance where you and your health insurance plan share the total cost of the covered medical services after a deductible has been met.

**deductible:** an amount of money that your health insurance plan may require you to pay on your own each year before the health insurance plan covers your services. Not all health insurance plans require a deductible.

**federal poverty level (FPL):** the set minimum amount of money that a family needs for food, clothing, transportation, shelter and other needs. In the United States, this level is determined by the Department of Health and Human Services and FPL varies depending on the size of the family.





State of California—Health and Human Services Agency  
Department of Health Care Services



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**DATE:** September 15, 2014

All Plan Letter 14-011

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing Behavioral Health Therapy (BHT) services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

**BACKGROUND:**

ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called ASD<sup>1</sup>. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant to section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and

<sup>1</sup> See Diagnostic and Statistical Manual (DSM) V.

treated as early as possible. When medically necessary, States may not impose limits on EPSDT services and must cover services listed in section 1905(a) of the Act regardless of whether or not they have been approved under a State Plan Amendment.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to include BHT services, including Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD, as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety (H&S) Code.

Pursuant to Section 14132.56 of the Welfare & Institutions Code (WIC), DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT as defined by H&S code section 1374.73, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. In consultation with stakeholders, DHCS will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law, and provide final policy guidance to MCPs upon federal approval.

**PROGRAM DESCRIPTION AND PURPOSE:**

BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are services based on reliable evidence and are not experimental.

**INTERIM POLICY:**

In accordance with existing contracts, MCPs are responsible for the provision of EPSDT services for members 0 to 21 years of age, including those who have special health care needs. MCPs shall: (1) inform members that EPSDT services are available for beneficiaries 0 to 21 years of age, (2) provide comprehensive screening and prevention

services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, lead toxicity screening, etc.), and (3) provide diagnosis and treatment for all medically necessary services, including but not limited to, BHT.

Effective September 15, 2014, the MCP responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age includes medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. MCPs shall ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP's contracts.

**CONTINUITY OF CARE:**

MCP beneficiaries 0 to 21 years diagnosed with ASD who are receiving BHT services through a Regional Center on September 14, 2014, will automatically continue to receive all BHT services through the Regional Center until such time that DHCS and the Department of Developmental Services (DDS) develop a plan for transition. Until DHCS and DDS develop a plan for transition and communicate this transition plan to Regional Centers and to MCPs (through a forthcoming APL), Regional Centers will continue to provide BHT services for Medi-Cal beneficiaries and reimburse providers for BHT services provided in accordance with existing federal approvals, unless the parent or guardian requests that the MCP provide BHT services to the beneficiary prior to the development and/or implementation of the transition plan. Beneficiaries presenting for BHT services at a Regional Center on or after September 15, 2014, should be referred to the MCP for services.

For Medi-Cal beneficiaries receiving BHT services outside of a Regional Center or the MCPs' network, upon parental or guardian request, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements and All Plan Letter (APL) 13-023, unless the parent or guardian requests that the MCP change the service provider to an MCP BHT in-network provider prior to the end of the 12 month period.

BHT services will not be discontinued during a continuity of care evaluation. Pursuant to Health & Safety Code section 1373.96, BHT services must continue until MCPs have established a treatment plan.

An MCP shall offer continuity of care with an out-of-network provider to beneficiaries if all of the following circumstances exist:

- The beneficiary has an existing relationship with a qualified autism service provider. An existing relationship means a beneficiary has seen an out-of-network provider at least twice during the 12 months prior to September 15, 2014;

- The provider is willing to accept payment from the MCP based on the current Medi-Cal fee schedule; and
- The MCP does not have any documented quality of care concerns that would cause it to exclude the provider from its network.

**HEALTH PLAN READINESS:**

DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCPs are providing timely medically necessary BHT services. DHCS and DMHC will engage in joint decision making processes when considering the content of any licensing filing submitted to either department. The departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to MCPs' readiness review requirements will be provided to MCPs separate from this APL.

**DELEGATION OVERSIGHT:**

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements, as well as DHCS guidance, including APLs.

**REIMBURSEMENT:**

DHCS will engage in discussions with the MCPs in order to develop capitation rates for the costs associated with the provision of BHT services as soon as possible. Any rate adjustments for BHT services will be retroactively applied to September 15, 2014, subject to federal approval.

To the extent Medi-Cal beneficiaries received BHT services from licensed providers between July 7, 2014, and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process ([http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal\\_Conlan.aspx](http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx)). On and after September 15, 2014, Medi-Cal beneficiaries that are not receiving BHT services from a Regional Center or an out-of-network provider must receive all BHT services from a MCP.

**CRITERIA FOR BHT SERVICES:**

In order to be eligible for BHT services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);
4. Have a comprehensive diagnostic evaluation<sup>2</sup> that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for BHT services ordered by a licensed physician or surgeon or developed by a licensed psychologist.

### **COVERED SERVICES AND LIMITATIONS:**

Medi-Cal covered BHT services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14132(v).
2. Prior authorized by the MCP or its designee; and
3. Delivered in accordance with the beneficiary's MCP approved treatment plan.

Services must be provided and supervised under an MCP approved treatment plan developed by a contracted and MCP-credentialed "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3). Treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3).
2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is supervised and employed by a qualified autism service provider.

BHT services must be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider and prior authorized by the MCP for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

BHT services shall be rendered in accordance with the beneficiary's treatment plan. The treatment plan shall:

1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed by a qualified autism service provider for the specific beneficiary being treated;
3. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;

<sup>2</sup> MCPs shall obtain a diagnostic evaluation of no more than four hours in duration that includes:

- A clinical history with informed parent/guardian, inclusive of developmental and psychosocial history;
- Direct observation;
- Review of available records; and
- Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team.

4. Identify long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;
5. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
6. Utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary;
7. Ensure that interventions are consistent with evidenced-based BHT techniques.
8. Clearly identify the service type, number of hours of direct service and supervision, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the beneficiary's progress is reported, and identifies the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

**BHT Service Limitations:**

1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. BHT services shall be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.
4. MCPs will comply with current contract requirements relating to coordination of care with Local Education Agencies to ensure the delivery of medically necessary BHT services.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered BHT services for reimbursement:

1. Therapy services rendered when continued clinical benefit is not expected;
2. Services that are primarily respite, daycare or educational in nature and are used to reimburse a parent for participating in the treatment program;
3. Treatment whose purpose is vocationally or recreationally-based;
4. Custodial care
  - a. for purposes of BHT services, custodial care:
    - i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
    - ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
    - iii. could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to:
  - a. resorts;
  - b. spas; and
  - c. camps.

6. Services rendered by a parent, legal guardian, or legally responsible person.

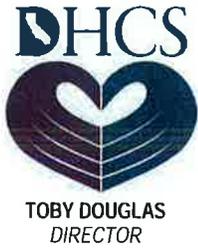
For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

*Original Signed by Sarah C. Brooks*

Sarah C. Brooks  
Program Monitoring and Medical Policy Branch Chief  
Medi-Cal Managed Care Division  
Department of Health Care Services

Attachments

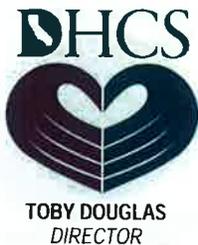


**What to Expect if You Suspect or You Have Been Told  
Your Child has Autism Spectrum Disorder**

If you have a concern about how your child is communicating, interacting or behaving, or your child has been diagnosed with autism spectrum disorder (ASD) but you have been unable to access services to treat your child, you are likely wondering what to expect now that Behavioral Health Treatment services to treat children with ASD are available in Medi-Cal.

The following guidance is provided to share information about obtaining an evaluation of your child's development and treatment options, if needed, and the approximate amount of time it will take to obtain evaluations and medically necessary treatment.

1. If you have concerns about your child's development or your child has been diagnosed with ASD, call your Health Plan's Call Center and/or make an appointment to see your child's doctor. Your child's doctor should offer you an appointment within 10 business days. The evaluation and approval processes for your child to receive Behavioral Health Treatment services could take approximately 60 to 90 days to complete.
2. At the appointment with your child's doctor, share your concerns about your child, noting how your child is different from other children the same age, or provide any documents you may have from a health care provider that state your child has been diagnosed with autism spectrum disorder.
3. Your child's doctor will listen to your concerns, review documents that you share, examine your child, and may conduct a developmental screening. The doctor may ask you questions or talk or play with your child during the examination to see how your child learns, speaks, behaves, and moves. This screening provides useful information to identify if your child is developing differently from other children.
4. As a result of this visit with the doctor, your child may be referred to a specialist who will meet with you and your child, conduct further tests/exams of your child, and then prepare a report. The specialist should offer you an appointment within 15 business days after your appointment with your child's doctor.
5. The specialist will submit his/her report to your child's Health Plan for review and approval of medically necessary services, if deemed necessary.



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6. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the recommendations of the specialist.
7. If the Health Plan determines that Behavioral Health Treatment services are medically necessary, your child will be referred to a qualified autism service provider who will meet with you and your child and develop a treatment plan. The qualified autism service provider should offer to meet with you within 15 business days after your Health Plan makes its determination.
8. The proposed treatment plan will be submitted by the qualified autism service provider to the Health Plan and reviewed by your Health Plan to determine whether or not the Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary.
9. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the treatment plan developed by the qualified autism service provider.
10. If the Health Plan determines that Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary, your child will be referred back to the qualified autism service provider who will meet with you and your child in your home or another community setting, such as a community clinic, to describe the treatment plan and specific services your child will receive. The qualified autism provider should offer you an appointment within 15 days after your Health Plan makes its determination.
11. You have the right to make complaints about your child's covered services or care. This includes the right to:
  - a) File a complaint or grievance or appeal certain decisions made by the Health Plan or health plan provider. For more information on filing a complaint, grievance, or appeal, contact your Health Plan.
  - b) Ask for an Independent Medical Review (IMR) of the medical necessity of Medi-Cal Services or terms that are medical in nature from the California Department of Managed Health Care (DMHC). For more information on asking for an IMR, contact DMHC's Help Center at 1-888-466-2219 or (TDD) 1-877-688-9891 or online at <http://www.dmhca.gov/FileaComplaint/ConsumerIndependentMedicalReviewComplaint.aspx>



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- c) Ask for a State Fair Hearing (SFH) from the California Department of Social Services (DSS). You can request a SFH over the phone by contacting DSS at 1-800-952-5253 or (TDD) 1-800-952-8349, by faxing DSS at 916-651-5210 or 916-651-2789, or by sending a letter to DSS. Additional information on the SFH process can be accessed at: <http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx>
12. The qualified autism service provider will meet with you and your child and describe the behavioral health treatment service type, the number of hours of direct service and the supervision of the service provider, parent or guardian participation needed, the frequency of reporting progress, and identify the individual providers responsible for delivering services to your child. Services will be scheduled at the location and in the frequency approved by the Health Plan.
13. The qualified autism service provider will provide a description of care coordination involving parents, guardians or caregivers, school, state disability programs, and others. The provider will also describe parent, guardian or caregiver training, support and participation that will be required.
14. The effectiveness of Behavioral Health Treatment is dramatically improved when parents or guardians receive training and are actively participating in their child's treatment. Your participation will ensure the best long term outcomes from the treatments your child is receiving.
15. If you have any questions or concerns about obtaining services for your child at any point in the process, call your Health Plan's Call Center or your child's doctor for assistance.
16. If you are concerned about what you can do when your child is not receiving services, the federal government and the Association for Children and Families has put together a guide to help parents facilitate development every day. This guide can be found at [www.acf.hhs.gov/ecd/ASD](http://www.acf.hhs.gov/ecd/ASD). Themes include:
- Engaging your child in play through joint attention
  - Using your child's interests in activities
  - Using a shared agenda in daily routines
  - Using visual cues
  - Sharing objects and books
  - Teaching your children to play with each other
  - Using predictable routines and predictable spaces for your child.

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## CMCS Informational Bulletin

**DATE:** July 7, 2014

**FROM:** Cindy Mann, Director  
Center for Medicaid and CHIP Services

**SUBJECT:** **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

### **Background**

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.<sup>1</sup>

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine.<sup>2</sup> While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)<sup>3</sup>. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

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<sup>1</sup> <http://www.cdc.gov/ncbddd/autism/facts.html>

<sup>2</sup> <http://www.cdc.gov/ncbddd/autism/treatment.html>

<sup>3</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf>

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

### **State Plan Authorities**

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such as state-wideness and comparability must also be met.

### **Other Licensed Practitioner Services**

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are “medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider’s qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state’s Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state’s Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

### **Preventive Services**

Preventive Services, defined at 42 CFR 440.130(c) are “services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

- (1) Prevent disease, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency”

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long as the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

### Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

### Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

### Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

### Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

#### Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

#### EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care; in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child’s health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child’s needs; that is, all services that can be covered under section 1905(a), including licensed practitioners’ services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

### **Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs**

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to [AutismServicesQuestions@cms.hhs.gov](mailto:AutismServicesQuestions@cms.hhs.gov).



# TASK FORCE UPDATES

ESTABLISHED 1862

# **Agenda for Developmental Services Task Force Meeting**

Wednesday, October 8, 2014  
10:00 am - 4:00 pm

California Department of Health Care Services  
First Floor Conference Room, 1700 K Street  
Sacramento, CA 95814

Conference Call Option: Dial-In: **1-800-779-8389**  
Participant Verbal Passphrase: **DS TASK FORCE**

- I. Welcome & Introductions
- II. Summary of July 24, 2014 Developmental Services Task Force Meeting and the California Department of Developmental Services (DDS) - Developmental Centers (DC) Task Force Implementation Workgroup Meetings
- III. Subject Areas from Last Meeting
- IV. Discussion of Each Subject Area
- V. Lunch
- VI. Continued Discussion of Each Subject Area
- VII. Discussion of Process and Workgroup Approach
- VIII. Public Comment



# DEVELOPMENTAL SERVICES TASK FORCE

## SUBJECT AREAS FOR DISCUSSION ON OCTOBER 8, 2014

Based on the July 24, 2014, meeting, the following organization of subject areas, and possible topics within those areas, has been identified for consideration by the Task Force. Input is needed from the Task Force on:

- The organization of the subject areas and possible scope;
- The relative priorities of the subject areas and the topics within the subject areas;
- What data are needed;
- How to identify the participants of each workgroup;
- What expertise is needed; and
- How to move forward.

### SUBJECT AREAS FOR DISCUSSION

#### 1. Future Services and Service Policies

##### Possible scope:

- Service trends, emerging issues and unmet needs
- The new Centers for Medicare and Medicaid Services (CMS) regulations for Home and Community-Based Services
- Past service reductions and freezes
- Service changes occurring throughout the California Health and Human Services Agency
- Policies and services that are needed

#### 2. Service Rates, the Rate-Setting Structure and Sustainability

##### Possible scope:

- The rate structure and rate-setting methodologies
- Factors impacting sustainability
- New development and innovation
- Cost of living and geographical considerations
- Minimum wage changes
- Initiatives that will strengthen community services

### **3. Regional Centers**

#### Possible scope:

- Regional center services and requirements
- Caseload ratios
- The core staffing formula and regional center funding
- Standardizing regional center functions
- Equity considerations

### **4. Employment and Higher Education Opportunities**

#### Possible scope:

- Meaningful opportunities for education and employment
- The new CMS regulations for Home and Community-Based Services
- The Workforce Innovation and Opportunity Act
- The Workforce Investment Board/boards
- Benefits management for consumers

### **5. Medical, Dental, Mental Health and Durable Medical Equipment**

#### Possible scope:

- Medication management and protocols
- Access to psychiatric and mental health services locally
- Safety nets for medical and mental health services
- Access to dental anesthesia
- Access to durable medical equipment and services
- Use of developmental center resources
- The impact/role of managed care
- Services funded by the Mental Health Services Act grants

### **6. Housing and Ensuring Safety**

#### Possible scope:

- Affordable housing and housing needs
- Successful housing models and investments
- Safety net(s)
- The stability and qualifications of the workforce
- Consumer health and safety, and protecting against abuse
- Use of developmental center resources

**DEVELOPMENTAL SERVICES TASK FORCE:  
STRENGTHENING THE COMMUNITY SYSTEM**

**Thursday, July 24, 2014 – 10:00 am to 4:00 pm**

**Sutter Center for Health Professions  
2700 Gateway Oaks Drive, Sacramento, CA 95833**

**MEETING SUMMARY**

**BACKGROUND**

Diana S. Dooley, Secretary of the California Health and Human Services Agency (CHHS), reconvened the Task Force that developed the Plan for the Future of Developmental Services in California (the Plan) issued January 13, 2014. During its previous work, the Task Force identified a number of community issues that were impacting the delivery of community services and their long-term sustainability. Recognizing that the community system issues were beyond the scope of its 2013 work, the Task Force included Recommendation 6 as part of the Plan, calling for another task force to be formed to address ways to make the community system stronger. Additionally, during the development of the Budget Act of 2014-15, the Legislature expressed specific interest in updating the core staffing formula for regional centers and the rate-setting methodologies for community-based services. In response, the Governor directed the CHHS to convene a task force to review both of these items and other community issues that were identified in the Plan.

On July 24, 2014, Secretary Dooley reconvened the original Task Force, made up of consumers, consumer advocates, regional centers, community service providers, organized labor, families of developmental center residents, members of the Legislature and the Department of Developmental Services (DDS). The Task Force had successfully come together, despite differences in experiences and perspectives, to produce a set of recommendations to chart a course for the future of the developmental centers in the Plan. This Task Force is uniquely positioned to build on this success by examining services in the community.

Secretary Dooley welcomed the meeting attendees including Task Force members and public participants, both in the room and on the telephone, as well as staff involved with supporting the work. After introductions, the Secretary identified the focus of the meeting to be Recommendation 6 from the Plan, indicating that the work of this group will be to first frame the agenda, how to go forward and what we want to achieve. The focus should be on building anew and not simply restoring what was. Further, the group will be identifying whether additional expertise is needed relevant to Recommendation 6.

Before getting into the agenda, Secretary Dooley also shared her concerns that the results of the resurvey at Sonoma Developmental Center are expected as soon as tomorrow (July 25, 2014) when an exit interview will be conducted. The Secretary shared that she was prepared for disappointing news given the delay in receiving the results. The State will continue to provide services in the most compassionate, responsible and efficient way possible, but she anticipates that challenges will continue.

John Doyle, Chief Deputy Director, DDS, provided a brief summary of the positive actions taken in the DDS budget this year. First, additional resources were provided to move forward with the Task Force recommendations in the Plan. Specifically, \$13 million in Community Placement Plan funds was re-appropriated from prior years. The funding will be used to develop the enhanced behavioral supports homes and the community crisis homes, and Regional Center staffing to support development efforts among other services. The development process will include stakeholder meetings in Southern, Central and Northern California tentatively scheduled to occur in late August and early September. DDS also received new General Fund money to develop acute crisis centers at both Sonoma and Fairview Developmental Centers.

Additionally, the Legislature, with Administration support, restored eligibility in the Early Start Program. DDS received \$7.9 million in General Fund to return Early Start to the pre-2009 level beginning January 1, 2015.

Secretary Dooley then laid out the process to be followed by the Task Force. The Task Force members were asked to identify their expectations and the major issues to be examined, what they need to know to address those issues, and what expertise and representation is needed to proceed. Once an inventory of issues is identified, they will be organized so that the Task Force can utilize a workgroup process, as they did in 2013. The workgroups will meet between Task Force meetings to work through the data that are needed to inform recommendations. The Secretary cautioned that the resulting recommendations will need to be supported by solid evidence and data so that they can be effectuated through the legislative process.

## **COMMUNITY ISSUES**

The meeting was opened to Task Force input and discussion, followed by public comment. Below is a high-level summary of the key points made by the meeting participants regarding the community.

### Discussion Themes

Throughout the discussion, themes that are important to the developmental disabilities services system were identified, including:

1. Protecting the spirit and intent of the Lanterman Developmental Disabilities Services Act (Lanterman Act);

2. Person-centered (“whole person”) planning using multidisciplinary teams with consumer and family participation, and the Individual Program Plan;
3. Comprehensive transition planning;
4. Ensuring a residential placement of last resort (that “can’t say no”), otherwise referred to as a “safety net” for individuals who have challenging service needs;
5. Supporting a stable and qualified workforce in the community;
6. Protecting individuals from harm and abuse;
7. Building transparency, accountability and fiscal responsibility into the system to ensure quality services and sustainability;
8. Creating a system of services that is flexible and reflects what people want. Emphasis should be placed on consumer employment.
9. Health and safety exemptions to provide needed flexibility;
10. Regulatory requirements and guidelines that are not unnecessarily restrictive or duplicative and focus on positive outcomes; and,
11. Self-Determination as a way to look at things differently, and allow choice and flexibility.

### Issues and Considerations

Specific issues affecting the delivery of services in the community and factors to be considered were identified by individual Task Force members for possible examination, as follows:

1. The core community issue is sustainability, or how does the system guarantee services in the future, with the key component being correct and appropriate rate-setting methodologies to encourage development, innovation and the longevity of services as a business.
2. Another key element of the system is affordable housing, which is closely associated with the cost of care/labor.
3. The work of the Task Force needs to be based on reality; recognizing that funding is rarely adequate and eligibility for services may not reach all who need it.

4. The issues should first be triaged for those that need to be addressed immediately, versus those that are longer-term. Time frames for the work should be established that consider priorities and the timing of the budget cycle.
5. When redesigning the community system, it should reflect new trends and federal modeling/encouragements indicated by recent Centers for Medicare and Medicaid Services (CMS) regulations. Consider the impacts of the CMS regulations and how we transition to the future. The impact of federal funding must be taken into account. Also consider long-range public policy.
6. Important to the examination of community issues is a services inventory, including services that have been impacted by rate reductions or freezes. There should be a correlation between funding and the services that are provided.
7. Resources are not unlimited. Priorities need to be established for preferred models of service for meeting peoples' needs, including those that provide a safety net. We need to understand where the gaps are now and in the future. We should encourage new development and innovation.
8. Look at system reductions over recent history (since 2009) and examine the impact in light of savings, and current and future requirements. Consider if they affected how we support people at home. Align our system changes with other systems' changes (e.g., In-Home Supportive Services as part of managed care).
9. As programs and services are redesigned, build in data collection, accountability, reporting (that is not intrusive for the consumer) and fiscal responsibility. Also, develop a funding structure for programs.
10. When examining the system, consider the changing composition of the population and the funding impacts, especially for serving individuals with autism. Consider needs that are still emerging and cultural competency.
11. Re-envision supports for all populations, and consider whether supports are adequate for families to care for consumers at home.
12. Examine the issue of equity in providing regional center services in light of the diverse populations served and geography. Also determine to what degree regional centers should be standardized.
13. Determine what the role of the State should be in the future of our system, and in providing services for individuals who are difficult to serve.

14. Define quality (less about ratios and more about staffing stability), and build quality and flexibility into our system.
15. Address gaps and funding for services in the primary areas of medical care, dental care and mental health services (especially psychiatry). Also, ensure proper medication protocols/management and durable medical equipment.
16. Consider creating a new fund for community development to support new service models.
17. Review regulations, licensing requirements, oversight mechanisms and regional center functions to be sure we are getting value. Improve the overall regulatory scheme to reduce duplication.
18. Ensure meaningful caseload ratios for regional center case management.
19. Utilize technology so that important information can be shared among the regional center, service providers and the State.
20. Improve the coordination of services at the local level, especially between regional centers and county mental health services for individuals with autism.
21. Consider using developmental center resources to support the community, as recommended in the Plan.

### **TASK FORCE REPRESENTATION**

In response to Secretary Dooley's request for suggestions as to possible changes and additions to the Task Force, and to augment the workgroups, the meeting participants identified the following representation and considerations:

1. Greater consumer representation from the community;
2. Independent family members and parents of consumers living in the community, including representation for school-age children and early intervention services;
3. Various service providers that represent currently non-represented services such as Intermediate Care Facilities, Community Care Facilities, Supported Living Services, Early Intervention and employment services. Also consider additional representation from regional center service provider groups;
4. Union representation from the community;

5. Involve other service partners in the discussions, such as the California Department of Education, the California Department of Rehabilitation, the California Department of Health Care Services, workforce investment boards and county mental health services;
6. As representatives are selected, consider the cultural and ethnic diversity of the group;
7. Consider including expertise in accessing medical and mental health services; and,
8. Consider adding Tony Sauer, former Director of the California Department of Rehabilitation, on employment issues.

### **DATA INQUIRIES AND ANALYSES**

Throughout the discussion, the Task Force identified various data interests and lines of inquiry and analysis for the work ahead, as follows:

1. Evaluate data for onsite (developmental center) crisis services versus jails for 2013;
2. Undertake an unmet-needs assessment, including what services are being requested the most;
3. Review the system reductions. Determine what the impact was and whether anything compels their restoration. Consider them in light of federal requirements;
4. If possible, compile data on abuse in the community, being careful that it is not intrusive for consumers;
5. Look at current and projected populations (trend data since approximately 2008) to identify future service needs;
6. Use data from the National Core Indicators (NCI) surveys, the Client Development Evaluation Reports (CDER) and other sources of information to assess the value, quality and equity of services;
7. Review closure processes to identify successes in the community;
8. Identify incremental housing needs based on aging consumers and parents;

9. Look at what regional centers are required to do today, what has changed over time, and evaluate the need to adjust the core staffing formula;
10. Identify creative regional center efforts to promote health and safety and encourage best practices;
11. Look at sustainability of the investments that have been made in program development;
12. Look at transition data for individuals between the ages of 18 and 25 and the impact on services, especially employment issues. Evaluate how individuals with autism are transitioning to adulthood;
13. Consider geographical impacts on services;
14. Evaluate the effectiveness of Special Incident Reporting on health and safety;
15. Consider the regional center comprehensive assessments and what they tell us about service needs;
16. To the degree possible, consider cost of service data from other states;
17. Develop a syllabus, or library of information for the Task Force to access. Include:
  - Waivers
  - NCI data
  - A glossary of terms
  - Explanation of funding and rates
  - The ways our system is regulated
  - The core staffing formula
  - The Association of Regional Center Agencies' reports on Regional Center Operations and Program Funding
18. Look at the services funded by the Mental Health Services Act (MHSA) grants for regional centers and determine their results;
19. Compile data on individuals with challenging service needs by regional center;
20. Compile data on the cost of living across the State as well as housing costs to inform "sustainability;"
21. Look at the impact of existing and future minimum wage levels;

22. Consider the survey of families that is being conducted at Sonoma Developmental Center. It should be available for the Task Force in September 2014;
23. Identify the prior residence of individuals who are being served at the Canyon Springs Community Facility;
24. Analyze median rates and how many providers are below them today versus when median rates were first implemented;
25. Look at the impact of the reduction in days for day programs;
26. Consider the cost of starting up new/replacement services and how they can be funded/reimbursed;
27. Look at data dealing with the tapering of medications in Supported Living Services;
28. Assess the success of different housing settings/approaches that have recently been developed;
29. Look at the impact of the new federal rules, particularly on Self-Determination;
30. Compare the cost of services in California to other states;
31. Look at consumers who are 50 years or older and still living with their families. Consider how to co-support the consumers and their parents in the future;
32. Look at vacancy rates for the residential resources we have;
33. Evaluate how well we are serving different ethnic communities;
34. Compile demographic data for individuals being served (previously done for the Purchase of Service Study);
35. Compile an inventory of service changes within CHHS (e.g., the universal assessment tool, and the Multi-Purpose Senior Services Program);
36. Evaluate the accountability and the quality assurance measures put in place for the coordinated care initiative;
37. Evaluate higher education opportunities and how those might be achieved (e.g., the Way Finders Program); and,

38. Look at the issue of benefits management and the risk of losing services for those who are employed.

### **NEXT STEPS**

Secretary Dooley indicated that the Task Force will proceed as a “rolling process” with no pre-set end date. The next step will be to summarize the meeting and share it with the Task Force. The Task Force will help organize the approach to be taken and the workgroups will begin their work. The Secretary supported the triage approach. We will be using an incremental process that will inform CHHS as we move forward.

The next Task Force meeting will tentatively be scheduled for early October 2014.



**DEPARTMENT OF  
LABOR/OVERTIME AND  
MINIMUM WAGE ISSUES**



DEPARTMENT OF LABOR

Wage and Hour Division

RIN 1235-AA05

Application of the Fair Labor Standards Act to Domestic Service; Announcement of Time-Limited Non-Enforcement Policy

Authority: 29 U.S.C. 216(c); Secretary's Order No. 05-2010.

**AGENCY:** Wage and Hour Division, Department of Labor.

**ACTION:** Notice.

**SUMMARY:** The Department of Labor's (Department) Final Rule amending regulations regarding domestic service employment, 78 FR 60454, October 1, 2013, which extends Fair Labor Standards Act (FLSA) protections to most home care workers, will become effective on January 1, 2015. The Department is not changing this effective date. This notice announces a time-limited non-enforcement policy. For six months, from January 1, 2015 to June 30, 2015, the Department will not bring enforcement actions against any employer as to violations of FLSA obligations resulting from the amended regulations. For the following six months, from July 1, 2015 to December 31, 2015, the Department will exercise prosecutorial discretion in determining whether to bring enforcement actions, with particular consideration given to the extent to which States and other entities have made good faith efforts to bring their home care programs into compliance with the FLSA since promulgation of the Final Rule. Throughout the 12-month duration of this policy, the Department will continue extensive outreach and technical assistance efforts, in particular with States regarding publicly funded home care programs.

**FOR FURTHER INFORMATION CONTACT:** Michael Hancock, Assistant

Administrator, Office of Policy, U.S. Department of Labor, Wage and Hour Division, 200 Constitution Avenue, NW., Room S-3502, FP Building, Washington, D.C. 20210; telephone: (202) 343-5940 (this is not a toll-free number), email: [HomeCare@dol.gov](mailto:HomeCare@dol.gov). Copies of this Notice may be obtained in alternative formats (Large Print, Braille, Audio Tape, or Disc), upon request, by calling (202) 693-0675 (not a toll-free number). TTY/TTD callers may dial toll-free (877) 889-5627 to obtain information or request materials in alternative formats.

**SUPPLEMENTARY INFORMATION:**

**I. Non-Enforcement Policy**

On October 1, 2013, the Wage and Hour Division of the Department of Labor (Department) issued Application of the Fair Labor Standards Act to Domestic Service; Final Rule, 78 FR 60454 (Home Care Final Rule or Final Rule). The Final Rule amended the domestic service employment regulations under the Fair Labor Standards Act (FLSA or Act), 29 U.S.C. 201 *et seq.*, which are contained in 29 CFR Part 552. Among other changes, the Final Rule (1) modified the definition of “companionship services” and (2) prohibited third party employers (i.e., employers of domestic service employees other than the individuals receiving services or the individuals’ families or households) from claiming either the companionship services exemption from the FLSA’s minimum wage and overtime compensation requirements or the live-in domestic service employee exemption from the FLSA’s overtime compensation requirement. *See* 78 FR 60463-73, 60480-83, 60557 (relevant regulatory changes to be codified at 29 CFR 552.6, 552.109).

The Department explained in the preamble to the Final Rule that the changes to the domestic service employment regulations should go into effect as soon as practicable because they were intended to serve the important purpose of extending basic labor

standards to home care workers, which in turn helps ensure that individuals and their families can rely on a professional, trained workforce to provide high-quality services. 78 FR 60455, 60495. The Department also acknowledged, however, that complex Federal and State systems fund a significant portion of the home care services provided across the country, and making adjustments to operations, programs, and budgets in order to comply with the FLSA could take time. *Id.* at 60494-95. Therefore, in response to comments received in the course of the rulemaking process, the Department set an effective date of January 1, 2015, an unprecedented 15 months after the publication of the Final Rule. *Id.*<sup>1</sup>

Since promulgating the Final Rule, the Department has conducted extensive technical assistance for the regulated community. Specifically, the Department has directly reached thousands of people through over 100 webinars, conference calls, meetings, and presentations, engaging representatives from State governments, associations of State Medicaid and other relevant agencies, consumers, disability and senior citizens' advocates, veterans' organizations, worker representatives, and industry groups, among others. Furthermore, to help stakeholders learn more about the changes associated with the Final Rule, the Department created a home care webpage, which contains links to fact sheets, FAQs, webinar recordings, interactive web tools, and other materials, including two Administrator's Interpretations issued this year in response to stakeholder questions regarding the application of the FLSA to shared living arrangements and joint employment of home care workers by public entities in consumer-directed programs. *See*

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<sup>1</sup> Typically, employers subject to FLSA regulatory changes have 30 or 60 days to adjust before a rulemaking becomes effective. *See* 5 U.S.C. 553(d), 801(a)(3)(A). Prior to the Home Care Final Rule, the longest effective date delay for a Wage and Hour Division rule was 120 days. *See* 78 FR 60495 (citing 69 FR 22126 (Apr. 23, 2004)).

[www.dol.gov/whd/homecare](http://www.dol.gov/whd/homecare). Moreover, the Department has engaged in targeted outreach to the governments of all 50 States. Through this outreach, the Department has provided extensive technical assistance to States as they implement the Home Care Final Rule in publicly funded programs in an effort to encourage implementation of the Final Rule in a manner that expands wage protections for most home care workers and ensures that Medicaid participants and their families continue to have access to the critical home and community-based services upon which they rely, particularly services delivered through innovative models of care.

Nevertheless, the Department has received requests to extend the effective date of the Home Care Final Rule, including from the National Association of Medicaid Directors (NAMD), the National Association of Directors of Developmental Disabilities Services (NASDDDS), the National Association of States United for Aging and Disabilities (NASUAD), organizations representing disability advocates, and the State of Kansas. The State of Oregon requested an extension of the effective date, or in the alternative a non-enforcement policy or waivers for certain States. The States of Maryland and Pennsylvania also requested an extension. These entities expressed the need for States to have more time to adjust their publicly funded home care programs in order to comply with the FLSA, and specifically noted that time was needed for budgetary, programmatic, and operational adjustments. The Department has also received requests to implement the Final Rule on January 1, 2015, as announced at the time of publication, including from Caring Across Generations, Direct Care Alliance, the National Domestic Workers Alliance, National Employment Law Project, Paraprofessional Healthcare Institute (PHI), the National Consumer Voice for Quality Long-Term Care, the American Geriatrics

Society, and other organizations of worker advocates. These entities wish to see the nearly two million home care workers in the United States be guaranteed the basic minimum wage and overtime protections of the FLSA without delay.

The Department has carefully considered these requests and is not extending the Final Rule's effective date. When the Final Rule becomes effective, the regulated community will have had 15 months to make any adjustments necessary to fulfill new FLSA obligations. Many employers, including States, are poised to pay home care workers in compliance with the FLSA's fundamental protections on January 1, 2015. For these reasons, the Final Rule's effective date will remain January 1, 2015.

The Department recognizes, however, that the implementation of the Final Rule raises sensitive issues. In particular, the Department has been committed to assisting the regulated community in considering methods of complying with the FLSA in a manner that avoids harmful impacts on the individuals who rely on home care. Additionally, the Department has historically provided compliance assistance prior to the enforcement of new regulations, and it will continue to focus on such assistance during the initial stages of implementing the Home Care Final Rule. Given the unique effects of this rule, the Department has been committed to providing extensive compliance assistance, reaching out to all 50 states individually and providing other varied technical assistance to States and other stakeholders. Therefore, the Department is announcing that between January 1, 2015 and June 30, 2015, it will not bring enforcement actions against any employer as to violations of FLSA obligations resulting from the Final Rule. *See* 29 U.S.C. 216(c) (giving authority to the Department to bring enforcement actions, including investigating potential violations of the FLSA, supervising settlements for unpaid wages owed under

the Act, or filing suit in Federal court to recover such wages); *see also* Secretary’s Order No. 05-2010 (delegating this authority to the Administrator of the Wage and Hour Division). This initial non-enforcement policy will apply to all employers. During this six-month period, the Department will concentrate its resources on continuing to provide intensive technical assistance to the regulated community, in particular State agencies administering home care programs, regarding the Final Rule and the application of the FLSA to home care arrangements. Although the Department will not conduct formal investigations of potential FLSA violations during this time, any information received during this time period suggesting non-compliance with FLSA requirements will be used as an opportunity to provide additional technical assistance to States and other potential employers in order to facilitate efficient and effective implementation of the Final Rule.<sup>2</sup>

After July 1, 2015, the Department will commence enforcement actions for FLSA violations resulting from the Home Care Final Rule. From July 1, 2015 until December 31, 2015, however, the Department will exercise its prosecutorial discretion in a manner that is consistent with this notice when making determinations on a case-by-case basis as to whether to bring enforcement actions in the home care context. During this six-month period, the Department will give strong consideration to an employer’s efforts to make

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<sup>2</sup> This non-enforcement policy does not apply to FLSA violations unaffected by the Final Rule, such as those involving home care services provided by registered nurses and licensed practical nurses. *See* current 29 CFR 552.6 (providing that the companionship services exemption does not apply to services that “require and are performed by trained personnel, such as a registered or practical nurse”); 78 FR 60469 (explaining this existing regulatory provision). Similarly, services provided in nursing homes, group homes, or other institutions in which the workers are not domestic service employees fall outside the scope of the Final Rule and therefore violations in those settings are not subject to the position described here. *See* 29 CFR 552.3 (defining “domestic service employment” as “services of a household nature performed by an employee in or about a private home (permanent or temporary)”); 78 FR 60461-43 (describing the meaning of the term “private home”).

any adjustments necessary to implement the Final Rule, and in particular a State's efforts to bring its publicly funded home care programs into FLSA compliance, in determining how best to use its prosecutorial discretion in this area. The Department will, as always, consider a variety of other factors in making enforcement decisions, including the Department's limited resources, the extent of the violations at issue, and the impact of a particular enforcement action on compliance more broadly. The Department's intensive outreach and technical assistance efforts will continue throughout this period.

## **II. Regulatory Requirements**

This Notice is non-binding guidance articulating considerations relevant to the Department's exercise of its enforcement authority under the FLSA. It is therefore exempt from the notice-and-comment rulemaking requirements under the Administrative Procedure Act pursuant to 5 U.S.C. 553(b).

Because no notice of proposed rulemaking is required, the Regulatory Flexibility Act does not require an initial or final regulatory flexibility analysis. 5 U.S.C. 603(a), 604(a). The Department has determined that this guidance does not impose any new or revise any existing recordkeeping, reporting, or disclosure requirements on covered entities or members of the public that would be collections of information requiring OMB approval under the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*

Dated: October 6, 2014

David Weil,

Administrator, Wage and Hour Division.



## California Supported Living Services & the Department of Labor Overtime Rule Change

CA SLS providers have been asking DOL for months if they are joint employers with IHSS and whether they need to aggregate both IHSS and SLS funded hours for each worker to determine overtime costs (for which SLS providers would be largely responsible).

CA state officials (DDS and DSS) claim that SLS and IHSS are completely separate programs, with separate employer authority, different program sources, different regulations, paying for completely different tasks (IHSS focused more on ADL support and SLS focused more on training of community living skills) and each program pays different rates---therefore, according to state officials, no aggregation of hours for a worker funded by both sources is needed to calculate potential overtime obligations.

SLS providers describe a much more composite situation on the ground where the two programs are blended to fill in the consumer's day-----the worker, if funded by the two separate funding sources, does indeed have separate tasks attributable to each fund source, but given a single worker is supporting a single consumer for large parts of the day, the hours and tasks begin to bleed into each other.

Furthermore, providers describe the hiring process for a worker funded by both fund sources as, by necessity, needing to be highly coordinated, since the consumer is ostensibly hiring the worker through IHSS, but the SLS living provider is hiring the same worker to work with the same consumer, just from a different funding source. It is similar when it comes to terminating an employee---in theory, the SLS provider can terminate a worker but the consumer could allow the same worker to remain on for the IHSS funded part of the work. Then, the SLS provider would have to bring in a second worker. In reality, however, termination decisions are more likely handled jointly between the consumer and SLS provider.

The overarching question to all the factors above is whether the lines are so blurred, or blurred enough, that a court would find all three parties ( the consumer, the State---since the State already concedes it is a joint employer in IHSS---- and the SLS provider) are co-employers and therefore responsible to count all hours toward overtime. And, if this were the case, would it still leave the SLS provider liable for the OT costs?

DOL continues to research this issue but, so far, has not provided clarification. For example, DOL is researching whether sleep time under certain conditions can be excluded from overtime considerations even though California law requires sleep time to be paid minimum wage.

**At this point, the position of DOL seems to be that SLS providers are joint employers with IHSS and are therefore responsible for aggregating the hours of each worker and paying OT costs. The CA State Legislature recently authorized a 5.82% rate increase for SLS providers. However, this rate increase is not nearly adequate to address the substantial increases in OT costs. Without further clarification from DOL or additional rate increases, some SLS providers may decide to terminate their programs and access to SLS may decrease significantly throughout the state.**





# Unanticipated CA Employer Mandates Impacting Service Providers



7/1/2014

## Minimum Wage increase to \$9.00/hr

Salaried employees must be paid at least \$18/hr



1/1/2015

## Domestic Service Employee Overtime Rules Start for Third Party Employers (AB241 and FLSA)

**NOTE: No state-wide consensus among providers and their labor attorneys on implementing the following as of 9/16/14:**



- Regional Center vendored programs (including SLS, Respite and FMS): 40+ hours/week = OT
- Non-RC programs (eg. Foster/MH): 8+hrs/day and 40+hrs/week = OT
- Travel time driving between customer homes must be paid

<http://www.dol.gov/whd/homecare/>

*\*See page 2 for additional Fact Sheets*

1/1/2015

## Obamacare Starts for Large Employers / "Employer Shared Responsibility" (Internal Revenue Code 4980H)

Patient Protection and Affordable Care Act Employer Mandate for large employers (50+ FTE employees) to provide health insurance to employees working average 30+hours/week (130+hrs/mo).



- Incurs non-tax-deductible penalty of \$2000/employee for "Employer Shared Responsibility Payment" for not providing affordable care to eligible employees (penalty not calculated toward the first 30 eligible employees)
- Large employers (100+ FTE) must cover 70% of employees in 2015 and 95% of employees in 2016
- Penalties won't take effect until 2016 for medium employers (50-99 EE's)

<http://www.nfib.com/cribsheets/employer-mandate-calculations/>

<http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act>

7/1/2015

## Sick Pay Accruals Begin (AB1522)

Employees who work more than 30 days/year are entitled to receive at least 24 hours/year of Sick Pay, which starts accruing 7/1/2015 at the rate of 1 hour for every 30 hours worked, after 90 days of employment. Accruals must be listed on paycheck stubs. Sick pay is not paid out when terminated.



1/1/2016

## Minimum Wage increase to \$10.00/hr

Salaried employees must be paid at least \$20/hr



## Resources:

### **\*FLSA Domestic Service Employee Overtime Rules – Dept. of Labor Fact Sheets:**

- **Fact Sheet #79** ([PDF](#), [TEXT](#)) — Private Home and Domestic Service Employment Under the Fair Labor Standards Act
- **Fact Sheet #79A** ([PDF](#), [TEXT](#)) — Companionship Services Under the Fair Labor Standards Act (FLSA)
- **Fact Sheet #79B** ([PDF](#), [TEXT](#)) — Live-in Domestic Service Workers Under the Fair Labor Standards Act (FLSA)
- **Fact Sheet #79C** ([PDF](#), [TEXT](#)) — Recordkeeping Requirements for Individuals, Families, or Households Who Employ Domestic Service Workers Under the Fair Labor Standards Act (FLSA)
- **Fact Sheet #79D** ([PDF](#), [TEXT](#)) — Hours Worked Applicable to Domestic Service Employment Under the Fair Labor Standards Act (FLSA)
- **Fact Sheet #79E** ([PDF](#), [TEXT](#)) — Joint Employment in Domestic Service Employment Under the Fair Labor Standards Act (FLSA)
- **Fact Sheet #79F** ([PDF](#), [TEXT](#)) — Paid Family or Household Members in Certain Medicaid-Funded and Certain Other Publicly Funded Programs Offering Home Care Services Under the Fair Labor Standards Act (FLSA)
- **Fact Sheet #79G** ([PDF](#), [TEXT](#)) — Application of the Fair Labor Standards Act to Shared Living Programs, including Adult Foster Care and Paid Roommate Situations

**NEW CENTER FOR  
MEDICARE AND MEDICAID  
RULES**



# HCBS Statewide Transition Plan

The California Department of Health Care Services (DHCS) is developing a Statewide Transition Plan (STP) as a result of the new Federal Home and Community-Based (HCB) Setting requirements effective March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F, which affect 1915(i) and 1915(c) HCB Services Waivers. Pursuant to the new rules, the State must develop an STP within 120 days of submission of any Waiver amendment or renewal. This trigger date was initiated with the submission of the Multipurpose Senior Services Program (MSSP) Waiver renewal on August 22, 2014. Please note there will be individual Waiver Transition Plans, and additional stakeholder input processes, required to be submitted to the Centers for Medicare and Medicaid Services (CMS) by March 16, 2015. Further, all 1915(i) and 1915(c) Waivers must be in full compliance with the new Federal rules by March 16, 2019.

DHCS has been working with partner agencies, including The Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Public Health (CDPH), and other interested parties to develop a STP draft for public and stakeholder input. The State has been reviewing all 1915(i) and 1915(c) Waiver services and provider-controlled residential settings for compliance with the new HCB Setting requirements.

The initial draft (September 19, 2014) of the STP that outlines the various services and identifies the specific provider types in the 1915(i) and 1915(c) that DHCS, DDS, CDA and CDPH consider needing special focus to ensure compliance. The State invites stakeholders to assist in the assessment of HCB Setting compliance with Federal requirements, and welcomes interested parties into the stakeholder input process for a transparent and effective transition of these critical Medi-Cal programs.

- [Draft HCBS Statewide Transition Plan \(PDF\)](#)

## Stakeholder Comments

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DHCS will review and analyze all stakeholder comments and will revise the STP accordingly. DHCS will post the STP on September 19, 2014 which initiates the 30-day public comment period. After our first STP stakeholder call, DHCS will post the revised STP for stakeholder review and final comments. After reviewing final public input, DHCS intends to post the final STP on the DHCS website and submit the STP to CMS by December 20, 2014.

- The first stakeholder call will be scheduled for October 21, 2014, 10am – 12pm.
  - The call in number is: 888-829-8671 Participant passcode: 7335142
- The second stakeholder call will be scheduled for December 2, 2014, 10am – 12pm.

- The call in number is: 888-829-8671 Participant passcode: 7335142

## **Public Comments**

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- The first public comment period will begin September 19, 2014 through October 19, 2014.
- The second public comment period will begin October 27, 2014 through November 26, 2014.

Summary of stakeholder comments and minutes from stakeholder calls will be posted online in tandem with revised STP drafts. Please submit all comments to: [STP@dhcs.ca.gov](mailto:STP@dhcs.ca.gov).

We look forward to working with our stakeholders to ensure compliance with the new Federal rules. Please note that conference call dates, times, and phone numbers may change. Please check the website for any such changes.



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## **Statewide Transition Plan Toolkit for Alignment with the Home and Community-Based Services (HCBS) Final Regulation's Setting Requirements**

*September 5, 2014*

The following information is intended to suggest alternative approaches and considerations for states as they prepare and submit Statewide Transition Plans as required by the HCBS final regulation published January 16, 2014 (available at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>). This toolkit relates specifically to the Federal requirements for residential and non-residential home and community-based settings. These regulatory requirements can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).

### **What is a Statewide Transition Plan?**

The Statewide Transition Plan is the vehicle through which states determine their compliance with the regulation requirements for home and community-based settings at 42 CFR 441.301(c)(4)(5) and 441.710(a)(1)(2), and describe to CMS how they will comply with the new requirements. A Statewide Transition Plan includes the state's assessment of the extent to which its regulations, standards, policies, licensing requirements, and other provider requirements ensure settings that comport with the requirements outlined at 42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2). The Statewide Transition Plan also describes actions the state proposes to assure full and on-going compliance with the HCBS settings requirements, with specific timeframes for identified actions and deliverables.

The Statewide Transition Plan is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii).

### **Who Submits?**

Each state operating a section 1915(c) waiver or a section 1915(i) state plan benefit that was in effect on or before March 17, 2014 is required to file a Statewide Transition Plan.

### **When to Submit?**

The trigger for filing a Statewide Transition Plan is the state's first 1915(c) waiver or 1915(i) SPA renewed or amended between March 17, 2014 and March 16, 2015. A Statewide Transition Plan must be submitted within 120 days after the submission date of the first renewal or amendment. If a state does not submit an amendment or renewal between March 17, 2014 and March 16, 2015, the state must submit a Statewide Transition Plan no later than March 17, 2015. States must be in full compliance with the Federal requirements by the time frame approved in their Statewide Transition Plan, not to exceed March 17, 2019.

**How can states determine alignment with the new Federal requirements on HCBS settings?**

The purpose of the Statewide Transition Plan is to describe how the state will bring all pre-existing 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements at 42 CFR 441.301(c)(4)(5) and Section 441.710(a)(1)(2). To determine whether state transition actions are needed for compliance, CMS expects that states must first determine their current level of compliance with the settings requirements and provide a written description to CMS. Included in the written description should be the state's assessment of the extent to which its standards, rules, regulations, or other requirements comply with the Federal HCBS settings requirements and the description of the state's oversight process to ensure continuous compliance. The state may also assess individual settings/types of settings to further document their compliance.

Possible scenarios might include:

- 1) Upon conducting its compliance assessment, a state may determine that existing state standards meet the Federal settings requirement, the state's oversight process is adequate to ensure compliance, and, therefore, any settings currently approved under the state's standards meet the Federal settings requirement. In this scenario, the state describes its process for conducting the compliance review and the outcomes of that review; or
- 2) The state conducts its compliance review and determines that its standards may not meet the Federal settings requirements. In this scenario, the state includes in the Statewide Transition Plan the specific actions to be taken to come into compliance. These actions might include proposing new state regulations or revising existing ones; revising provider requirements; and conducting statewide provider training on the new state standards. The Statewide Transition Plan should also include the time frames for completing these actions, an estimate of the number of settings that likely do not meet the Federal settings requirement and the time frame necessary to bring individual settings into compliance.

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In situations where the state standards do not coincide with the Federal standards, it is possible that specific settings are still in compliance with the Federal requirements. In this case, a state may choose to assess individual sites to determine which are/are not in compliance with the Federal standard. Such an assessment may impact the time frames proposed to bring settings into compliance; if so, the Statewide Transition Plan should include these additional actions and timeframes.

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States may conduct specific site evaluations through a variety of standard processes including, but not limited to licensing reviews, provider qualification reviews, and support coordination visit reports. States may also engage individuals receiving services as well as representatives of consumer advocacy entities (such as long-term care ombudsman programs and protection and advocacy systems) in the assessment process.

States may conduct – or develop a tool for qualified entities to conduct – site specific evaluations of settings using the Federal requirements as a basis for the evaluation. Such evaluations may be conducted by entities including, but not limited to state personnel, case managers that are not associated with the agency operating the setting in which services are provided, licensing entities, Managed Care Organizations, individuals receiving home and community-based services, representatives of consumer advocacy entities such as long-term care ombudsman programs and/or protection and advocacy systems. States may also perform on-site assessments of a statistically significant sample of settings. When states do not have full knowledge of the settings in their system, CMS strongly encourages, at a minimum, a sampling approach to on-site reviews.

States may also administer surveys to providers to determine whether the settings in which those providers operate meet the home and community-based settings requirements. In this instance, providers could “self-assess” their compliance with the Federal requirements or provide information required by the state to make a determination of compliance. In either situation, states could perform assessments of individual settings to verify compliance. If providers indicate they do not meet the new requirements, states should include remediation strategies in the Statewide Transition Plan, including actions and associated time frames for bringing the programs/settings into compliance.

It should be noted that assessment of individual settings is not a substitute for ensuring that state standards, regulations, policies, and other requirements are consistent with Federal requirements and that the state has an oversight system in place to assure ongoing compliance with the requirements. In addition, where the state is submitting evidence that a setting presumed not to be home and community-based is in fact home and community-based and does not have the qualities of an institution, evidence of a site visit will facilitate the heightened scrutiny process.

The state’s determination of compliance is the first step in Statewide Transition Plan development. The next step is developing and describing to CMS the state’s actions to come into full compliance, including timelines and milestones.

#### **What does CMS expect to see in a Statewide Transition Plan?**

Presence of the following items will facilitate CMS review of the states’ submitted plans:

- A detailed description of the state’s assessment of compliance with the home and community-based settings requirements and a statement of the outcome of that assessment.
  - If the state determines on the basis of the review of current state regulations, standards, and policy that settings within the state are consistent with Federal settings requirements, the state should describe the process of the compliance assessment, the basis for the conclusion and the oversight (monitoring) process that ensures this. If the process of assessment

is not yet complete and has required, or will require, greater than six (6) months for review, the state must submit justification for the additional time frame.

- If the assessment is based on state standards, the state needs to provide their best estimate of the number of settings that: 1) fully align with the Federal requirements; 2) do not comply with the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals; 4) are presumptively non-home and community-based but for which the state will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process). In instances where a system review identifies settings which are presumed not to be home and community-based (home and community-based) and the state intends to submit evidence that the setting is home and community-based and does not have institutional characteristics, CMS would expect an onsite assessment that supports the state's assertion.
  - If the state conducts site specific evaluations, the state needs to provide the best estimate of the number of settings that 1) fully comply with the Federal requirements; 2) do not meet the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals; 4) are presumptively non-home and community-based but for which the state will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process).
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- A detailed description of the remedial actions the state will use to assure full compliance with the home and community-based settings requirements, including timelines, milestones and monitoring process. Remedial actions might include:
    - At the state level, remedial actions might include, but are not limited to, new requirements promulgated in statute, licensing standards or provider qualifications, revised service definitions and standards, revised training requirements or programs, plans to relocate individuals to settings that are compliant with the regulations, and a description of the state's oversight and monitoring processes.
    - At the provider level, remedial actions might include, but are not limited to, changes to the facility or program operation to assure that the Medicaid beneficiary has greater control over critical activities like access to meals,

engagement with friends and family, choice of roommate, and access to activities of his/her choosing in the larger community, including the opportunity to seek and maintain competitive employment.

- If the state decides to submit evidence to CMS for the application of the heightened scrutiny process for settings that are presumed not to be home and community-based, the Statewide Transition Plan should include evidence sufficient to demonstrate the setting does not have the characteristics of an institution and does meet the home and community-based setting requirements. Evidence of a site visit by the state, or an entity engaged by the state, will facilitate the heightened scrutiny process. CMS will consider input from the state, information collected during the public input process, and information provided by other stakeholders as part of the heightened scrutiny process. CMS may also conduct individual site visits as well.
- When relocation of beneficiaries is part of the state’s remedial strategy, the Statewide Transition Plan should include:
  - An assurance that the state will provide reasonable notice to beneficiaries and due process to these individuals;
  - A description of the timeline for the relocation process;
  - The number of beneficiaries impacted; and
  - A description of the state’s process to assure that beneficiaries, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice of an alternate setting that aligns, or will align, with the regulation, and that critical services/supports are in place in advance of the individual’s transition.
- The time frame and milestones for state actions, including assessment and remedial actions. If state standards must be modified in order to effect changes in the state system, the state should propose a reasonable time frame for making the modifications. If the state intends to conduct an assessment after adopting new standards, the state should provide information on how, in the interim, the state will communicate the need for change, educate providers, inform individuals and families, and establish a time frame for the activities. The state must also include a complete timetable for coming into full compliance.
- A description of the public input process, with a summary of public comments, including the full array of comments whether in agreement or not with the state’s determination of the system-wide compliance and/or compliance of specific settings/types of settings; a summary of modifications to the Statewide Transition Plan made in response to public comment; and in cases where the state’s determination differs from public comment, the additional evidence and rationale the state used to confirm the determination (e.g. site visits to specific settings).
- The URL where the Statewide Transition Plan is posted.

### **When is Public Input Required?**

Prior to filing with CMS, a state must seek input from the public on the state's proposed Statewide Transition Plan, providing no less than a 30-day period for that input. CMS encourages states to seek input from a wide range of stakeholders representing consumers, providers, advocates, families, and other related stakeholders. The process for individuals to submit public comment should be convenient and accessible for all stakeholders, particularly individuals receiving services. CMS requires states to post the Statewide Transition Plans on their website in an easily accessible manner and include a website address for comments. At least one additional option for public input, such as public forums, is required.

The Statewide Transition Plan requirements set forth that states must provide evidence of two statements of public notice and requests for public input, the timeframe for public input (which verifies that a minimum of 30-days was afforded for public review and comment), and a description of the public input process. To accomplish this, the state could include in the Statewide Transition Plan the actual date of the public notice, the processes used for providing the public notice (e.g., publication in newspapers, announcement via websites) and how public input was received (e.g., testimony, web response).

When filing the Statewide Transition Plan with CMS, the state must provide a summary of public comments, including comments that agree/disagree with the state's determinations about whether types of settings meet the home and community-based settings requirements; a summary of modifications to the Transition Plan made in response to public comment; and in the case where the state's determination differs from public comment, the additional evidence and the rationale the state used to confirm the determination (e.g. site visits to specific settings). At the time the state files the Statewide Transition Plan with CMS, the state must simultaneously post the submitted plan on the state's website. The URL for that posting should be included in the Statewide Transition Plan submission to CMS.

The state must also provide an assurance that the Statewide Transition Plan, with any modifications made as a result of public input, is posted for public information no later than the date of submission to CMS, and that all public comments on the Statewide Transition Plan are retained and available for CMS review for the duration of the transition period or approved waiver, whichever is longer.<sup>1</sup>

CMS wishes to ensure that states recognize the changes in the public notice and public input process required by this regulation. States must ensure the document is posted and, in the case of public forums, available or distributed for comment. States can use summary documents or offer explanations of contents of the Statewide Transition Plan, in addition to the document itself. However, the state must ensure the full Statewide Transition Plan is available to the

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<sup>1</sup> States filing waiver renewals or amendments to existing 1915(c) waivers require a public input process in addition to the public input process for the embedded waiver specific Transition Plan. A state could use one public input process to meet both requirements.

public for comment, including individuals receiving services, individuals who could be served, and the full stakeholder community. While a state may find meetings held with selected representatives of types of stakeholder useful, such meetings will not be sufficient to demonstrate adequate notification or input.

Finally, consistent with the Toolkit document “STEPS TO COMPLIANCE FOR HCBS SETTINGS REQUIREMENTS IN A 1915(c) WAIVER and 1915(i) SPA” substantive changes in a Statewide Transition Plan will require public comment. For example, when a state submits an amendment or modification to a Statewide Transition Plan where additional assessment has resulted in a change in the findings or where the state adds more specific remedial action and milestones, the state must incorporate the public notice and input process into that submission. CMS believes it would be very helpful for the states to use public input in the assessment of the state’s progress on the milestones approved in the Statewide Transition Plan. Therefore, states are strongly encouraged to describe their process for ensuring ongoing transparency and input from the stakeholders in the Plan.



## Foreword

### *Background – 1915(c) Waivers*

The Federal government authorized the “Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver program” in 1981 under Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35). It is codified in section 1915(c) of the Social Security Act. The original legislative intent of the HCBS Waiver program was to slow the growth of Medicaid (Medi-Cal in California) spending by providing services in less expensive settings. In order to contain costs, the federal legislation limited waiver services to individuals who would be institutionalized if the services were not provided. However, the costs of those waiver services cannot be higher than what they would cost in an institutional setting.

The law permitted states to waive certain Medicaid program requirements and in doing so, deviate from Medicaid requirements, such as providing services only in certain geographic areas (“waive statewideness”). The HCBS Waiver program also allowed states flexibility to offer different types of services to individuals with chronic disabilities. Prior to this, with the origin of Medicaid in 1965, beneficiaries could only receive comprehensive long-term care in institutional settings (“budget neutrality”).

The initial waiver application is approved by the Centers for Medicare & Medicaid Services (CMS) for three years with additional renewal applications needing to be approved every five years. The waiver can be designed for a variety of targeted diagnosis-based groups including individuals who are elderly, and those who have physical, developmental, or mental health disabilities, or other chronic conditions such as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The waiver can be designed to offer a variety of services including case management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other services specifically requested by the state. 1915(c) HCBS waivers have subsequently become mechanisms for many states, including California, to provide Medicaid-funded community-based, long-term care services and supports to eligible beneficiaries.

### *Background – 1915(i) State Plan*

The Deficit Reduction Act of 2005 (DRA) gave states starting January 1, 2007 a new option to provide HCBS through a state plan amendment (SPA). Once approved by CMS, 1915(i) SPAs do not need to be renewed nor are they subject to some of the same requirements of waivers; for example, budget neutrality. Under this option, states set their own eligibility or needs-based criteria for providing HCBS. States are allowed to establish functional criteria in relation to certain services. The DRA provision eliminated the skilled need requirement and allowed states to cover Medicaid beneficiaries who have incomes no greater than 150 percent of the federal poverty level and who satisfy the needs-based criteria. The Patient Protection and Affordable Care Act of 2010 created several

amendments including elimination of enrollment ceilings, a requirement that services must be provided statewide, and other enrollment changes.

In early January 2014, CMS announced it had finalized important rules that affect HCBS provided through Medicaid/Medi-Cal, and subsequently published the regulations in the Federal Register on January 16, 2014. The rules became effective 60 days from publication, or March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F.

### *Issues addressed in this Plan*

This Statewide Transition Plan will present ways in which the State of California will evaluate home and community-based (HCB) settings where 1915(c) waivers and 1915(i) state plan program services are currently available. If it is determined that there are settings that do not meet the final regulations' HCB settings requirements, such HCB settings will be required to make changes that will bring them into compliance.

Information included in this document includes:

- Overview of State Responsibility
- HCB Settings
  - Summary of New Federal Requirements
  - Requirements for Modification of Compliance
- Overview of HCBS Programs
  - Multipurpose Senior Services Program (MSSP) Waiver
  - HIV/AIDS Waiver
  - HCBS Waiver for Persons with Developmental Disabilities (DD) Waiver
  - Assisted Living Waiver (ALW)
  - Nursing Facility/ Acute Hospital Transition and Diversion (NF/AH) Waiver
  - In-Home Operations (IHO) Waiver
  - San Francisco Community Living Support Benefit (SFCLSB) Waiver
  - Pediatric Palliative Care (PPC) Waiver
- Existing Settings in HCB Programs – Review and Analysis
  - California Plan for Determination of HCB Setting Compliance

## **Overview of State Responsibility**

The State's HCBS program administrative teams are comprised of employees from the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Developmental Services (DDS), and the California Department of Aging (CDA). The San Francisco Department of Public Health (SFDPH) administers a 1915(c) waiver in accordance with terms of an Agreement with DHCS.

Existing waivers and corresponding state administrative teams are as follows:

1. MSSP Waiver (0141), CDA, Long Term Care & Aging Services
2. HIV/AIDS Waiver (0183), CDPH, Office of AIDS

3. DD Waiver (0336), DDS, Community Services
4. ALW (0431), DHCS, Long-Term Care Division
5. NF/AH Waiver (0139), DHCS, Long-Term Care Division
6. IHO Waiver (0457), DHCS, Long-Term Care Division
7. SFCLSB Waiver (0855), SFDPH
8. PPC Waiver (0486), DHCS, Systems of Care Division

Existing 1915(i) SPAs 09-023A and 11-041 are administered by DDS.

## HCBS Settings

Prior to the final rule, HCBS setting requirements were based on location, geography, or physical characteristics. The final rules define HCBS settings as more process and outcome-oriented, guided by the consumer's person-centered service plan by:

1. Being integrated in and supporting full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. Giving individuals the right to select from among various setting options, including non-disability specific settings and an option for a private unit in a residential setting.
3. Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizing autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.
5. Facilitating choice regarding services and supports, and who provides them.

For Medi-Cal provider-owned or controlled HCBS settings, the provider must offer:

- A legally enforceable agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protection against eviction.
- Privacy in units including lockable doors, choice of roommates and freedom to furnish and decorate units.
- Options for individuals to control their own schedules including access to food at any time.
- Individuals the freedom to have visitors at any time.
- A physically accessible setting.

Any modification(s) of the new requirements must be supported by a specific and individually assessed need and justified in the person-centered service plan.

Documentation of all of the following is required:

- Identification of a specific and individualized assessed need.
- The positive interventions and supports used prior to any modification(s) to the person-centered plan.

- Less intrusive methods of meeting the need that have been tried but did not work.
- A clear description of the condition(s) that is directly proportionate to the specific assessed need.
- Review of regulations and data to measure the ongoing effectiveness of the modification(s).
- Established time limits for periodic reviews to determine if the modification(s) is still necessary or can be terminated.
- Informed consent of the individual.
- An assurance that interventions and supports will cause no harm to the individual.

## Overview of HCBS Programs

California currently has two approved 1915(i) SPAs that allow the State to access federal financial participation for services provided to individuals with developmental disabilities who do not meet the institutional level-of-care criteria required for participation in the DD Waiver, which is described in greater detail below.

California currently administers eight 1915(c) HCBS waivers.

Descriptions of the individual waivers follow below.

- *Multipurpose Senior Services Program (MSSP) Waiver.* The objective of this program is to provide opportunities for frail seniors age 65 or older to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement. Care management is the cornerstone of this waiver and involves beneficiary assessment; person-centered care planning; service arrangement, delivery and monitoring; as well as coordinating the use of existing community resources. The 39 MSSP sites maintain wait lists independently; average wait in days statewide is 91 (during 10/1/12 through 12/31/12). The current waiver was approved on July 1, 2009.

MSSP Waiver provider types include all of the following:

- Adult Day Care/ Support Center
- Building Contractor or Handyman/Private Nonprofit or Proprietary Agency
- Congregate Meals Setting
- Home Health Agency
- Licensed/Certified Professionals
- Private Nonprofit or Proprietary Agency
- Registered Nurse Care Manager (RN)
- Social, Legal, and Health Specialists
- Social Worker Care Manager
- Title III (Older Americans Act)
- Translators/Interpreters
- Transportation Providers

- *HIV/AIDS Waiver.* The purpose of this waiver is to allow persons of all ages with mid- to late-stage HIV/AIDS to remain in their homes through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities. There is no waiting list for eligible beneficiaries. The current waiver was approved on January 1, 2012.

HIV/AIDS Waiver provider types include all of the following:

- Clinical Psychologist
  - Foster Parent
  - Home Health Agency
  - Licensed Clinical Social Worker
  - Local Pharmacy or Vendor
  - Marriage and Family Therapist
  - Masters Degree Nurse; Psychiatric and Mental Health Clinical Nurse Specialist or Psychiatric and Mental Health Nurse Practitioner
  - Private Nonprofit or Proprietary Agency
  - Registered Dietician
  - RN
  - Social Work Case Manager
  - Waiver Agency with Exception Approved by CDPH/Office of Aids
- *HCBS Waiver for Persons with Developmental Disabilities (DD Waiver).* The purpose of this waiver is to serve participants of all ages in their own homes and community settings as an alternative to placement in hospitals, nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF/DD). Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private non-profit corporations known as regional centers. Regional centers provide fixed points of contact in the community for persons with developmental disabilities and their families. The DD Waiver has been in operation since 1982 to assist in funding services for individuals who live in the community and who meet the ICF/DD level-of-care requirements. DD Waiver participants live in the setting of their choice, such as with their families, in their own homes or apartments, or in licensed settings. There is no waiting list for eligible beneficiaries. The current waiver was approved on March 29, 2012.

DD Waiver provider types include all of the following:

- Activity Center
- Adaptive Skills Trainer
- Adult Day Care Facility
- Adult Development Center
- Adult Residential Facility
- Adult Residential Facility for Persons with Special Health Care Needs

- Associate Behavior Analyst
- Behavior Analyst
- Behavior Management Consultant
- Behavior Management Program
- Behavioral Technician/Para-professional
- Building Contractor or Handyman
- Camping Services
- Certified Family Home
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Client/Parent Support Behavior Intervention Training
- Clinical Psychologist
- Community-Based Training Provider
- Contractor
- Creative Arts Program
- Crisis Intervention Facility
- Crisis Team - Evaluation and Behavioral Intervention
- Dentist
- Dental Hygienist
- Dietitian; Nutritionist
- Dispensing Optician
- Driver Trainer
- Durable Medical Equipment Provider
- Facilitators
- Family Home Agency: Adult Family Home/Family Teaching Home
- Financial Management Services Provider
- Group Home
- Hearing and Audiology Facilities
- Home Health Agency
- Home Health Aide
- Independent Living Program
- Independent Living Specialist
- Individual (Landlord, Property Management)
- Individual or Family Training Provider
- In-Home Day Program
- Licensed Clinical Social Worker
- Licensed Psychiatric Technician
- Licensed Vocational Nurse (LVN)
- Marriage Family Therapist
- Occupational Therapist
- Occupational Therapy Assistant
- Optometrist
- Orthoptic Technician
- Parenting Support Services Provider
- Personal Assistant
- Personal Emergency Response Systems Provider
- Physical Therapist

- Physical Therapy Assistant
  - Physician/Surgeon
  - Psychiatrist
  - Psychologist
  - Public Transit Authority
  - Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company
  - Registered Nurse
  - Residential Care Facility for the Elderly
  - Residential Facility (Out-of-State)
  - Respite Agency
  - Small Family Home
  - Social Recreation Program
  - Socialization Training Program; Community Integration Training Program; Community Activities Support Service
  - Special Olympics Trainer
  - Speech Pathologist
  - Sports Club: (e.g., YMCA, Community Parks and Recreation Program, Community-Based Recreation Program)
  - Supported Employment
  - Supported Living Provider
  - Translators/Interpreters
  - Transportation Providers
  - Vehicle Modification and Adaptations
  - Work Activity Program
- *Assisted Living Waiver (ALW)*. This waiver offers eligible seniors and persons with disabilities age 21 and over the choice of residing in either a licensed Residential Care Facility for the Elderly or an independent publicly subsidized housing with Home Health Agency services as alternatives to long-term institutional placement. The goal of the ALW is to facilitate nursing facility transition back into community settings or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement. Eight care coordinator agencies serving seven counties independently maintain wait lists. The current waiver was approved on March 1, 2009.

ALW provider types include all of the following:

- Care Coordination Agency
  - Home Health Agency in Public Subsidized Housing
  - Residential Care Facility for the Elderly
- *Nursing Facility/Acute Hospital (NF/AH) Waiver*. This waiver combined three 1915(c) waivers into one waiver. The NF/AH Waiver offers services in the home to Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult

subacute, pediatric subacute, intermediate care facility for the developmentally disabled – continuous nursing care and Nursing Facility A/B levels of care with the option of returning and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The current NF/AH Waiver was approved on January 1, 2012.

NF/AH Waiver provider types include all of the following:

- Durable Equipment Provider
  - Employment Agency
  - Home and Community-Based Continuous Care Facility
  - Home Health Agency
  - In-Home Support Services Public Authority
  - Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing Care
  - Licensed Clinical Social Worker
  - Licensed Psychologist
  - LVN
  - Marriage Family Therapist
  - Non-Profit or Proprietary Agency
  - Personal Care Agency
  - Private Nonprofit or Proprietary Agency
  - Professional Corporation
  - RN
  - Waiver Personal Care Services Provider
- *In-Home Operations (IHO) Waiver.* This waiver serves eligible individuals who:
    - 1) were previously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and who require direct care services provided primarily by a licensed nurse; or
    - 2) have been receiving continuous care in a hospital for 36 months or longer and have physician-ordered direct care services that are greater than those available in the NF/AH waiver for the participant's level of care. The current waiver was approved on January 1, 2010 .

IHO Waiver provider types include all of the following:

- Durable Medical Equipment Provider
- Employment Agency
- Home and Community-Based Continuous Care Facility
- Home Health Agency
- In-Home Support Services Public Authority
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Marriage Family Therapist
- Personal Care Agency

- Private Nonprofit or Proprietary Agency
  - Professional Corporation
  - RN
  - Waiver Personal Care Services Provider
- *San Francisco Community Living Support Benefit (SFCLSB) Waiver.* This waiver utilizes certified public expenditures for provision of waiver services to persons with disabilities age 21 and over who reside in the City and County of San Francisco and who are either homeless, residing in a nursing facility, or are at imminent risk of entering a nursing facility. Eligible individuals can move into licensed Community Care Facilities (CCFs) or Direct Access to Housing (DAH) sites (e.g., private homes). Services consist of care coordination, community living support benefits, and behavior assessment and planning in both CCFs and DAHs; and home delivered meals and environmental accessibility adaptations in DAH sites.

SFCLSB Waiver provider types include all of the following:

- Adult Residential Facility
  - Clinical Psychologist
  - Durable Medical Equipment Provider, Building Contractor or Handyman
  - Private Nonprofit or Proprietary Agency
  - Home Delivered Meal/Meal Preparation Vendor
  - Home Health Agency
  - Licensed Clinical Social Worker
  - Marriage Family Therapist
  - Not-For-Profit Case Management Agency
  - Private Nonprofit or Proprietary Agency
  - Residential Care Facility for the Elderly
  - Therapist (Various Specializations)
- *Pediatric Palliative Care (PPC) Waiver.* This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: care coordination, expressive therapies, family training, individual and family caregiver counseling/bereavement services, pain and symptom management, personal care and respite care.

PPC Waiver provider types include all of the following:

- Agency Certified Nursing Assistant
- Art Therapist
- Associate Clinical Social Worker
- Child Life Specialist
- Congregate Living Health Facility
- Home Health Agency

- Home Health Aide
- Hospice Agency
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Masters Level Social Worker
- Massage Therapist
- Music Therapist
- RN

## **Existing Settings in HCBS Programs – Review and Analysis**

### *California Plan for Determination of HCB Setting Compliance:*

The standards, rules, regulations and other requirements for the following HCB settings will be analyzed and reviewed by DHCS, CDA, DDS and CDPH to determine the extent to which they comply with federal regulations. State departments will be responsible for ensuring appropriate provision of HCBS by all providers that serve Medi-Cal beneficiaries.

- Adult Family Home/Family Teaching Home
- Adult Residential Facility
- Adult Residential Facility for Persons with Special Health Care Needs
- Certified Family Home
- Congregate Living Health Facility
- Home and Community-Based Continuous Care Facility
- Foster Family Home
- Group Home
- Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing Care
- Residential Care Facility for the Elderly
- Residential Facility (Out-of-State)
- Small Family Home

The compliance determination process includes all of the following:

- An initial State-level assessment of standards, rules, regulations, and other requirements to determine if they are consistent with the federal requirements. This will be completed within six months of CMS approval of the Statewide Transition Plan.
- This State-level assessment will be conducted jointly by DHCS and the State Department(s) responsible for operating each Waiver with stakeholder input.
- Results of this assessment will be available for public comment and will be used to determine and develop the remedial strategies that may be necessary to ensure that

all HCB settings conform to the federal requirements.

- In addition to the State-level assessment, on-site evaluations of individual settings will be conducted as follows:
  - On-site evaluations will be conducted at all settings that, per CMS guidance, are presumed not to be HCB settings.
  - For all other settings, a representative random sample of on-site evaluations will be conducted.
  - It is anticipated that the on-site evaluations will be completed within one year of CMS approval of the assessment tool.
- The on-site evaluations will be conducted by a survey team that includes one or more of the following: State personnel, service recipients or their family members, case managers or other representatives of case management entities, representatives of consumer advocacy organizations, and/or other stakeholders.
- The responsibility for ensuring completion of these evaluations rests with the program staff as specified under the “Overview of State Responsibility” section of this document. The State will support the provision of training for all participants of survey teams to ensure that HCB settings are built around the person-centered plan approach and are compliant with the new federal requirements.
- DHCS will develop an assessment tool for use in the on-site evaluations of HCB settings. The assessment tool will include each new federal requirement that will be used to determine if the HCB setting meets or does not meet the required federal rule. The completed assessment tool will be maintained in the appropriate State file for each waiver and will be used to verify compliance at the time of CMS renewal of the HCBS waiver.

Note: this assessment tool shall be developed and circulated for stakeholder comments no later than 60 days after CMS approval of this Statewide Transition Plan.

- The assessment tool will be forwarded to each HCB setting selected for evaluation with instructions to complete a self-assessment prior to the evaluation completed by the survey team. The completed assessment will be forwarded back to the Waiver program for review.
- Using the completed assessments, each selected HCB setting (selected from the list identified under the “California Plan for Determination of HCB Setting Compliance” subsection of this document) will be evaluated by a survey team described above.
- Written results of each survey will be forwarded back to the HCB setting with specific information regarding improvements that will be required in order to come into compliance with the federal requirements and a timeline for completion.

- Completed assessments for all settings, including documentation of any required follow-up actions as a result of the on-site evaluations, will be maintained in the appropriate State file for each waiver.
- An appeal process, to be developed, which allows the HCB setting to dispute the HCB setting's compliance or the need to comply with the specific requirement when the HCB setting determines the requirement is not applicable to the particular setting.

Note: the appeal process shall be developed and circulated for stakeholder comments no later than 60 days after CMS approval of this Statewide Transition Plan.

- All State-level and individual setting level remedial actions will be completed by no later than March 17, 2019.
- Progress on completion of this Statewide Transition Plan will be monitored at least every six months and will include public posting on the status with opportunity for public input.



## DEVELOPMENTAL DISABILITIES BOARD AREA 10

*Protecting and Advocating for Persons with  
Developmental Disabilities in Los Angeles County*

### INPUT REGARDING HCBS STATEWIDE TRANSITION PLAN

Developmental Disabilities Area Board 10 is mandated to protect and assert the legal, civil, and service rights of people with developmental disabilities in Los Angeles County. California has a system of 13 Area Boards, covering all regions of the state. It is on behalf of our Board of Directors and over 83,000 people with a developmental disability who reside in Los Angeles County that we submit comments regarding California's draft HCBS Statewide Transition Plan. Please note that our comments are limited to the services contained within the DD waiver.

Overall, we observe that the Transition Plan is skimpy on many details including who will be evaluated and in what manner they will be evaluated.

The new HCBS rule includes five substantive standards that all home and community based services need to meet:

1. **Integration into the community**, including competitive work settings, the ability to control one's personal resources and to engage in community life.

**Comments:** The Transition Plan is silent on whether or how the state will evaluate non-residential services that are current HCB services, like Activity Centers, Adult Development Centers, and Work Activity Programs, to name just a few. Many of these services are provided in non-integrated settings. Since the draft Transition Plan does not even address a plan for determining compliance with the HCBS rules, does the state intend to phase out segregated services? Area Board 10 would surely support such a proposal.

2. **Individual choice**, including the ability to choose among various options and locations, identified and documented through a person-centered service plan.

**Comments:** In order to determine whether the state is compliant on this standard, an evaluation of regional center case management practices is essential. It is at that level that "person-centered planning" is supposed to occur. We believe that in evaluating this standard it is essential that a cross section of service recipients be surveyed to determine their personal experience. It is one thing to call a service plan "person-centered" and quite another to actually conduct a meeting in that manner. Stakeholder input is critical to assessing this standard.

3. **Individual Rights**, including right to privacy, the right to choose or not choose a roommate, the right to meet privately with friends.

**Comments:** In order to properly assess whether a specific provider is compliant with this standard, past and current residents must be interviewed in confidence. Further, this standard is not limited to residential settings; the state must establish a plan for assessing compliance on the part of the

non-residential settings as well. The state must also assess the extent to which regional center service coordinators explicitly encourage people to identify who they want to live with. In our experience, that question is virtually never raised, especially in group settings, like adult residential facilities. In developing its compliance determination process, the state should also include a review of regional center quality assurance policies, practices and outcomes to determine the extent to which regional centers review and ensure compliance with privacy standards.

4. **Autonomy**, meaning to encourage the making of life choices, including but not limited to daily activities, physical environment and with whom to interact.

**Comments:** The comments under standard #3 apply here as well. It is our belief that the extent to which the person's setting is individualized will likely determine the degree of autonomy enjoyed. A person living in his/her own chosen apartment will invariably have greater freedom to establish one's own daily routine and activities than an individual living with other people under the roof of a provider. Therefore, it is important to determine to what extent the individual freely chose their living arrangement; hence the need to examine the individual program planning process.

#### 5. **Choice Regarding Services and Providers**

**Comments:** California's Lanterman Act encourages but does not require that the state utilize providers selected by the person. In fact, during the recession, statute was changed to further limit choice due to cost being a paramount concern. In order to comply with this new rule and because it is in the best interest of the people being served, we urge the Legislature to amend WIC to make client choice the first standard for selecting a provider. Certainly, the implementation of California's Self-Determination model will effectively address this standard but it must be codified for all services in all settings.

We are especially pleased by CMS' emphasis on Person-Centered Service Plans. We believe that California has a ways to go before it is in compliance with the spirit and intent of the person-centered guidelines. There is a great need for training of regional center staff, service recipients, family members and providers. New forms and new procedures are needed. We would like to see this compliance need also addressed in the Statewide Transition Plan.

We further recommend that DHCS include it's proposed "assessment tool(s)" as an attachment to the next draft of its Transition Plan or at a minimum, provide a timeline for its development. It is difficult if not impossible to determine whether the Transition Plan is adequate to properly assess compliance without knowing how compliance will be measured.

We look forward to reviewing the next draft of the Transition Plan and working with the Administration to enhance our developmental disability service system.


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## The State needs to hear your voice! Comment about home and community based settings by October 15

### New Rules about Home and Community Based (HCB) Settings

New federal rules say that community settings (group homes & day and work programs) must give people choice, privacy, and independence. People also have a right to have a say in their planning and to be included into their communities.



### What Do the New Rules Say?

The new federal rules say that HCB settings and services:

- Must be integrated in and support full access to the greater community;
- Are selected by the person from among setting and service options;
- Make sure peoples' rights to privacy, dignity and respect, and freedom from coercion and restraint are protected;
- Maximize support of peoples autonomy and independence in making life choices; and
- Support choice regarding services people get and who provides them.

### Are There Rules About Group Homes?

Yes. If the provider owns or controls the setting, then the provider must make sure that people who live there:

- Have a lease or other legally enforceable agreement providing similar protections;
- Have privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- Can control their own schedule including access to food at any time;
- Can have visitors at any time; and that
- The setting is physically accessible.

(any exceptions must be justified by individual need and be in the person's IPP or care plan)

### Which Settings Are Not Covered by the New Rules?

- Settings and services that are not HCBS settings: nursing facilities, IMDs, ICF-DDs, and hospitals.
- Some places that people live are "presumed to have institutional qualities", and the State must show that they are in fact HCB. These are:
  - in a publicly-owned or privately owned facility that provides inpatient treatment;
  - on the grounds of, or immediately adjacent to, a public institution; or
  - that have the effect of isolating people receiving Medicaid-funded HCBS from the broader community

***The State needs to hear your stories, examples and input about the quality of the services that people with disabilities are getting and if their rights are being respected. Please act now!***

***THERE IS ONLY A LITTLE TIME***

### How Do I Give the State My Input?

There are 2 ways!

The first way is:

1. Complete the survey at this link and submit it to Disability Rights California by OCTOBER 15! You can submit it to us electronically using the link below or the QR Code at the top of this page

Link to survey: <http://fs12.formsite.com/disabilityrightsca/form63/index.html>

OR, you can print out the survey and mail or fax it to us at:

Disability Rights California, HCBS Transition Plan

1300 Broadway, Suite 500

Oakland, CA 94612

FAX: 510-267-1201

The second way is:

2. By October 19, 2014 send an email directly to [STP@dhcs.ca.gov](mailto:STP@dhcs.ca.gov), and give them your opinion about:

a) Whether you have choice, independence and privacy in your group home or day activity. If not, give some examples. Some things we have heard in the past are:

- "I am only allowed visitors on certain days"
- "I have to eat at the same time as the group, and I am not allowed to choose what I want for dinner"
- "When I want to go shopping, I have to wait for a certain day when everyone in my home goes together"
- "I would like to work at a store, but I was told I have to work at the workshop instead"
- "I have to share a room, but I really want my own room"
- "There are 'house rules' that I have to follow"

b) Also, you can tell the State that when they visit or review settings to see if they meet the new rules, you want the chance to assess your own home and/or work/day program.

c) Tell the state if you want the State assessment team to visit your home and/or work/day program.

Make sure you include your name and the name of the home or day program you are talking about.

For more information, please contact: Marinda Reed (916) 504-5800

# VISION FOR COUNCIL'S FUTURE



## Designing SCDD Future



The SCDD Council Leadership and Executive Management Team are currently developing a roadmap that will lead the organization in advocacy, systems change, and capacity building. We are seeking input from committee members to assist with this process by requesting input on the following for questions:

1. Please write down three recent Council accomplishments.
2. How can the Council establish itself as a model leader in California and throughout the Nation?
3. What uniqueness can the Council bring to improving the California Developmental Disabilities System?
4. How does the Council want to improve and impact the lives of people with disabilities and their family in the next 10 years?

