

**Guidelines
for
Regional Center
Community Placement Plan**

For

Fiscal Year 2015-16 Requests

January 2015

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Department of Developmental Services

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Department of Developmental Services

Community Placement Plan Guidelines

The Department of Developmental Services (Department) has statutory responsibility to ensure that individuals with developmental disabilities live in the least restrictive setting, appropriate to their needs. Under the authority of Welfare and Institutions Code (WIC) Section 4418.25, the Department shall establish policies and procedures for the development of an annual community placement plan (CPP) by regional centers (RC). The CPP is designed to assist RCs to provide the necessary services and supports for individuals with challenging service need to transition to and be supported in the community. In Sanchez v. DDS, the court found that the Department's CPP constituted a "comprehensive, effectively working plan" as envisioned by the U.S. Supreme Court in its landmark decision, Olmstead v. L.C., 527 U.S. 581 (1999).

I. Goals

The Department's goal for the CPP is to enhance the capacity of the community service delivery system and to reduce reliance on developmental centers (DC), mental health facilities [e.g., Mental Health Rehabilitation Centers (MHRC) and Institutions for Mental Disease (IMD)] ineligible for Federal Financial Participation (FFP), and out-of-state placements. Effective July 1, 2012, there is a moratorium on DC admissions unless an individual is admitted to restore competency, is determined to be incompetent to stand trial, or is in an acute crisis as defined by WIC Section 4418.7(d)(1).

Commencing January 1, 2015, Fairview Developmental Center (FDC) and Sonoma Developmental Center (SDC) shall be the only DCs authorized to admit a consumer due to an acute crisis pursuant to a court order and the approval of the Department, as described in WIC Section 4418.7

The CPP is designed to support two of the Department's strategic goals:

Goal One: *Expand the availability, accessibility and types of services and supports to meet current and future needs of individuals and their families.*

Goal Two: *Develop systems to ensure that quality services and supports in the least restrictive environment are provided to individuals in the community.*

II. Priorities

Each CPP proposal submitted by the RC should be driven by the outcomes of annual comprehensive and updated assessments of consumers residing at the DCs and reflect their needs and the needs of their community. The proposals should demonstrate collaborative efforts among the RC, the individual and his or her family, the DC, and the regional resource development project. Additionally, the Department supports

collaborative proposals between two or more RCs to develop specialized resources to meet the statewide needs of individuals who have challenging service needs.

Funding priority will continue to be given to projects that are collaborative and regionally based.

The Department's statewide priorities include the following:

- Completing an initial or an updated comprehensive assessment for any consumer residing in a DC [WIC Section 4418.25(c)(2)(A)] or in a mental health facility ineligible for FFP [WIC Section 4648(a)(9)(B) and (C)];
- Developing resources to support individuals transitioning from a DC consistent with comprehensive assessments;
- Developing and/or identifying community living options for individuals residing in DCs, mental health facilities ineligible for FFP, or out-of-state placements;
- Meeting individual and community needs for developing specialized services, including regional community services for individuals with challenging service needs;
- Development of new models of community care residential services including Enhanced Behavioral Supports Homes [WIC Section 4684.80], Community Crisis Homes [WIC Section 4698], Adult Residential Facility for Persons with Special Health care Needs (ARFPSHN), Transitional Homes and Crisis Support; and
- Developing resources within compliance of recent Centers for Medicare and Medicaid Services (CMS) ruling in accordance with Code of Federal Regulations (CFR), Title 42, Section 441.530(a)(2)(v)(Home and Community-Based Setting), as summarized in *Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community*. [see Enclosure A]

III. CPP Proposals

Fiscal Year (FY) 2015-16 CPP proposals for Placement, Assessment, Start-up, Deflection purchase of service (POS), and for Operations (OPS) funding must be justified based upon the RC's comprehensive analysis of their DC population; historical and projected placements from DC's, out-of-state, mental health facilities ineligible for FFP; and service development needs as identified.

The Department expects to work closely and in collaboration with each RC to develop realistic and workable CPPs and CPP budgets. When developing a new CPP, consideration should be given to all the CPP projects currently in progress and the RC's ability to complete those projects, including projects that are in collaboration with the Southern California Integrated Health and Living Project. The RC should consider current community options with capacity as available resources prior to proposing new development.

FY 2015-16 CPP proposals shall include the following information:

1. Individuals, identified by UCI, who will receive an initial or updated comprehensive assessment in FY 2015-16 for possible transition to the

- community, including the information specified in Section III(B) of these CPP guidelines;
2. An overall summary and/or analysis of comprehensive assessment including outcomes and development needs;
 3. Individuals, identified by UCI, who will be moving in FY 2015-16 from a DC, mental health facility ineligible for FFP, or out-of-state service, and the needed services and estimated expense to support those transitions;
 4. Resources needed to reduce reliance on DCs, mental health facilities ineligible for FFP, or out-of-state services based on a review of the unique resource needs of each RC; and,
 5. Regional development being proposed, including the following information:
 - a. RCs involved;
 - b. Description of service(s) proposed for development;
 - c. The detailed need the proposed development will fulfill; and,
 - d. Estimated timeline/schedule of development.

The following are guidelines specific to the types of requests that may be submitted in FY 2015-16 CPP proposals.

A. Placement Funding Requests

A CPP placement occurs when a consumer who is currently residing in a DC, mental health facility ineligible for FFP, or receiving services out-of-state, moves to the community within California. Placement funding should be based on projected service and support costs for those consumers projected to be placed in FY 2015-16, and include only costs associated with transitioning and maintaining a consumer previously living in a DC, mental health facility ineligible for FFP, or out-of-state.

CPP funded beds designated for CPP placements should only be used for CPP placements. The RC may request from the Department an exception to this designation if there is no appropriate placement match for someone who is currently residing in a DC, mental health facility ineligible for FFP, or receiving services out-of-state. Prior to requesting an exception, consideration should be given to supporting a consumer who has challenging service needs and requires a specialized resource. The Department may require priority use of the resource made available to another RC for an individual in a DC, prior to approval of an exception.

Placement funding will be allocated based on claims associated with CPP placements that occur during the FY. As part of the POS claims review process, the Department may periodically request verification of consumers who have transitioned to the community and their associated costs. For consumers who moved from a mental health facility ineligible for FFP or an out-of-state placement, only the placement costs associated with the transition into the community above current base funding will be funded utilizing CPP funds.

B. Assessment Funding Requests

The RC's FY 2015-16 CPP proposal requesting Assessment funds must include the following:

1. Name and UCI of each consumer residing in a DC, mental health facility ineligible for FFP, and out-of-state;
2. Date of each consumer's last comprehensive assessment;
3. Projected cost of all initial and updated comprehensive assessments scheduled for FY 2015-16; and
4. Identification of all consumers residing in a DC due to a Penal Code 1370.1 commitment.

With the enactment of the FY 2013-14 Budget, comprehensive assessments are required as follows:

- DCs: RCs shall complete a comprehensive assessment for each consumer residing in a DC who is not committed pursuant to Section 1370.1 of the Penal Code, has resided in a DC for more than one year, and has not had a comprehensive assessment in the previous two years. An initial comprehensive assessment must be completed no later than December 31, 2015, with input from the RC, DC, the consumer, and when appropriate, the consumer's family, guardian, or conservator. The comprehensive assessment should identify the types of community based services and supports that are available and/or needed for each individual consumer. Updates to the comprehensive assessment are required on an annual basis as part of the individual program planning process for as long as the consumer resides in the DC. [WIC Section 4418.25(c)(2)]
- Mental Health Facilities Ineligible for FFP: A comprehensive assessment shall be completed within 30 days of admission to a mental health facility ineligible for FFP, and prior to the consumer's next scheduled individual program plan (IPP) meeting. [WIC Section 4648(a)(9)(B) and (C)]
- Out-of-State: A comprehensive assessment must be completed by the RC prior to submitting a request for out-of-state services and for any extension beyond the initial six months. [WIC Section 4519(a)]

C. Start-Up Funding Requests

Start-up funds are intended to assist in the development of new resources, but not projected to cover 100 percent of the development costs. It is expected that the potential or existing vendor will identify funds that, along with CPP funds, would demonstrate financial capacity to complete a project. The Department may request an estimated and/or final "Sources and Uses" project development budget outlining the project cost and funding sources of a RC approved project.

Start-up funding may be used to develop a variety of innovative resources as identified through individual comprehensive assessments including, but not limited to, Enhanced Behavioral Support Homes, Community Crisis Homes, ARFPSHN, Transitional Homes and, specialized residential facilities utilizing delayed egress, vocational or day programs, transportation services, and crisis services. Residential Start-up projects funded by CPP funds must have a minimum percentage of placements dedicated to consumers residing in a DC, mental health facility ineligible for FFP, or out-of-state placement. The ratio criteria for placements are as follows:

- For CPP residential resource development, a minimum of 50 percent of the capacity must be dedicated for use by individuals transitioning from a DC.
- For CPP, if the residential resource development is or will be a Non Profit Housing Organization (NPO)-owned property, a minimum of 50 percent of the beds must be dedicated for use by individuals transitioning from a DC.

If the above ratio criteria cannot be met, a RC may request approval from the Department to utilize the available resource to meet a specific community need and list the vacancy on the Statewide Specialized Resource Service (SSRS). For information about the SSRS, refer to Section IV(D) of these CPP Guidelines.

Once a residential service is developed, or when a facility is licensed, it should be fully occupied within 90 days. Provider start-up funds may be used for this transition period.

The number of beds that may be developed statewide utilizing secured perimeters in combination with delayed egress devices is limited as required by Title 17, California Code of Regulations, Section 56074. The Department will only consider proposals for new development with the use of delayed egress and secured perimeter for Enhanced Behavioral Supports Homes.

Provider Contracts: The RC must ensure that the CPP contracts between the RC and service providers contain the following provisions:

1. Holding the vendor accountable for the expenditure of funds consistent with the contract terms and for program outcomes;
2. The service provider's obligation of service to individuals with developmental disabilities for a specified length of time.
3. In the event a project cannot be completed within the approved timeframe, the Start-up funds must be returned to the State; and,
4. Upon completion of the project and the reconciliation of contract funds, if the RC determines that the contract amount has not been fully expended, the unexpended contracted funds will be recouped by the RC and returned to the State.

The RC may request from the Department approval for Start-up funds for the purchase of CPP related housing through an approved NPO. CPP proposals requesting CPP Start-up funding for the acquisition of real estate must meet the established FY 2015-16 CPP Housing Guidelines. When Start-up projects result in the renovation of a vendor's property that is not owned by an approved NPO, the contract between the RC and vendor shall include provisions including, but not limited to, detailing the service obligation for use of CPP funds, the service model to be provided, and the action by the RC to recoup funds for failure to comply with the terms of the contract. The RC shall summarize the terms of the contract in their CPP proposal.

The Department may request the RC to provide a copy of the fully executed RC/Vendor Start-up contract.

As part of the reconciliation process, the RC shall provide to the Department a quarterly fiscal and program update on all CPP funded Start-up projects, as

specified in Section V(E)(3) of these CPP Guidelines. Quarterly reports will be due by the 20th of the month following the end of the quarter. For example, Quarter 1 is from July through September; the quarterly report is due by October 20th.

D. Deflection Funding Requests

A deflection occurs when additional services and supports are provided to enable a consumer who has challenging service needs to remain in the community and avoid admission to FDC or SDC due to an acute crisis, a mental health facility ineligible for FFP, or an out-of-state service.

When submitting its FY 2015-16 CPP proposal, the RC shall provide an estimate of Start-up costs for projects designated for deflection purposes and estimated Deflection costs for proposed deflection placements into CPP funded deflection living arrangements. If a bed developed specifically for deflection becomes vacant after the initial placement, it should be filled by a consumer meeting the deflection criteria above.

The RC may request Start-up funds for deflection activities in the FY 2015-16 CPP proposals for innovative services, including, but not limited to, behavioral and crisis services, and unique services to meet the needs of those who present the most challenging service needs. The RC's FY 2015-16 CPP proposal requesting Deflection funds must include the following:

1. Name of CPP funded home and CPP Start-up project number;
2. Type of facility;
3. Date the facility opened; and,
4. UCI of the individual moving into the home.

The RC will only be reimbursed for Deflection costs for residential services and residential costs associated with deflection from admittance to FDC or SDC due to an acute crisis, a mental health facility ineligible for FFP, or an out-of-state placement above current residential base funding; and, only if:

1. The RC has consulted the SSRS;
2. The RC has received approval from the Department to designate the community transition as a deflection;
3. Community transition is into a bed designated for deflection;
4. Deflection occurs in the first year of a facility's operation;
5. The need for deflection services and/or resources is included in the consumer's IPP; and,
6. Prior information regarding identified consumers' deflection needs is provided to the Department.

The Department will periodically request verification of those consumers who have been deflected (as defined above) in order to process Deflection funding claims.

E. Operations Funding Requests

CPP OPS funding is one-time only and must be used exclusively for CPP approved purposes. The amount funded in one FY will not automatically be funded in the next FY. Approval of CPP OPS funding will be based on several factors including the RCs past CPP performance, the number of Start-up projects the RC is engaged in and is requesting, and the proposed number of consumers for which the RC plans

to provide services (including placements, assessments, and deflection) during FY 2015-16.

CPP OPS funding must be used for RC employees and/or consultants only and cannot be used to fund operation/administrative costs for any other entity. Examples of RC employees and/or consultants that may be funded with CPP OPS funds include staff to assist with resource development, assessments, placements, crisis services teams and quality management staff necessary to implement the approved CPP. Staffing levels shall be approved in .25, .50 and 1.0 Full Time Equivalent increments only.

The RC shall provide the Department with the following information for each person dedicated for CPP purposes:

1. Name
2. Hire date
3. Position title
4. Full-time position/part-time position/consultant
5. Any position identified for the FY 2015-16 on-going workload of the LDC closure activity

IV. Additional Guidelines and Relevant Statute

A. Money Follows the Person (MFP)

The MFP program, funded under a grant with CMS, provides increased FFP for services provided to consumers during their first year after transitioning from a DC or certain other licensed healthcare facility. To access the increased FFP, the RC should ensure all eligible consumers are enrolled in the MFP program. Eligibility requirements include the following:

1. The consumer has lived in an institution/licensed healthcare facility for at least 90 consecutive days;
2. The consumer is moving to a four-bed or less community setting; and,
3. The RC completes a MFP Quality of Life Survey within 30 days prior or ten days after the consumer moves. The completed survey, and a California Community Transitions Participant Information form, must be sent to the Department.

For more information regarding the MFP program, please contact Marina Olivas, at (916) 654-1620.

B. Median Rates

Effective July 1, 2008, in accordance with WIC Section 4691.9, a RC may not negotiate a rate higher than the RC's median or the statewide median for the same service code and same unit of service, whichever is lower. Please note, the Department issued revised median rates that became effective December 15, 2011. For any consumer that may require services and supports that dictate a service rate that exceeds the established median rate, a Health and Safety Exemption may be requested from the Department. The process for requesting a Health and Safety Exemption is outlined in the Department's October 23, 2007, letter to regional

centers, entitled, *Instructions for Requesting Health and Safety Waiver Exemptions*. [see Enclosure B]

C. *Inter-Regional Center Transfers*

RCs may need to negotiate case transfers to accommodate an individual's choice of living option. When considering transfers to another RC, the RCs shall follow the Department's December 8, 1998, correspondence to stakeholder organizations, entitled, *Inter-Regional Center Transfer Guidelines*. [see Enclosure C] In situations where RCs agree to a project specific Memorandum of Understanding, the RCs must adhere to the Department issued transfer guidelines, allowing for exceptions with Department approval.

D. *Statewide Specialized Resource Service*

In accordance with WIC Section 4418.25, an SSRS was created to track the availability of and share amongst RCs specialized residential development and clinical services. Pursuant to WIC Section 4418.25(b)(2), in order to track and share needed resources, RCs shall provide the Department with updates on newly developed resources and current vacancies in specialized resources developed with CPP funds from FY 2005-06 forward. For more information regarding SSRS contact the Department at ssrs@dds.ca.gov or (916) 654-1956.

E. *Vacancies*

RCs may not contract for the payment of vacant beds with CPP funds unless authorized by state law or regulations (i.e., Title 17, California Code of Regulations, Section 56917 and WIC Section 4684.55). Start-up funds may only be used for the initial 90-day period of transitioning consumers into a new home. Use of Provider Start-up funds beyond the 90-day period may be permitted with the Department's written approval. Once the home is operating, subsequent vacancies cannot be funded through CPP Start-up.

V. Submission, Approval and Follow-up

A. *Timelines*

- FY 2015-16 CPP Initial Projections are due to the Department no later than **45 calendar days from the release date of these CPP Guidelines.**
- FY 2015-16 CPP Housing Proposals are due to the Department no later than **90 calendar days from the release date of the FY 2015-16 CPP Housing Guidelines.**

B. *Submission and Modification to the CPP*

The RC must submit in writing to their Department CPP Liaison any proposed modifications being made to the original, approved CPP. The RC must receive DDS approval for any modifications to their approved plans prior to implementation of modifications.

C. *Approval Process*

The Department will review the FY 2015-16 CPP proposal in its entirety and approve the CPP request(s) based on feasibility, reasonableness, the justification for the resources, alignment with statewide priorities, FFP eligibility of services, and

availability of funding. The Department's ability to fund approved CPP proposals is dependent upon sufficient appropriation of funds. If the proposal meets the requirements of these CPP Guidelines, the Department will send a conditional approval letter to the RC's Executive Director, Administrator and CPP Liaison.

D. Reconciliation

Each July, the RC shall submit to the Department an end of year reconciliation of placements, admissions, deflections and Start-up projects.

E. Performance

The Department will evaluate the CPP performance success of the RC on a quarterly basis, based on a combination of factors that will measure placements, assessments completed, and resource development efforts that are aligned with the CPP priorities outlined in these CPP Guidelines. The RC shall report to the Department quarterly on the progress of their CPP to include, but not be limited to, the following:

1. Placement activity that identifies consumers who transitioned into the community.
2. Assessment activity that identifies completed initial and updated comprehensive assessments for those consumers identified in its approved FY 2013-14 and 2014-15 CPPs; and projected assessments for FY 2015-16.
3. Start-up activity:
 - a. Status of Request(s) for Proposals;
 - b. Anticipated or actual completion date(s);
 - c. Date(s) contract(s) signed;
 - d. Contracted amount(s);
 - e. Amount(s) expended or updated estimate(s);
 - f. Updated "Sources and Uses" budget(s), if changed;
 - g. Date(s) of occupancy (Placement/Deflection); and
 - h. Number of vacant beds (Placement/Deflection).
4. Deflection activity that identifies individuals who have been deflected.
5. Operations activity that includes hire dates and staff identified for each position approved.

VI. CPP Claims

An integral part of the CPP is the monitoring and reconciliation of CPP claims submitted by the RC. CPP claims will be reconciled to the State Claims File (SCF) of the Uniform Fiscal System and monitored based on the RC's use of approved allocated funding. The RC will be required to claim CPP in the manner allocated (i.e., POS - Placement, POS - Assessment, POS - Start-up, and POS - Deflection) in the approved CPP. Submission of the claim must be accompanied by sufficient detail to support the claim.

IMPORTANT: In order for claims to be processed and paid, the RC must follow the POS claiming procedure developed by the Department. [see Enclosures D & E]

It is the responsibility of the RC to correct discrepancies in the SCF. Technical support

is available from the Department's Regional Center Technology Support Section by calling (916) 654-1466, or the Rates and Fiscal Support Section's Liaison, Stella Bertrand, at (916) 654-2052.

VII. CPP Allocations

The Department will allocate CPP POS and OPS funds based on plan implementation and verification of progress. Failure to demonstrate progress on the CPP may affect future funding to the RC. Any unspent funds shall revert to the State General Fund, be redirected to the DCs if they exceed population estimates, or be reallocated for the use of other CPP projects with prior Departmental approval.

The allocation process is described as follows:

1. Assessment and Start-up: Assessment and Start-up funds will be allocated in the first contract amendment based on the approved CPP.
2. Operations: There will be two allocations for OPS funds. Approved OPS funding will be initially allocated at 75 percent. The remaining 25 percent of OPS funds will be allocated in a subsequent contract amendment.

To receive the full amount of the remaining 25 percent, the RC must meet 100 percent of its prior year DC placement goal. If only a percentage of the goal is met then that same percent will be used to calculate the amount of the remaining OPS funds to allocate. For example, if the RC placed eight consumers but had a goal of ten, they will receive 80 percent of their remaining OPS funding.

3. Placement and Deflection: Placement and Deflection funds will be allocated based on actual POS costs at various points during the year. Adjustments will be made year end to reflect actual reconciled placement and deflection costs.

**GUIDANCE ON SETTINGS THAT HAVE THE EFFECT OF ISOLATING
INDIVIDUALS RECEIVING HCBS FROM THE BROADER COMMUNITY**

The purpose of this guidance is to provide more information to states and other stakeholders about settings that have the effect of isolating individuals receiving HCBS from the broader community.

The final rule identifies settings that are presumed to have institutional qualities and do not meet the rule's requirements for home and community-based settings. These settings include those in a publicly or privately-owned facility that provide inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. A state may only include such a setting in its Medicaid HCBS programs if CMS determines through a heightened scrutiny process, based on information presented by the state and input from the public that the state has demonstrated that the setting meets the qualities for being home and community-based and does not have the qualities of an institution. (For more information about the heightened scrutiny process, see Section 441.530(a)(2)(v)Home and Community-Based Setting).

Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.

Settings that isolate people receiving HCBS from the broader community may have any of the following characteristics:

- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
- People in the setting have limited, if any, interaction with the broader community.
- Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

The following is a non-exhaustive list of examples of residential settings that typically have the effect of isolating people receiving HCBS from the broader community. CMS will be issuing separate guidance regarding non-residential settings.

- **Farmstead or disability-specific farm community:** These settings are often in rural areas on large parcels of land, with little ability to access the broader community outside the farm. Individuals who live at the farm typically interact primarily with people with disabilities and staff who work with those individuals. Individuals typically live in homes only with other people with disabilities and/or staff. Their neighbors are other individuals with disabilities or staff who work with those individuals. Daily activities are typically designed to take place on-site so that an individual generally does not leave the farm to access HCB services or participate in community activities. For example, these settings will often provide on-site a place to receive clinical (medical and/or behavioral health) services, day services, places to shop and attend church services, as well as social activities where individuals on the farm engage with others on the farm, all of whom are receiving Medicaid HCBS. While sometimes people from the broader community may come on-site, people from the farm do not go out into the broader community as part of their daily life. Thus, the setting does not facilitate individuals integrating into the greater community and has characteristics that isolate individuals receiving Medicaid HCBS from individuals not receiving Medicaid HCBS.
- **Gated/secured “community” for people with disabilities:** Gated communities typically consist primarily of people with disabilities and the staff that work with them. Often, these locations will provide residential, behavioral health, day services, social and recreational activities, and long term services and supports all within the gated community. Individuals receiving HCBS in this type of setting often do not leave the grounds of the gated community in order to access activities or services in the broader community. Thus, the setting typically does not afford individuals the opportunity to fully engage in community life and choose activities, services and providers that will optimize integration into the broader community.
- **Residential schools:** These settings incorporate both the educational program and the residential program in the same building or in buildings in close proximity to each other (e.g. two buildings side by side). Individuals do not travel into the broader community to live or to attend school. Individuals served in these settings typically interact only with other residents of the home and the residential and educational staff. Additional individuals with disabilities from the community at large may attend the educational program. Activities such as religious services may be held on-site as opposed to facilitating individuals attending places of worship in the community. These settings may be in urban areas as well as suburban and rural areas. Individuals experience in the broader community may be limited to large group activities on “bus field trips.” The setting therefore compromises the individual’s access to experience in the greater community at a level that isolates individuals receiving Medicaid HCBS from individuals not receiving Medicaid HCBS.

- Multiple settings co-located and operationally related (i.e., operated and controlled by the same provider) that congregate a large number of people with disabilities together and provide for significant shared programming and staff, such that people's ability to interact with the broader community is limited. Depending on the program design, this could include, for example, group homes on the grounds of a private ICF or numerous group homes co-located on a single site or close proximity (multiple units on the same street or a court, for example). In CMS' experience, most Continuing Care Retirement Communities (CCRCs), which are designed to allow aging couples with different levels of need to remain together or close by, do not raise the same concerns around isolation as the examples above, particularly since CCRCs typically include residents who live independently in addition to those who receive HCBS.

DEPARTMENT OF DEVELOPMENTAL SERVICES

1600 NINTH STREET, Room 320, MS 3-9
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1958



October 23, 2007

TO: REGIONAL CENTER EXECUTIVE DIRECTORS

SUBJECT: INSTRUCTIONS FOR REQUESTING HEALTH AND SAFETY WAIVER EXEMPTIONS

Current trailer bill language provides a mechanism for regional centers to obtain written authorization from the Department of Developmental Services (Department) granting a residential service ARM level increase and/or a rate increase to other services subject to the rate freeze to protect consumer's health and safety. All regional center requests for written authorization from the Department to approve a residential service level increase or a rate increase must be signed by the Executive Director of the requesting regional center.

This memorandum details the information that must be submitted by the regional center when seeking the Department's written authorization granting approval for a service level increase or other service rate increase.

Required Information for All Service Level Rate and/or Increase Requests

- Vendor number
- Service code and type
- Vendor name and address
- Capacity
- Current rate
- Unit of rate - For example, \$25 per day or \$10 an hour
- Proposed Rate and supporting justification
- An estimate of the fiscal impact of the rate increase for both current year and subsequent fiscal year
- Complete explanation of health and safety basis of the request and ramifications of a denial
- Signed statement from the regional center Executive Director that he/she concurs with the information and request being submitted to the Department
- Proposed effective date of implementation and, if temporary, the end date

"Building Partnerships, Supporting Choices"

Rate Increase Requests for Community-based day programs, WAPs, In-home Respite Agencies and Other Services (contracted) Impacted by Freezes (WIC 4691.6 (d) and (c) and WIC 4648.4 (a) (b).

A health and safety waiver request shall be for only one vendor, but may be for one individual consumer or a group of individuals.

The regional center must submit the following:

1. Description of the risk to health and safety to either a consumer or group of consumers including a description of current services and why those services are inadequate to mitigate specific risk(s) to health and safety.
2. A description of how health and safety may be affected if the rate increase is not granted.
3. Documentation of the cost basis for the rate increase with an explanation of how it will mitigate the risk to health and safety of a consumer or group of consumers. Back-up documentation must include detail regarding current costs and the additional costs (and proposed new rate), by type and amount of service without which health and safety will be at risk and whether these costs are short-term or long-term.
4. Information as to the availability of alternative comparable local resources to meet the needs of the impacted consumers.
5. Detailed verification that alternative services (ex., 1:1 staffing support, different vendor) have been considered, including staffing augmentation specific to risk mitigation for a consumer or groups of consumers that might be provided under another vendor code and that such alternatives do not exist and/or are not appropriate.
6. Detailed documentation that the rate increase is the most cost-effective and consumer-centered strategy to mitigate the identified risk.

Increase In Rate Associated With Approval of Program Design Modification/Re-Vendorization of Community-Based Day Program, and In-Home Respite Agencies (WIC 4691.6)

Regional centers must submit the following:

1. Justification citing the specific matters relating to consumers' health and safety and a detailed plan outlining how proposed changes will eliminate health and safety concerns.
2. A new or revised program design addressing the specific health and safety concerns cited.
3. A list of the proposed specific and direct costs related to eliminating health and safety concerns including the recommended amount of increase to the existing rate.
4. Information as to the availability of alternative comparable local resources to meet the needs of the impacted consumers.
5. An analysis comparing the most recent cost statement upon which the current rate is based with updated cost information specific to health and safety request.
6. Detailed verification that alternative services (ex., 1:1 staffing support, different vendor) have been considered, including staffing augmentation specific to risk mitigation for a consumer or groups of consumers that might be provided under another vendor code and that such alternatives do not exist and/or are not appropriate.

Change in ARM Facility Service Level Resulting in a Rate Increase (WIC 4681.5)

Regional centers must submit documentation with their written request that:

1. Confirms that the planning teams for a majority of the consumers currently living in the CCF have reassessed the residents' needs and have determined that the consumers require a higher level of care than the service provider is currently funded to provide pursuant to Title 17, Sections 56005 and 56022; or, there has been a change in facility ownership.

Regional Center Executive Directors

October 23, 2007

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2. The residents' health and safety is at risk if a higher level of care is not provided.
3. Detailed verification that alternative services (e.g., 1:1 staffing support) have been considered, why such interventions are not sufficient, and how a service level increase is the most cost-effective approach to ensuring residents' health and safety.

If you have any questions about these guidelines, please contact David Temme, Chief, Community Rates Section, at (916) 654-2201.

Sincerely,

ORIGINAL SIGNED BY

RITA WALKER
Deputy Director
Community Operations Division

cc: Regional Center Administrators
Association of Regional Center Agencies

4781.5. (a) For the 2006-07 fiscal year only, a regional center may not expend any purchase of service funds for the [REDACTED] of any new program unless one of the following criteria is met:

(1) The expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances.

(2) The program to be developed promotes and provides integrated supported work options for individuals or groups of no more than three consumers.

(3) The program to be developed promotes and provides integrated social, civic, volunteer, or recreational activities.

(b) Notwithstanding subdivision (a), a regional center may approve grants for the 2006-07 fiscal year only to current providers to engage in new or expanded employment activities that result in greater integration, conversion from sheltered to supported work environments, self-employment, and increased consumer participation in the federal Ticket to Work program.

(c) Startup contracts for programs funded under this section shall be outcome-based.

(d) The department shall develop criteria by which regional centers shall approve grants, and shall provide prior written authorization for the expenditures under this section.

(e) This section shall not apply to any of the following:

(1) The purchase of services funds allocated as part of the department's community placement plan process.

(2) Expenditures for the startup of new programs made pursuant to a contract entered into before July 1, 2002.

4781.6. (a) For the 2007-08 fiscal year only, a regional center shall not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of extraordinary circumstances, and the department has granted prior written authorization for the expenditures.

(b) This section does not apply to the purchase of services funds allocated as part of the department's community placement plan process.

4782. Parents of children under the age of 18 years who are receiving 24-hour out-of-home care services through a regional center or who are residents of a state hospital or on leave from the state hospital shall be required to pay a fee depending upon their ability to pay, but not to exceed (1) the cost of caring for a normal child at home, as determined by the Director of Developmental Services, or (2) the cost of services provided, whichever is less. The State Department of Developmental Services shall determine, assess, and collect all parental fees in the manner as provided in Section 7513.2. The method of determination of the amount of the fee shall be the same, whether the child is placed in the state hospital or in a public or private community facility. In no event, however, shall parents be charged for diagnosis or counseling services received through the regional centers.

DEPARTMENT OF DEVELOPMENTAL SERVICES

1600 NINTH STREET
SACRAMENTO, CA 95814
(916) 654-1958
Fax (916) 654-1913



DATE: DECEMBER 8, 1998

TO: STAKEHOLDER ORGANIZATIONS

SUBJECT: INTER-REGIONAL CENTER TRANSFER GUIDELINES

Enclosed is the final version of the Inter-Regional Center Transfer Guidelines. Section 4643.5 (c) of the California Welfare and Institutions Code requires the development of such guidelines to help ensure "... a smooth transition of services and supports from one regional center to another ..." We thank all of you who provided comments on the three earlier drafts of the document.

Please contact Dale Sorbello, of my staff, at 916/654-1954, if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Eileen M. Richey".

EILEEN M. RICHEY
Deputy Director
Community Services Division

Enclosure

"Building Partnerships, Supporting Choices"

INTER-REGIONAL CENTER CONSUMER TRANSFER GUIDELINES

(December 4, 1998)

Introduction

Section 4643.5 (c) of the Welfare and Institutions Code (Chapter 294, Statutes of 1997, effective August 18, 1997) states that *"The department shall develop guidelines that describe the responsibilities of regional centers in ensuring a smooth transition of services and supports from one regional center to another, including, but not limited to, pretransferring planning and a dispute resolution process to resolve disagreements between regional centers regarding their responsibilities related to the transfer of case management services."* The following guidelines represent the Department's response to this mandate.

Guidelines

1. A well-planned and coordinated transition for consumers moving between regional center catchment areas helps minimize the trauma, frustration and disruption in services and supports that may occur without such planning and coordination. Therefore, it is incumbent on all those involved in the transition process (regional centers, consumers, families, vendors, etc.) to work in a coordinated and collaborative manner before, during, and after the transfer occurs.
2. Advance or pretransfer planning, when possible, is the foundation for successfully transitioning consumers between regional center catchment areas. A consumer or, where appropriate, his or her parents, legal guardian, conservator, or authorized representative needs to communicate planned move activities to the sending regional center as soon as possible. Both the sending and receiving regional centers should communicate and coordinate, as appropriate, with vendors and the consumer/family about a pending move as soon as it is known.
3. When the regional center becomes aware that a consumer/family is planning to move to another regional center, and if the family desires to meet, the sending regional center should contact the receiving regional center and a meeting or telephone conference should be convened to discuss transition services and supports during and after the move. Communication among all the involved parties should ensure there is clarity as to who is responsible for which transfer activity(ies), what the specifics of the responsibility are, and when the specified transfer activity(ies) will take place.
4. Transfers between regional centers should be coordinated between the Chief Counselors, or at a similar level reflecting the importance of this responsibility.
5. The provision of services and supports to a consumer or his/her family should not be delayed or withheld by either regional center pending the administrative transfer of a case.

6. The sending regional center should retain case management and fiscal responsibility for a consumer until the receiving regional center has effectively assumed such responsibilities. The receiving regional center should be deemed to have "effectively assumed" responsibility when a new service coordinator has been identified, a new or revised individual program plan (IPP) or individual family service plan (IFSP) has been developed, and the consumer is receiving the services and supports listed in the new or revised IPP or IFSP.
7. Consumers moving into a new regional center catchment area should have the same opportunity to receive services and supports as existing consumers. The sending and receiving regional centers should make best efforts to ensure that both regional center funded and generic services are provided with no gaps or delays.
8. When a disagreement exists between regional centers over case transfer, the sending regional center should maintain case management and fiscal responsibilities until such time as the issues are resolved. At no time should a consumer/family be without services due to disputes between regional centers.
9. The regional center must ensure its policies and practices conform with statutory provisions that may relate to consumer transfer activities. Some of these provisions include, but are not limited to, the following: Welfare and Institutions Code §§ 4418.3, 4519, 4643.5, 4646.5 (a)(4), 4648 (a)(10), 4652, 4805, 5008 (d), 42 CFR §§ 482.61 (e), 482.62 (a)(4), and 482.62 (f)(2).

Dispute Resolution Process

The following procedures are recommended in the event there is a dispute regarding the transfer of a consumer or funding from one regional center to another.

1. Regional centers should attempt to resolve all transfer disputes at the local level.
2. If resolution cannot be attained, either regional center or the consumer or the consumer's authorized representative may ask the Deputy Director of the Community Services Division, Department of Developmental Services, to review the case and to render a decision.
3. The request to the Department for intervention should be submitted in writing. A copy of the letter should be provided to the other regional center, or to both regional centers when the case review request is initiated by a consumer or authorized representative, and to any other involved parties.
4. The involved regional centers should provide the Department a written explanation of their respective positions within five working days. The written explanation may be submitted electronically. The Department may request additional information as

necessary. The Department may initiate a telephone conference call with the involved regional centers in lieu of, or in addition to, receiving the written information.

5. The Deputy Director, or his or her designee, will provide a written opinion on the disputed transfer case and/or funding within 30 days after receiving all the information needed from the involved parties to render a decision. The Deputy Director's decision will be binding on the involved regional centers to the extent the disputed matter involves the enforcement of an existing law or a provision in the Department's contract with the regional center.

Nothing in this dispute resolution process replaces or substitutes for the complaint process contained in Welfare and Institutions Code § 4731, or the consumer fair hearing process pursuant to Welfare and Institutions Code § 4700 et seq.

**COMMUNITY PLACEMENT PLAN (CPP) CLAIMS PROCESSING/
RECONCILIATION PROTOCOL**

An integral part of the CPP is the reconciliation of CPP claims with the State Claim File (SCF) of the Uniform Fiscal System (UFS) and monitoring the regional center's (RC) use of approved Purchase of Service (POS) and Operations (OPS) allocated CPP funding. This is accomplished by extracting CPP claims data from SCFs submitted by the RC, comparing that data with the paper claims submitted by the RC, and reconciling the total claims against the RC's allocations. The monitoring and review process for CPP claims ensures that funds approved and allocated for CPP are expended for the purposes intended, as required by Welfare and Institutions Code (WIC) section 4418.25(e), the RC's contract with the Department of Developmental Services (DDS), and DDS' CPP Guidelines.

The following is the established CPP Claim Protocol:

I. **RC CPP CLAIMS**

- A. Use the attached Regional Center Claims Reimbursement Summary CSS -1 (11-14-2014).
- B. Enter claim amount per OPS and/or POS category by the following CPP Claims program codes (PC) and service codes (SC):
 - 1. **OPS** Program Codes
 - a) PC 01 – CPP
 - b) PC 03 – Agnews Ongoing Workload
 - c) PC 11 – LDC Closure
 - 2. **POS** Program Codes and Service Codes
 - a) Placement POS
 - (1) PC 01 and any SC except 056, 780, 785, 999
 - b) Assessment POS
 - (1) PC 01 and SC 056, 780, 785
 - c) Startup POS [WIC sections 4648(e)(2), 4781.5(a), (c), and (e)(2)]
 - (1) PC 01 and SC 999
 - (2) For LDC Closure use subcode 'Lantr'
 - d) Deflection POS
 - (1) PC 06 and residential SC
- C. Monitor amount expended based on approved allocated amount.
- D. Submit claims within three years, by June 15th of the third year.

- E. Submit all claims as timely as possible, and no later than June 15th of any fiscal year.
- F. Work with DDS to reconcile discrepancies between SCF data and paper claims submitted by the RC.
- G. Contact the DDS Fiscal Support Section's Liaison if there are questions regarding claims that need reconciliation.
- H. Make appropriate corrections or updates to UFS and/or paper claims as timely as possible.

II. PROCESSING CPP CLAIMS

Once claims are verified and reconciled with the approved CPP and its associated allocations, the claims will be signed by the DDS Fiscal Support Section's Liaison and returned to DDS' Accounting Section for processing.

III. DDS' RESPONSIBILITIES

- A. Provide claims template to RCs.
- B. Provide technical support to RCs.
- C. Build and maintain a CPP claims log for approved/allocated CPP funds, UFS submissions, and paper claims.
- D. Work with RCs to reconcile discrepancies between SCF data and paper claims submitted by the RC.
- E. The DDS Fiscal Support Section's Liaison will review claims to ensure expenses and claims are in line with approved funding amounts and intended purposes, and will work with RCs to reconcile UFS and paper claims as needed.

IV. DDS TECHNICAL SUPPORT

- A. For technical assistance, RCs may contact DDS' Regional Center Technology Support Section (RCTSS), at (916) 654-1466, or the DDS Fiscal Support Section's Liaison, Stella Bertrand, at (916) 654-2052.

V. ADJUSTING CLAIMS

- A. Instruction from DDS' RCTSS:
 - 1. **OPS**
 - a) The RC can make adjustments using manual journal entries and manual state claims – the general ledger (GL) and the state claim should always be in sync when the final claim is generated. The only time the GL and state claim should not be in balance is if there has been a correction to a prior month out of balance situation. In this case, the year-to-date figures should be correct.

2. POS

- a) The RC should make their adjustments through prepaid invoices – the GL and state claim should always be in balance. If the RC has a system error – it is possible that a manual journal entry or manual state claim would need to be entered to fix something that is out of balance.

- b) Some RCs have used manual journal entries and manual claims for corrections, but DDS recommends against this as it does not create an audit trail. If this method is used, the GL and the state claim should always be in balance and the RC should certainly never claim an amount that is not supported by the claim report.

**REGIONAL CENTER CLAIMS REIMBURSEMENT SUMMARY
COMMUNITY PLACEMENT PLAN (CPP)**

Fiscal Year 2015-16 Supplemental #: _____ Addendum

DESCRIPTION		AMOUNT
OPERATIONS :	Regular CPP (program code 01)	
	Unified CPP (program code 03)	
	LDC Closure (program code 11)	
	SUBTOTAL	\$
PURCHASE OF SERVICES :	Regular Placement (program code 01)	
	Regular Assessment (program code 01)	
	Regular Start-Up (program code 01 & SC 999)	
	Regular Deflection (program code 06)	
	SUBTOTAL	\$

TOTAL NET CLAIM for the month of _____	\$
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I hereby certify that the amounts claimed herein are in accordance with the Contract Number HD _____ from July 1, 20____ through June 30, 20____, between the Regional Center and the Department of Developmental Services, and that the client services have been purchased in accordance with the fee schedule established by the Department.

Signature:	Title:	Date:
Regional Center:		
Contracting Agency:		
Mail Check To :		