

**DEPARTMENT OF DEVELOPMENTAL SERVICES  
PROPOSALS TO ACHIEVE \$200 MILLION GENERAL FUND SAVINGS  
MAY 2012**

**INTRODUCTION**

The Department of Developmental Services (DDS or Department) is currently responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring over 250,000 persons with developmental disabilities receive the services and support they require to lead more independent and productive lives and to make choices and decisions about their lives.

California provides services and supports to individuals with developmental disabilities in two ways: the vast majority of people live in their families' homes or other community settings and receive state-funded services that are coordinated by one of 21 nonprofit corporations known as regional centers. A small number of individuals live in four state-operated developmental centers and one state-operated community facility. The number of consumers with developmental disabilities in the community served by regional centers is expected to grow in Fiscal Year (FY) 2012-13 to nearly 256,000. The number of consumers living in state-operated residential facilities is expected to decrease by the end of FY 2012-13 to 1,440.

Due to lower than anticipated revenue projections, the Department of Finance announced on December 13, 2011, that the Department's Current Fiscal Year (2011-12) budget would be reduced by \$100 million General Fund (GF) in accordance with Assembly Bill 121, Chapter 41, (Statutes of 2011). The Department released its plan to achieve the savings on March 28, 2012, which can be found on the Department's website at [www.dds.ca.gov](http://www.dds.ca.gov).

The January 2012 Governor's Budget for FY 2012-13 includes the full year impact of the revenue trigger reduction for DDS of \$200 million GF. To address the budget year reductions, the Department initiated a process to receive stakeholder input in the development of savings proposals.

**PROCESS FOR DEVELOPING PROPOSALS**

The process to develop proposals was guided by three priorities: 1) preserve the Lanterman Act entitlement; 2) minimize the impact on consumers; and 3) spread the impact across the System. To solicit input, in February and March 2012 the Department held stakeholder workgroups in Los Angeles, Sacramento, San Diego, Riverside, Oakland and Fresno. Similar to the process used to develop reduction proposals for the FY 2011-12 Budget, stakeholder organizations were invited to appoint individuals to the workgroups that represent their respective services or role in the provision of services to consumers. To ensure individuals who receive

services and their families had the opportunity to participate, the Department asked the organizations to appoint consumer or family representatives to the workgroups.

This process provided valuable input from a wide variety of stakeholders on various strategies to achieve the required savings. The Department also invited written suggestions and comments from members of the community. The following proposals were developed by DDS informed by the stakeholder process and additional input from the community.

## **PROPOSALS FOR ACHIEVING SAVINGS**

### **1. MAXIMIZE THE USE OF FEDERAL FUNDING**

#### **Summary:**

Federal financial participation in the funding of regional center consumer services is a critical component of the State's budget. Currently, federal funding comprises nearly \$1.7 billion of the money available for regional center services. Through this proposal, additional federal financial participation is achieved, with a corresponding decrease in needed State GF dollars. The proposal includes two components, as follows:

#### **Aggressive Enrollment to the Home and Community-Based Waiver**

Medicaid, known as Medi-Cal in California, is a jointly-funded, federal-state health insurance program for eligible low income people that includes long-term care benefits. In 1981, the Medicaid Home and Community-Based Services Waiver (HCBS Waiver) program, section 1915(c) of the Social Security Act, was established. The HCBS Waiver provides a vehicle for California to offer services not otherwise available through the Medi-Cal program to individuals in their own homes and communities.

The Department, through the regional center system, operates a HCBS Waiver for individuals with developmental disabilities. The Centers for Medicare and Medicaid Services (CMS) recently approved California's five-year renewal of the HCBS Waiver effective March 29, 2012. The approved HCBS Waiver allows enrollment of 100,000 individuals, with an annual increase of 5,000 participants each March. During the workgroup process, the Department received recommendations on expanded receipt of federal funding through maximized enrollment in the HCBS Waiver. With an aggressive enrollment campaign conducted by the regional centers, families, and providers, the Department anticipates savings of \$61.0 million GF under the HCBS Waiver Program.

#### **Expansion of the federal Community First Choice Option - 1915(k)**

The Community First Choice Option (CFCO) is a State Plan service available under Section 1915(k) of the Social Security Act that provides an additional six percent in federal matching payment for certain eligible personal care activities.

California submitted a CFCO State Plan Amendment which is under consideration by the CMS.

The Department is proposing to amend the State's 1915(k) State Plan Amendment (SPA) to include related services provided by regional centers. State Plan services are available to all Medi-Cal beneficiaries, thereby limiting the regional center services appropriate for inclusion in the CFCO. Although the Department's budget included CFCO funding in both FY 2011-12 (\$1.2 million) and FY 2012-13 (\$1.9 million), DDS services were ultimately not included in California's initial SPA submittal. This proposal will amend the CFCO one year after the issuance of the federal regulations. This delay will allow California to maximize funding under its existing application, based on recently released federal regulations. The proposal will require some bundled services, such as Supported Living Services, to be restructured to isolate the CFCO eligible services. The Department will work with the Department of Social Services and the Department of Health Care Services to develop the SPA. Inclusion of regional center services will allow reimbursement at the currently budgeted FY 2012-13 amount and increase federal funding in FY 2013-14 to \$7.0 million.

**Savings:**

**FY 2012-13 savings**

Total Funds (TF):	\$0.0 million (fund shift)
GF:	\$61.0 million (in addition to \$1.9 million already in the budget)

This proposal assumes an aggressive enrollment campaign involving the regional centers, families, and providers to increase the number of HCBS Waiver participants to the 100,000 cap by February 2013. Enrollment would continue with the increase of the cap in March 2013. This aggressive enrollment activity will save \$61.0 million GF.

Inclusion of regional center services in the CFCO State Plan will allow reimbursement at the currently budgeted FY 2012-13 amount of \$1.9 million GF (no new savings) and increase federal funding in FY 2013-14 to \$7.0 million.

**2. IMPLEMENTATION OF SENATE BILL 946 – INSURANCE COVERAGE OF BEHAVIORAL SERVICES**

**Summary:**

Senate Bill (SB) 946, effective July 1, 2012, requires health care insurers to provide coverage for behavioral health treatment, for pervasive developmental disorder or autism. The proposal is consistent with the requirement that regional centers utilize available generic resources before purchasing services. The enacted statute excluded CalPERS and Healthy Families coverage. However, the

California Department of Managed Health Care (DMHC) recently announced that under the requirements of mental health parity, CalPERS and Healthy Families insurance plans would be required to cover behavioral health treatment. The estimate associated with implementation of SB 946 is \$69.4 million GF. The recent DMHC announcement increases the anticipated savings by \$10.4 million for a total savings in regional center services of \$79.8 million.

**Savings:**

**FY 2012-13 savings**

TF: \$79.8 million

GF: \$79.8 million

This proposal assumes certain behavioral services will be available through private health insurance that are currently provided by regional centers to individuals who have a diagnosis of autism, have health care insurance coverage, and are not a Medi-Cal beneficiary . The cost of maintenance therapies was excluded from the estimated savings.

**3. REDESIGN SERVICES FOR INDIVIDUALS WITH CHALLENGING SERVICE NEEDS**

**Summary:**

California's service delivery system continues to face a growing need for specialty services for individuals with significant challenges and often resorts to high cost State-operated Developmental Centers (DC), locked mental health facilities and out-of-state placements to meet the immediate needs of these consumers. During the workgroup process, there was significant discussion regarding the importance of reducing the long-term reliance on the DC's, mental health facilities not eligible for federal funding and out-of-state placements. This discussion facilitated the development of a package of proposals that represent a multi-year effort to redesign services to address the special needs of the individuals entering and residing in these facilities. This proposal will achieve \$20 million in GF savings in FY 2012-13. The primary components of this package include:

- A moratorium on new admissions to DC's, with limited exceptions for individuals who are committed by the criminal or juvenile justice system to restore competency; individuals involved in the criminal or juvenile justice system who are a danger to themselves or others whose competency cannot be restored; or individuals in acute crisis needing short-term stabilization.
- Operation of a short-term crisis program at Fairview Developmental Center to meet the needs of individuals in acute crisis that otherwise would likely result in placement in a locked mental health facility ineligible for federal funding. Crisis admissions will require a time-limited court order; a

comprehensive assessment completed within 30 days of admission; and development of a plan by the Individual Program Plan (IPP) team for transition back to the community.

- A restriction on admissions to a DC as a result of criminal conviction or where the person is competent to stand trial for a criminal offense and admission is ordered in lieu of trial.
- A restriction on admissions to a DC when the Department determines it cannot safely serve the consumer without placing the safety of other residents at risk.
- Comprehensive assessments of the service and support needs and available resources for current DC residents.
- Expanding the Transition services at Porterville DC – Secure Treatment Program from 30 to 60 residents.
- Reducing reliance on service and supports ineligible for federal funding.
- Maximizing the use of available Community Placement Plan program resources to meet statewide specialized service needs to reduce the reliance on the DC's, locked mental health facilities and out-of-State placements.
- Expanding the development of SB 962 homes (Adult Residential Facilities for Individuals with Special Health Care Needs) statewide to increase community options for DC residents.

**Savings:**

**FY 2012-13 savings**

TF: \$20.4 million  
GF: \$20.0 million

The savings associated with this package of proposals is interrelated and impacts both community and DC services. The savings in community services is estimated at \$11.7 million TF (\$10.0 million GF) primarily related to reduced reliance on facilities that do not receive federal funding participation. The savings in the DC's is estimated at \$8.7 million (\$10.0 GF) primarily associated with reduced admissions and increased federal funds.

#### **4. REDESIGN SUPPORTED LIVING ASSESSMENTS**

##### **Summary:**

Supported Living Services (SLS) is a community living option that supports adult consumers who choose to live in homes they control through ownership, lease, or rental agreement. In supported living, a consumer pays for living expenses, (e.g. rent, utilities, food, and entertainment) out of Social Security income, work earnings, or other personal resources. The regional center pays the vendor to provide SLS. The consumer may also receive other kinds of publicly-funded services like Medi-Cal, mental health services, vocational services, and In-Home Supportive Services.

Current statute requires an independent needs assessment for all consumers who have SLS costs that exceed 125 percent of the annual statewide median cost of providing supported living services. The assessment is completed by an entity other than the SLS agency providing service and is used during the IPP meetings to determine that authorized services are necessary, sufficient and utilize the most cost effective methods of service.

During the workgroup process, it was suggested that additional savings could be realized if the independent assessment requirement was rescinded, thereby saving the cost of these evaluations, and was replaced by an assessment process applied more broadly. This proposal ensures that consumers in or entering supported living arrangements receive the appropriate amount and type of supports to meet the person's choice and needs as determined by the IPP team and that generic resources are utilized to the fullest extent possible. The IPP team shall complete a standardized assessment questionnaire at the time of development, review, or modification of a consumer's IPP. The questionnaire shall be used during the team meetings, in addition to the provider's assessment, to assist in determining whether the services provided or recommended are necessary and sufficient and that the most cost-effective methods of supported living services are utilized. With input from stakeholders, the department shall develop and post the standardized assessment questionnaire and provide it to the regional centers by June 30, 2012. This proposal achieves a net increase of \$4.2 million in GF savings.

##### **Savings:**

##### **FY 2012-13 savings**

TF: \$7.6 million  
GF: \$4.2 million

The proposal assumes all individuals residing in a supported living setting would receive a standardized assessment rather than the 3,000 consumers required to receive an independent assessment under current statute. Avoiding the cost of

independent assessments (\$3.0 million TF) also contributes to the net GF savings from this proposal.

## **5. REGIONAL CENTER AND PROVIDER RATE REDUCTION**

### **Summary:**

Regional Centers and service providers have operated under a payment reduction since February 2009 when a 3 percent reduction was first initiated. The reduction was increased to 4.25 percent on July 1, 2010 and is scheduled to sunset June 30, 2012. The reduction does not apply to payments for supported employment services; usual and customary rates for businesses that serve the general public without specialty services for persons with developmental disabilities; and payments to offset reductions in Supplemental Security Income/State Supplementary Payment (SSI/SSP) benefits for consumers receiving supported and independent living services.

The Governor's Budget in January did not assume the extension of the payment reduction but did assume the \$200 million GF trigger savings. However, given the size of the budget savings, the continuation of some or all of the current payment reduction was discussed at the workgroups. The Department heard many concerns about the destabilizing affect of the current 4.25 percent payment reduction.

Recognizing the significant impact of the payment reduction at its current level, the Department is proposing to decrease the amount of the reduction by 3 percent and continue a 1.25 percent payment reduction for regional centers and service providers to achieve \$30.7 million in GF savings. The provisions for workload relief associated with the current payment reduction will continue as well.

### **Savings:**

#### **FY 2012-13 savings**

TF: \$45.5 million

GF: \$30.7 million

## **6. ADDITIONAL COST SAVINGS AND EFFICIENCIES**

### **Summary:**

The Department has identified three additional areas of savings associated with reduced need for funding and efficiencies, as follows:

### Downsizing Funds

The Department budget includes funds earmarked for the downsizing of Community Care Facilities to allow them to meet federal requirements for funding participation. The need for these funds has declined due to prior proposals that restricted the use of Community Care Facilities that do not qualify for federal funding. The Department is proposing to reduce these funds by \$2.0 million GF.

### “Gap” Funds

The Department budget includes funds earmarked to address the gap in federal funding when a Community Care Facility transfers ownership and is temporarily ineligible for federal funding until the facility is recertified. The need for Gap funds has declined due to efforts to minimize the time between change of ownership of residential facilities and certification for federal funding. The Department is proposing to reduce these funds by \$0.3 million GF.

### Use of Technology to Achieve Efficiencies

The Department heard from many participants in the workgroups on how technology can assist in the delivery of services and assist consumers in their day to day lives. The Department is proposing to expand the use of technology that will achieve \$2.0 million in GF savings. This proposal will focus, but is not limited to the following areas:

- Remote access to court proceedings for DC residents (\$0.4 million GF);
- Expanded use of electronic/virtual Direct Service Provider training methods (\$0.5 million GF); and
- Promotion of appropriate service delivery methods using existing and available technology, such as electronic visits to professionals for individual and group services (\$1.1 million GF).

### **Savings:**

#### **FY 2012-13 savings**

TF: \$5.2 million  
GF: \$4.3 million