



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

Posted at www.scdd.ca.gov

DATE: December 8, 2014

TIME: 2:00 p.m. – 5:00 pm

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

TELECONFERENCE LOCATION:

Westside Regional Center, Rm 3c
5901 Green Valley Circle #320
Culver City, CA 90230
Phone number: (310) 258-4000

TELECONFERENCE INFORMATION:

Phone Number: 1(800) 839-9416
Passcode: 8610332

Pursuant to Government Code Sections 11123.1 and 11125(f), individuals with disabilities who require accessible alternative formats of the agenda and related meeting materials and/or auxiliary aids/services to participate in the meeting, should contact Michael Brett at 916/322-8481 or michael.brett@scdd.ca.gov by 5 pm on Monday, December 1, 2014.

1. **CALL TO ORDER** J. Lewis
2. **ESTABLISHMENT OF QUORUM** J. Lewis

- | | | | |
|-----|---|----------|-----------|
| 3. | WELCOME AND INTRODUCTIONS | J. Lewis | |
| 4. | MEMBER REPORTS | Members | |
| 5. | APPROVAL OF 5/7/2014 & 10/23/2014 MINUTES *ACTION ITEM* | J. Lewis | 3 |
| 6. | PUBLIC COMMENTS | | |
| | <i>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.</i> | | |
| 7. | LANTERMAN COALITION UPDATE *ACTION ITEM* A. Detail Sheet B. ARCA Publication: "Inadequate Rates for Service Provision in California" | J. Lewis | 17 |
| 8. | LPPC PRIORITIES FOR 2015 *ACTION ITEM* A. Description of LPPC in SCDD Bylaws B. 2015 Tentative Legislative Calendar C. LPPC Platform D. 2015 LPPC Legislative Priority Setting Exercise | J. Lewis | 85 |
| 9. | PLANNING FOR NEXT MEETING | J. Lewis | |
| 10. | ADJOURNMENT | J. Lewis | |

Item 5
APPROVAL OF MEETING
MINUTES

LEGISLATION AND PUBLIC POLICY COMMITTEE

Meeting Minutes

May 7, 2014

1. CALL TO ORDER

Meeting was called to order at 10:05 am.

2. ESTABLISHMENT OF QUORUM

Quorum was established.

3. WELCOME AND INTRODUCTIONS

4. APPROVAL OF 4/9/14 MINUTES

A motion was moved by Lapin/seconded by Allen to approve the minutes upon amending a vote by Davidson to abstain on SB 1046.
Y=5, N=0, A=2

5. PUBLIC COMMENTS

There were no public comments.

6. MEMBER REPORTS

Members gave verbal reports.

7. STATE BUDGET

Mark Polit gave a status report on the current budget.

8. LEGISLATION

A. Status of Bills with Council Position

Mark Polit gave a status report on legislation with Council positions.

B. AB 1335 (Maienschein) and SB 922 (Knight), Sentencing of Sex Offenders:

No action was taken.

C. SB 1396 (Hancock), Positive Behavior Intervention:

A motion was moved by Ceragioli/seconded by Lapin to support this bill. Y=7, N=0, A=0

D. AJR 36 (Gonzalez), Sub-minimum Wage:

A motion was moved by Forderer/seconded by Banh to recommend to the Employment First Committee to take a support position on AJR 36. Y=7, N=0, A=0

E. SB 1109 (Hueso), State Contracting and Sub-minimum Wage

Mark Polit reported that the bill is no longer active.
No action was taken.

F. SB 1160 (Beall), State Contracting and Log-term SEP

A motion was moved by Lapin/seconded by Forderer to support if amended to require payment of at least minimum wage for state contracts under section 4870. Y=7, N=0, A=0

G. SB 1176 (Steinberg), Tracking Insurance Out of Pockets

A motion was moved by Lapin/seconded by Forderer to support SB 1176. Y=6, N=0, A=1

H. SB 1178 (Correa), Housing for People with IDD

Agenda item for next meeting.

I. AB 1687 (Conway), Timely Investigation

A motion was moved by Lapin/seconded by Forderer to support SB 1687. Y=7, N=0, A=0

**J. SB 1428 (Evans) and AB 2349 (Yamada),
Sonoma DC Land Use and transition**

A motion was moved by Ceragioli/seconded by Forderer to support SB 1428 if amended to clearly reflect the recommendations of the DC Task Force. Y=6, N=0, A=1

A motion was moved by Allen/seconded by Davidson to watch SB 2349. Y=7, N=0, A=0

K. Other legislation

9. IHSS TRAINING BALLOT MEASURE

Debra Doctor from Disability Rights California teleconferenced into the meeting to discuss the IHSS training ballot measure. The committee asked for a presentation from a union representative and

an IHSS consumer from Washington State to discuss the training program there.

10. PLANNING FOR NEXT MEETING

Next meeting is June 11, 2014.

11. ADJOURNMENT

Meeting was adjourned at approximately 2:30 pm.

Legislative and Public Policy Committee Meeting

MINUTES

10/23/14

SACRAMENTO, CA

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| MEETING CALLED BY | Janelle Lewis, Chair |
| TYPE OF MEETING | State Council Committee Meeting |
| FACILITATOR | Janelle Lewis |
| NOTE TAKER | Michael Brett |
| COMMITTEE MEMBER ATTENDEES | Janelle Lewis, April Lopez, David Forderer, Jennifer Allen, Lisa Davidson, Connie Lapin, and Tho Vinh Banh |
| COMMITTEE MEMBERS NOT IN ATTENDANCE | Feda Almaliti |
| SCDD STAFF ATTENDEES | Anastasia Bacigalupo, Vicki Smith, Roberta Newton, and Karim Alipourfard |
| PUBLIC | No public in attendance |

Agenda Topics

CALL TO ORDER

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| CONCLUSIONS | Meeting called to order at 10:11 am by Ms. Lewis. |
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APPROVAL OF MEETING MINUTES

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| DISCUSSION | <p>Committee member reviewed the September 4, 2014 meeting minutes and provided follow up on action items:</p> <ul style="list-style-type: none">• May LPPC meeting minutes are still missing.• Ms. Lopez will email Down Syndrome camp information to LPPC members.• Ms. Bacigalupo reported on the action item to provide a fact sheet on Medi-Cal/Autism Services in multiple languages. She shared with the group that 'Autism Deserves Equal Coverage' (ADEC) has an extensive FAQ in multiple languages that SCDD should circulate.• Ms. Bacigalupo reported that Roberta Newton, executive director of Area Board 10, would be covering the intersection of EPSDT services and the new CMS rules in her presentation later in the meeting.• Ms. Lewis tabled the discussion of dead bills/bills to be resurrected to agenda item #6.• Ms. Lewis reported that the SCDD approved LPPC's recommendation at the last SCDD meeting to support the Military Children with Developmental Disabilities Act.• Ms. Lewis reported that she attended the Developmental Center Task Force workgroup meeting.• Mr. Phillips provided the follow up on his action item via email. The email was circulated to LPPC members. |
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| | <ul style="list-style-type: none"> Ms. Lewis discussed the ongoing idea of forming a Self Determination workgroup. Ms. Lewis suggested that the group meet either before or after LPPC meetings in order to reduce travel costs. Members who volunteered were: Mr. Forderer, Ms. Lapin, Ms. Lewis, Ms. Davidson, and Ms. Lopez. Ms. Lewis asked Ms. Bacigalupo and Ms. Smith to provide staff support. Ms. Bacigalupo reported that SCDD did not receive the requested documents from Ms. Sasson but that Ms. Doctor's presentation later in the meeting would provide the most current and updated information on the subject. Ms. Lewis reported that she, Ms. Bacigalupo and Ms. Smith had a very productive teleconference call in planning today's meeting. |
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| CONCLUSIONS | <p>Ms. Davidson asked for an edit to the Members reports section of the September meeting minutes- she asked that the sentence regarding her report state "...and that Area Board 10 is working on staffing the regional center Self Determination committees." Ms. Lapin made the motion to approve the minutes with Ms. Davidson's edit. Motion was seconded by Ms. Davidson. Tho Vinh Banh abstained. Motion passes.</p> <p>LPPC members asked that SCDD staff: track down the May LPPC meeting minutes, and post the ADEC FAQ (if permission given) on the SCDD website.</p> <p>Ms. Lewis will talk to Ms. Kennedy (chair of SCDD) about having Self Determination workgroup meetings before or after LPPC meetings.</p> |
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| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
|---|---------------------------|-----------------|
| Track down May LPPC meeting minutes. | SCDD Staff | Ongoing |
| Request permission from ADEC to post their Medi-Cal/Autism FAQ on the SCDD website and share statewide. | Anastasia Bacigalupo | 11/23/2014 |
| Discuss Self Determination work group idea with Ms. Kennedy. | Janelle Lewis | 12/01/2014 |

PUBLIC COMMENT ON MATTERS NOT ON THE AGENDA

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| DISCUSSION | No public comment offered. |
| CONCLUSIONS | No public comment offered. |

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

MEMBERS REPORTS

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| DISCUSSION | Ms. Lapin reported on progress statewide informing communities about the Self Determination Program. |
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| CONCLUSIONS | Committee members agreed that it was important to follow the new developments as they happened around the state. | | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE | |
| None at this time. | N/A | N/A | |

LEGISLATION

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| DISCUSSION | <p>Committee members discussed supporting legislation for the next legislative term.</p> <p>Ms. Banh gave an overview of SB 1093 which will go into effect January 1, 2015. She focused on one section of the new law which authorizes regional centers to pay for independent living services (ILS) for consumers who live at home with their parent, family member or other person. Historically consumers have been denied ILS while living at home with family members and many regional centers would only agree to ILS if there was a plan to move out of their family home.</p> <p>Ms. Lewis proposed that the LPPC table the discussion of the legislative priorities for a separate meeting just dedicated to that topic. Committee members liked the idea and offered December 8th at 2:00 pm as a good date/time for everyone's schedule.</p> | | |
| CONCLUSIONS | <p>Committee members would like SCDD staff to research the following dead bills and see if they will be introduced as new bills for the next legislative term: AB 1753, AB 2041, AB 2299, SB 391, SB 1046, SB 1160, SB 1176, and SB 1178. Committee members were not sure about SB 840.</p> <p>Committee members would like SCDD staff to develop a flyer on the change of law re: ILS and collaborate with Ms. Banh/DRC on the flyer, if possible.</p> <p>Mr. Forderer motioned that the LPPC meet on December 8, 2014 at 2 pm for the purpose of developing legislative priorities for the upcoming legislative term and for reviewing the LPPC platform. Ms. Allen seconded the motion. No abstentions. Motion passes.</p> | | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE | |
| Research and report at January LPPC meeting whether selected dead bills will come back for the next legislative term by contacting the dead bill authors/sponsors. | Karim Alipourfard | 01/15/2014 | |
| Create a flyer on the change of law re: ILS and collaborate with Ms. Banh/DRC on the flyer, if possible. | Anastasia Bacigalupo | 11/23/2014 | |
| Organize LPPC meeting for December 8, 2014 at 2:00 pm. | Janelle Lewis, Vicki Smith and Anastasia Bacigalupo | 12/08/2014 | |

AUTISM BEHAVIORAL SERVICE/MEDI-CAL COVERAGE

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| DISCUSSION | Ms. Lewis stated that there are ongoing meetings about the changes to the Medi-Cal coverage of Autism related services. | |
| CONCLUSIONS | Committee members agreed that it was important to follow the new developments as they happened around the state. | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
| None at this time. | N/A | N/A |

SPECIAL EDUCATION

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| DISCUSSION | Ms. Almaliti was not present. Mrs Lewis shared that the Department of Education, Office of Civil Rights did an excellent "Dear Colleague" letter on bullying directed at local education agencies (LEAs). The letter can be found at: http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.html She shared the letter with the LPPC members. | |
| CONCLUSIONS | Committee members did not take any action and did not request any action items. | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
| None at this time. | N/A | N/A |

TASK FORCE UPDATES

| | | |
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| DISCUSSION | Ms. Lewis shared earlier in the meeting her experience attending the Developmental Centers Task Force workgroup meeting. These meetings happened regionally- Los Angeles, Sacramento and Fresno. Ms. Lapin reported on the Developmental Services Task Force meetings. The notes along with the agenda are located in the LPPC packet. Ms. Lapin mentioned that there were no school age children represented at these meetings which she found discouraging. Also nothing on creating/structuring workgroups was mentioned. Secretary Dooley encourages the public to get involved in these meetings which is a plus. No future meetings were discussed, however, that does not mean there is an end to these meetings- there could be more in the future. | |
| CONCLUSIONS | Committee members agreed that it was important to follow the new developments from the task force. | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
| None at this time. | N/A | N/A |

DEPARTMENT OF LABOR/OVERTIME AND MINIMUM WAGE ISSUES

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| DISCUSSION | Ms. Doctor conducted her presentation, which was provided in hard copy to LPPC members. She made the following points: <ul style="list-style-type: none"> • Advocacy efforts should focus on putting pressure on |
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California re: overtime rule; not focus on putting pressure on federal government because it is very unlikely they will reverse their decisions about minimum wage, etc.

- Advocacy efforts should focus on making better rules around overtime at the state level and creating exceptions to the rules for respecting and preserving consumer choice.
- Timecards have already changed significantly and the overtime rules and minimum wage requirements will impact the timecards even further. Information about the changes to timecard can be found on the California Department of Social Services website.
- Right now there are no guidelines for those consumers who need to receive “advance pay” for their IHSS workers. This will definitely cause a problem for families who need advance pay. If you know someone experiencing this problem or any other problem related to the new overtime rules, please have them call Disability Rights of California at 1-800-776-5746.
- It’s okay to share her PowerPoint- distribute wide and far! Contact SCDD staff for an electronic copy of the presentation.
- Advocacy efforts should focus on increasing provider rates and seeing ways to infuse money into the system. The Lanternman Coalition was discussed and the need for SCDD to become active on it again.
- SCDD can draft and send a letter to Health and Human Services Agency Secretary Dooley and Governor Brown outlining the issues presented with the implementation of the overtime rule and ask for the creation of exceptions if there is no agreement to changing the rule.

CONCLUSIONS

Committee members agreed that SCDD could do the following on this issue:

- Draft and send a letter to Health and Human Services Agency Secretary Dooley and Governor Brown outlining the issues presented with the implementation of the overtime rule and ask for the creation of exceptions if there is no agreement to changing the rule.
- Send a representative to the Lanterman Coalition meeting in November.

Ms. Lapin motioned that SCDD send a representative to the Lanterman Coalition meeting and that Ms. Lewis represents the LPPC/SCDD at the meeting. Ms. Davidson seconded the motion. No abstentions. Motion passed.

| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
|---|---------------------------|-----------------|
| Recommend to the State Council that staff draft letters for approval by the State Council Chair addressed to Health and Human Services Agency Secretary Dooley and Governor Brown | Janelle Lewis | 11/19/2014 |

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| about the challenges presented by the implementation of the overtime rule and ask for the creation of exceptions where there is no ability to modify the rule. | | |
| Determine when the next Lanterman Coalition meeting will be and send Ms. Lewis as LPPC/SCDD representative. | SCDD Staff | 10/31/2014 |

SENATE BILL 577 EMPLOYMENT PILOT PROGRAMS

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| DISCUSSION | Ms. Smith shared that the Department of Developmental Services (DDS) has not said which regional centers will be picked to be the pilots for this program. | |
| CONCLUSIONS | Committee members did not take any action and did not request any action items. | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
| Discuss any updates to the Senate Bill 577 Employment Pilot Programs statewide. | Vicki Smith | Ongoing |

NEW CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) RULES

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| DISCUSSION | <p>Ms. Newton gave a teleconference presentation on this issue. Materials in packet provided technical and basic information on the new rules.</p> <p>Highlights are:</p> <ul style="list-style-type: none"> • The goal is that California is fully compliant with the rules by March 2019. CMS requires that all states submit a transition plan. California drafted a plan for public comment. Two public comment periods- first one ending on 10/19 and the second one starting 10/27 and ending 11/16. • The problems with the draft transition plan are that it is extremely broad and fails to address adult residential programs. The second draft of the transition plan will be released to the public at the end of October/beginning of November. <p>Recommendations for SCDD:</p> <ul style="list-style-type: none"> • SCDD should be recognized as a stakeholder on evaluation teams for the development of the transition plan, assessment tools and assessing various waiver settings. • SCDD should develop a position statement/provide written input on the new CMS rules. • SCDD, with the involvement of its regional office, develop consumer-friendly information materials to educate consumers and their families as to the new CMS rules and explain the implications of the CMS rules on various services and supports. |
| CONCLUSIONS | <p>Committee members asked that staff:</p> <ul style="list-style-type: none"> • Determine ways to have SCDD being active as a stakeholder on evaluation teams for the development of the |

transition plan, assessment tools and assessing various waiver settings.

- Draft a position statement/provide written input on the new CMS rules as outlined in the above recommendations.
- Develop consumer-friendly information materials to educate consumers and their families as to the new CMS rules and explain the implications of the CMS rules on various services and supports.

Also committee members asked that they receive DRC's position statement, shared by Ms. Banh.

| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
|--|--------------------|--|
| Determine ways to have SCDD being active as a stakeholder on evaluation teams for the development of the transition plan, assessment tools and assessing various waiver settings. | SCDD Staff | To be discussed at 12/08/2014 LPPC meeting |
| Recommend to the State Council that staff draft a position statement with recommendations for approval by the State Council Chair addressed to Health and Human Services Agency Secretary Dooley and the Centers on Medicaid and Medicare Services that addresses the involvement of the State Council as a stakeholder, the development of the transition plan, the development of assessment tools, and the evaluation of various waiver settings. | Janelle Lewis | 11/19/2014 |
| Develop consumer-friendly information materials to educate consumers and their families as to the new CMS rules and explain the implications of the CMS rules on various services and supports. | SCDD Staff | To be discussed at 12/08/2014 LPPC meeting |
| Email DRC's position/input on the new CMS rules to LPPC members. | SCDD Staff | 10/31/2014 |

SELF DETERMINATION

| DISCUSSION | Ms. Lapin provided an update on advocacy around the state on the Self Determination Program (SDP). DDS released SDP definitions and related information on their website. DDS still has not submitted the SDP application for review/approval to the federal government. | |
|--|--|-----------------|
| | Ms. Lapin is an organizer and contributor to the SDP conference being held on November 7-8, 2014 in Southern California. | |
| CONCLUSIONS | Committee members asked that Ms. Lapin report on the conference at the January LPPC meeting. | |
| ACTION ITEMS | PERSON RESPONSIBLE | DEADLINE |
| Report on SDP conference in Southern California. | Connie Lapin | 01/15/2014 |

VISION FOR COUNCIL'S FUTURE

At the request of the State Council Chair, LPPC members participated in a visioning /brain storming session for the State Council.

Accomplishments

1. Legislation: Self Determination, Employment First, AB 1595, influence on SB 577, rapport with legislature
2. CAP, AIDD goals, strong collaboration with partners (DRC and UCEDDs)
3. SSAN , SAAC
4. Filing vacancies
5. National Core Indicators (NCI) (in line with other states)
6. Mini grants (community progress)
7. Area Board offices more unified; providing boots on the ground work for the council

How to Become a Model Leader in California and Nation

1. Focus on public relations, representation in public (hearings, meetings; etc.)
2. Stimulate thinking and develop plans/ideas for moving support services for peeps with developmental disabilities
3. Education and Outreach- public and people with developmental disabilities
4. Achieving statewideness to our diverse populations (underserved disabilities, economic, geographic, ethnic groups)
5. Strong advocacy: a system that promotes individual rights and equality.
6. Ensuring the implementation of laws
7. Increase our availability and visibility to legislators
8. Have an impact
9. Use of social media
10. Create forums- Be a "convener"

Improving the CA DD System

1. Fully fund the DD Act (state and federal)
2. Training: regional center case managers on services available
3. System monitoring (fear us!)
4. Council make up is unique to its diversity
5. Network and convene: leadership, stakeholders; DD Sustainability
6. Innovative and autonomous as a system
7. Leadership of self advocates
8. Look at what other state councils do
9. Create an ambitious/great state plan

Improve/Impact Next 10 years

1. Train and educate general public (bullying of adults and kids, etc.) 90% have been abused; 46% have been abused more

DISCUSSION

- than once.
- a. Social media
 - b. Community outreach
 - c. PSAs
2. Conveners- the concept; how to revive/revitalize our system
 3. "Truly" implement Self Determination, Employment First, Independent Living Services
 - a. Doctors
 - b. First Responders (cops and firefighters)
 4. Resources for help in navigating systems and services
 - a. Ombudsmans
 - b. Information and referral
 - c. Ongoing and periodic measurement (how are we doing?)
 - d. Secure implementation of parental fees for new creative and innovative programming
 5. Think of SCDD as being the one to call for resources
 6. Information highway (statewide then local)
 7. Abuse education: school districts
 8. Integrated individuals with developmental disabilities
 9. Age 3-22 Children (Focus on Public Education)
 10. Ensure that public benefits are available and council is responsive to needs
 11. Consumers without family members represented and supported
 12. Train future advocates/Sustainability
 13. Partners in Policy Making: continue to educate self advocates on changing the system so that self advocacy continues successfully
 14. Ensure services council provides responsive to diversity of state's developmentally disabled population

ADJOURNMENT

Ms. Lewis reminded committee members that the next scheduled meetings are: 12/08/2014 2 pm- 5 pm and 01/15/2014 10 am-3 pm.

Ms. Lewis adjourned the meeting at 3:07 pm.

Item 7
LANTERMAN COALITION
UPDATE

LPPC AGENDA ITEM DETAIL SHEET

ISSUE: Endorsement of the Lanterman Coalition's proposal of a 10% rate increase system-wide for California's community based developmental services system.

SUMMARY: The Lanterman Coalition is a network of 17 major stakeholders in California's community based developmental services system. For the 2015 legislative term they are seeking endorsements from stakeholders like the State Council on their proposal that the legislature provide a 10% rate increase system-wide for community based developmental services system.

BACKGROUND/ISSUES/ANALYSIS: Consumers of all ages, their families and circles of supports have suffered the greatest as a result of the consistent cuts to the developmental services system. These cuts have meant that adult consumers have lost access to a network of agencies to receive services and supports from in California in the areas of Supportive Living Services, Independent Living Services, Supportive Employment Services and residential programs that empower adult consumers to live independently in our communities. As time has marched on and these agencies have seen their costs rise but the rates of pay remain the same, many have closed or limited their availability to provide services and supports to large numbers of consumers. The consequences of the cuts mean that consumers end up relying more on government benefits and have less of a chance of moving out of poverty.

For children with developmental disabilities, families experience the cuts in a similar but different way. As families attempt to access therapeutic and/or respite services, agencies are limiting the number of children they will take (creating wait lists for services), limiting the availability of their staff or closing up shop because they simply cannot afford to do business with rates that have remained the same for the past 10, 15 or 25 years. Families experience frustration in not having an array of agencies to choose from. Also since agencies cannot afford to hire highly qualified staff based on the rates, families often are forced to work with underqualified staff that provides low quality services and/or families end up training the staff to provide appropriate services and supports to their child.

From a policy perspective, California's developmental services system is poised to promote better service outcomes for the over 265,000 individuals with developmental disabilities. Services can be more individualized and lead to greater levels of community participation, employment, and independence.

Unfortunately, long-standing underfunding of the service system not only undermines this potential forward progress, but also the adequacy of the community-based provider network.

These concepts are not new. Studies dating back many years all draw the same conclusion: quality services and achievement of outcomes for children and adults with developmental disabilities are directly related to the ability to hire qualified staff, maintain staff by paying them a decent wage and having an array of agencies that have resources to provide innovative and high quality services and supports. Acknowledging the problem without taking a position does not help the over 265,000 Californians with developmental disabilities, their families and circles of support to move forward. Instead, the 2015 legislative term provides a unique opportunity for the State Council to become an active participant in systemic change for the improvement of services and supports. One such opportunity is to endorse the Lanterman Coalition's proposal that the legislature provide a 10% rate increase system-wide for community based developmental services system. The 10% rate increase is the beginning step of systemic change needed to reform the service system.

The Lanterman Coalition is made up of the following agencies: California State Council on Developmental Disabilities, The Arc and Cerebral Palsy California Collaboration, the Autism Society of California, California Disability Services Association, California Supported Living Network, Disability Rights California, Family Resource Center Network of California, People First of California, Service Employees International Union, Cal-TASH, Easter Seals, The Alliance, Autism Speaks, the Alliance of California Autism Organizations, ResCoalition, and the California Respite Association and the Association of Regional Center Agencies. They are seeking the State Council's endorsement for their proposal.

The State Council's approved 2014 legislative and public policy platform states: "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." The State Council endorsing the Lanterman Coalition's proposal fits the State Council's position as a beginning step to restoring rates for services in the developmental service system.

RECOMMENDATION: LPPC recommend to the State Council that the State Council endorse the proposal of a 10% rate increase system-wide for California's community based developmental services system.

COUNCIL STRATEGIC PLAN OBJECTIVE: State Plan Goal #13 (a): The Council will collaborate with 150 local community agencies and organizations – including child care, recreation, transportation and others - to protect the rights of individuals with developmental disabilities and ensure their inclusion in the community.

State Plan Goal #14 (a): Public policy in California promotes the independent, productivity, inclusion and self-determination of individuals with developmental disabilities and their families.

ATTACHMENTS: *Inadequate Rates for Service Provision in California*, written by the Association of Regional Center Agencies, January 2014.

PREPARED: Anastasia Bacigalupo, prepared November 20, 2014.

INADEQUATE RATES FOR SERVICE PROVISION IN CALIFORNIA



**Prepared by the
Association of Regional Center Agencies**

January 2014

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| APPENDIX E – WORK ACTIVITY PROGRAM (WAP) AND SUPPORTED EMPLOYMENT PROGRAMS (SEP) RATES | |

INADEQUATE RATES FOR SERVICE PROVISION IN CALIFORNIA EXECUTIVE SUMMARY

The Association of Regional Center Agencies (ARCA) represents the 21 regional centers in supporting and advancing the intent and mandate of the Lanterman Developmental Disabilities Services Act (the Lanterman Act). ARCA advocates on behalf of the 265,000 individuals served by the regional centers statewide, and works in cooperation with other entities to promote services for persons with developmental disabilities.

Regional center budgets are divided into two parts: Purchase of Service (POS) which provides funding to pay more than 45,000 direct service providers in the community, and Operations (OPS), which provides funding to support the regional center's role in service coordination, resource development, and quality assurance.

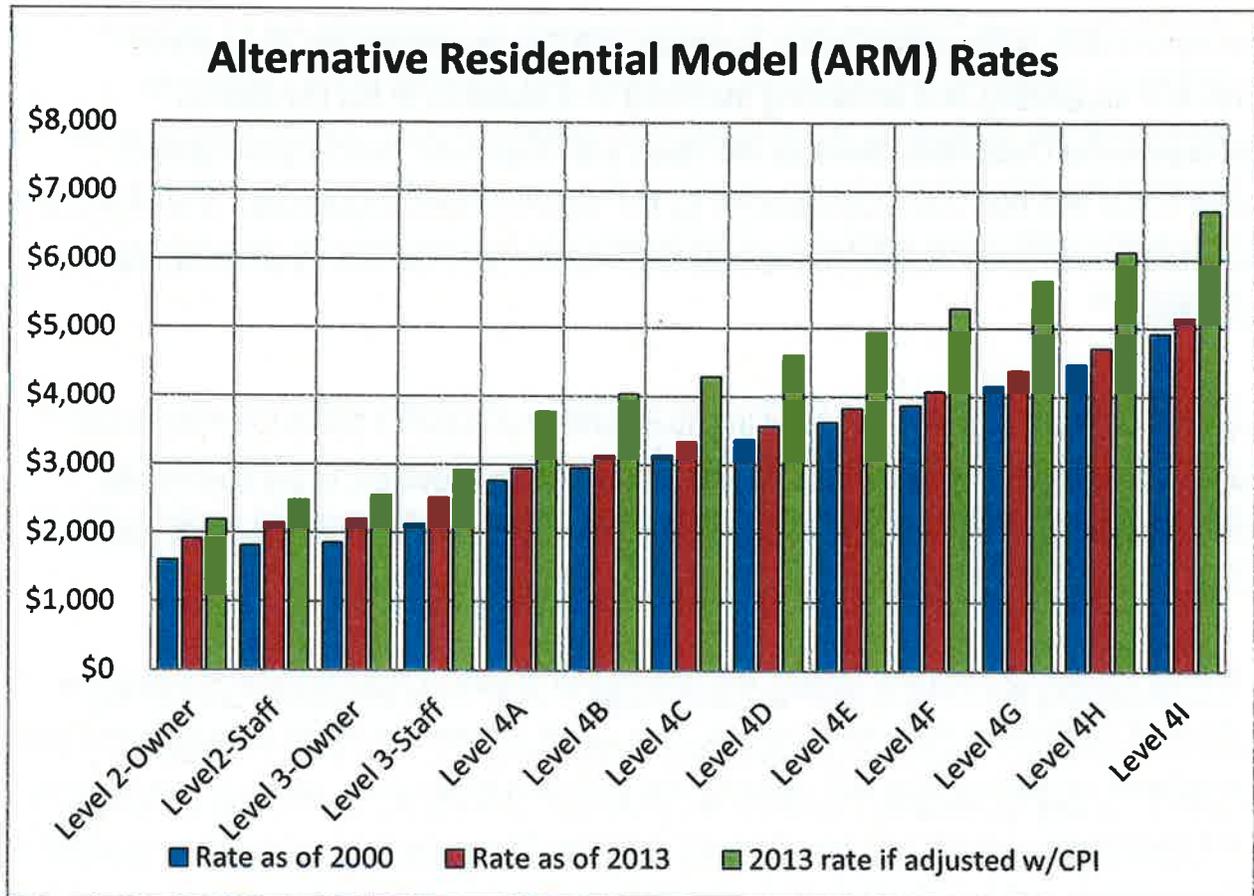
Issues impacting the OPS budget are addressed in ARCA's publication *Funding the Work of California's Regional Centers*. This paper focuses on the POS budget and the problems caused by stagnant rates for the provision of services, which in turn impacts the clients regional centers are charged to serve. There are five major areas covered in this paper in order to illustrate the issue of underfunding for services.

1. Overview of Rate-Setting Processes in California

There are six primary mechanisms to establish rates for service providers: Alternative Residential Model (ARM), Non-Negotiated Rate Community Based Programs, Supported Employment, Negotiated Rates, Usual and Customary, and Schedule of Maximum Allowances (SMA). As the regional centers are not involved in the rate-setting for SMA or Usual and Customary, this paper addresses the first four rate types.

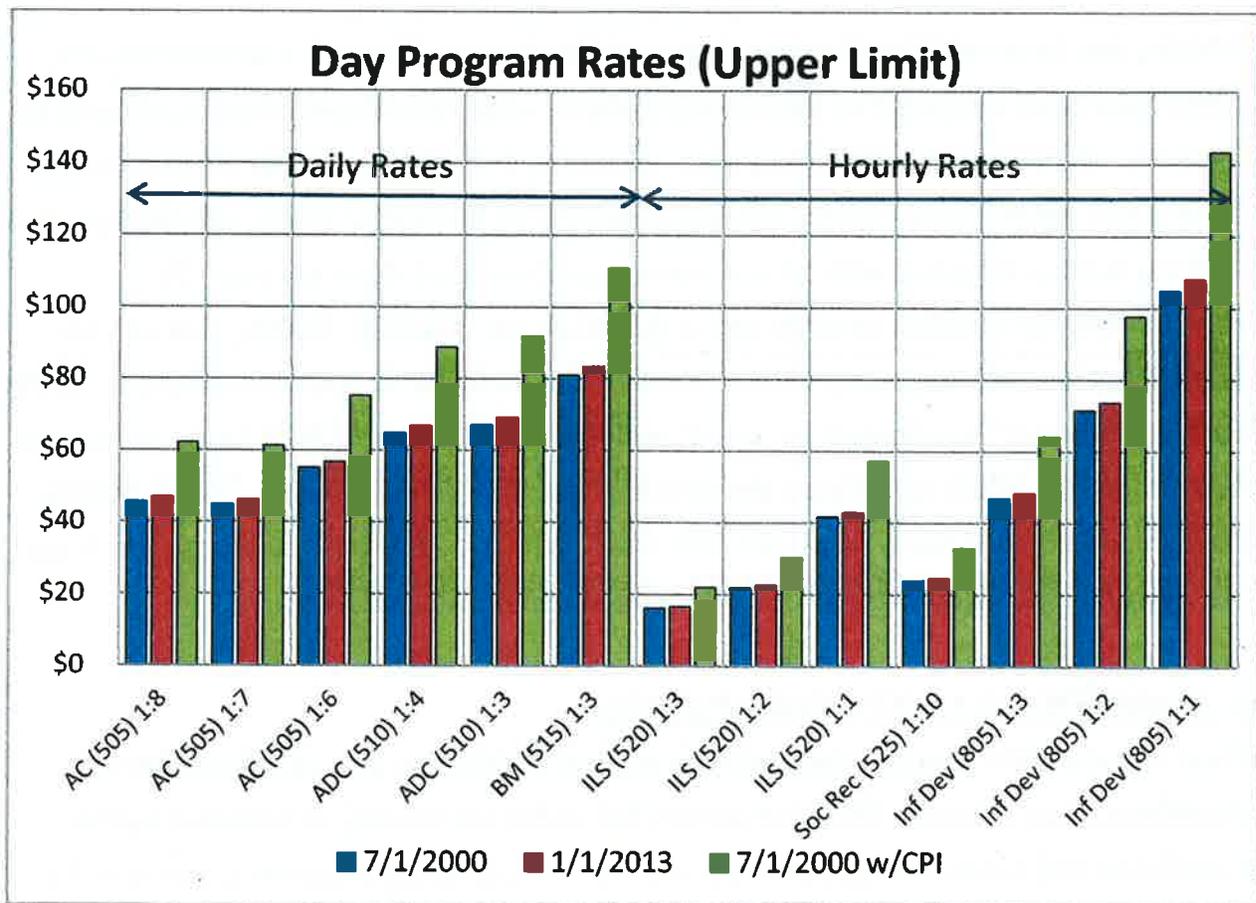
2. Rate-Setting Processes

The ARM rates and the community-based day program rates are set by DDS. The chart below illustrates the ARM rates as of July 1, 2000, the current ARM rates, and what the ARM rates would be if they had kept pace with inflation.



Source: DDS Rates Lists.

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The chart below compares the day program upper limit rates as of July 1, 2000, the current upper limit rates, and what the upper limit rates would be if the day program rates had kept pace with inflation.



Source: DDS Rates Lists.

Negotiated rates became subject to legislation that imposed a freeze and a maximum allowable rate (the median), regardless of the provider's actual costs. These two measures have created extreme difficulties for regional centers in their attempts to develop new and specialized services. Supported employment is the only service with rates that are set statutorily. They have been unchanged since 2008. In order for individuals with developmental disabilities to achieve full participation in the community, they must have integrated living and employment options, as well as the necessary supports to achieve those. This has become increasingly difficult to provide.

3. California Budget Crises And Their Effects

Since 2000, the budget crises in California have caused rate increases to be infrequent and minimal. There has been legislation that resulted in payment reductions, as well as

freezes that have kept the reimbursement rate stationary. For over a decade service rates have been subjected to this holding pattern, while actual costs have continued to increase. All new service providers were subject to the median rate, which was frozen once it was established. Finally, there was additional legislation which established: 1) a uniform holiday schedule with 14 non-service and non-paid days per year; 2) requirements for provider reviews and audits at a cost of \$4000-15,000; 3) a cap on administrative costs impacts providers when costs increase to absorb changes in health care and workers' compensation; and 4) restriction on the use of POS funds to start up new programs, which can impact the development of needed services. These actions have impacted services in many different ways, but ultimately they put at risk the fiscal viability of the services for individuals with developmental disabilities.

4. Changing Needs For A Changing Population

Over the years the services necessary to support individuals with developmental disabilities have evolved. Most individuals live in the community as intended by the Lanterman Act, but this integration requires new and different services to assist in the achievement of independence, self-sufficiency, and quality of life. The demographics of the individuals served by Regional Centers has changed. There are more individuals with autism. There is a significant number of children who will be exiting the public education system and entering adult services provided through regional centers. Over the next twelve years there will be over 70,000 young adults exiting the school system, and of these, 24,000 will need services in the next three years. Advanced medical interventions let people served by regional centers live longer. Parents who have supported their adult children in their homes are aging as well. Statistics indicate there are over 5,400 persons between the ages of 52 and 62 and older with disabilities still living with their parents. Regional centers will need to develop community services for these individuals. Over the next ten to twelve years all of these variables will add significant stress to the system via a need for services that are difficult to develop and sustain at current inadequate funding levels.

5. Reports And Studies

The serious concerns about the effect of low reimbursement rates on services have been long-standing. A number of studies and reports have drawn the same conclusion; the rate system is inadequate and does not effectively support services as they were intended. Although some changes to the system have been attempted, there needs to be a long-term solution through overall rate adjustment to reflect the realities of the costs. The client population has changed over time and the service delivery system has evolved, but the rate system has not kept pace with those changes.

SUMMARY

From a policy perspective, California's developmental services system is poised to promote better service outcomes for the over 265,000 individuals with developmental disabilities. Services can be more individualized and lead to greater levels of community participation, employment, and independence. Unfortunately, long-standing underfunding of the service system not only undermines this potential forward progress, but also the adequacy of the community-based provider network.

The concepts in this paper are not new. Studies dating back many years all draw the same conclusion; quality services and achievement of outcomes is directly related to staff qualifications, retention and continuity of care. But this goal is unachievable within the limitations of the current rates. Acknowledging the problem with a passive response does not help the over 265,000 individuals served to move forward. The task before us seems insurmountable because it has been ignored for so long.

Forty-five years ago, California made a promise to the state's most vulnerable residents. The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge...." Without a definitive response to the

problem presented, the state risks the health and well-being of clients and their families for whom the state has accepted responsibility.

PREFACE

The Association of Regional Center Agencies (ARCA) represents the 21 regional centers in supporting and advancing the intent and mandate of the Lanterman Developmental Disabilities Services Act. ARCA advocates on behalf of the over 265,000 individuals served by the regional centers statewide, and works in cooperation with other entities to promote services for persons with developmental disabilities.

Since the 1990s, the regional center system has experienced extensive budget reductions. The state budget crises have resulted in provider rate freezes, inadequate median rates, and limited start-up funding. The quality and effectiveness of purchased services and supports for individuals with developmental disabilities has suffered, and many individuals and families are facing barriers to receiving the services and supports they need.

ARCA considers the preservation of services for individuals with developmental disabilities as one of its highest priorities. Towards that end, ARCA has made a commitment to pursue rate reform in order to maintain needed services for persons with developmental disabilities. ARCA's Strategic Plan includes rate reform for the developmental services system as a primary area of focus.

INTRODUCTION

Californians with developmental disabilities receive direct services from approximately 45,000 service provider agencies throughout the state. Those service providers deliver needed community-based supports and services as an alternative to institutional care. These services include residential care, day programs, independent and supported living services, respite services, transportation, behavioral services, and many others. Regional centers assist individuals with developmental disabilities in understanding the services that are available to them in order to live in the community. These services are designed to meet the unique needs and choices of the individuals. The developmental services system is focused on ensuring minor children can remain in their family homes, and seeing adults achieve the greatest level of independence possible. There are more than 150 service category types (service codes) that define each specific service available. Eighty-seven and one-half percent of the regional center budget, called "Purchase of Services" (POS) funding, funds those service providers. For fiscal year 2014-15, it is estimated that approximately \$3.9 billion will be spent on these services.

Although the expenditures for developmental services are significant, it is important to look at California's expenditures from a national perspective. Data in the publication *The State of the States in Developmental Disabilities* illustrates California's spending compared to other states. Calculation of a state's fiscal effort is the measure used in this report to compare and rank states.

Based on the most recent data, California's fiscal effort for community and institutional services is ranked 34th among all states, or 16% below the national average. California

"...Regional centers are mandated to access generic and other services for consumers and families before expending regional center funds. There are both fiscal and philosophical reasons for this mandate. The backdrop precipitating the Lanterman Act was the devaluation of people with developmental disabilities, with the attending discrimination and segregation, which limited their access to services commonly available to others... Despite heavy reliance on accessing alternative resources, the special service and support needs of people with developmental disabilities are such that the needs cannot always be met through generic resources. In such cases, the regional centers are required to develop and fund needed services and supports. Thus, regional center consumers receive services from a broad array of public and private providers or vendors..."ⁱ

has consistently fallen in the bottom half in fiscal effort for many years. For example, California ranked 37th in 1997, then ranked 39th in 2002, and is currently ranked at 34th.

The funding the state invests in services is linked to the quality of the services. In order to provide quality services, it is important for providers to be able to hire, train, and retain qualified staff for consistency and continuity of care. Lack of adequate revenue affects the ability of providers to:

- Compete with other types of employers in the recruitment of experienced and educated staff due to lower staff wages
- Retain staff due to lower wages and the inability to offer benefits comparable to other employers

These constraints, as a result of an inadequate rate system and outdated rates, are a serious impediment to the provision of the specialized services necessary to meet the needs of persons served. Individuals with autism, challenging behaviors, or complex medical needs require providers to hire more experienced and educated staff to provide services that produce the intended outcomes. Over the past 20 years, laws, regulations, and best practices have changed, placing increased expectations on providers.

“Although little data is available on direct-support workers, the last available survey of community-care facilities documented average wages of \$10.24 per hour in 2001 after wage pass-through legislation—a rate augmentation earmarked to increase compensation by almost 20% in order to retain direct-support workers. In the five years since then, reimbursement rates have been frozen. This wage is lower than a single worker with no dependents would have needed for basic self-sufficiency in California in 2005. Data on access to health insurance is even more limited.

Low wages are the main cause of very high turnover rates in community settings. In Wyoming, for example, when total compensation rose from \$9.08 in 2001 to

\$13.19 by 2004, turnover dropped from 52% per year to 32%. California does not collect data on turnover, but small surveys reported turnover rates ranging from 24% to over 50%. High turnover forces providers to struggle to find qualified workers, undermines training, continually disturbs relationships between workers and clients, and ultimately undermines quality of care.”ⁱⁱ

The serious concerns about the effect of low reimbursement rates on the quality of services have been long-standing. A number of studies and reports show the rate system is inadequate. Some changes to the system have been attempted, but there needs to be a long-term solution through overall rate improvement. The needs of people served have changed over time, and the service delivery system has evolved, but the rate system has not kept pace with those changes. It no longer supports the services to meet the needs of the individuals regional centers serve. Years of underfunding, paired with increased statutory and regulatory requirements, have pushed the system to its breaking point, causing shortages in services and supports needed now and in the future.

OVERVIEW OF RATE SETTING PROCESSES IN CALIFORNIA

In order to understand the costs for the provision of services, and thus see their underfunding, it is important to know how rates are established. There are six primary mechanisms to establish rates for service providers. None of those rates, once set, can be adjusted without (funded) legislative action.

1. *Alternative Rate Model (ARM)* – Community Care Facilities (CCFs), which make up the bulk of residential care providers, are paid a rate according to the ARM. The rate depends on the program design for the facility. The program design shows services and level of care, which is the basis for the number of direct care hours (staff-to-client interaction) provided to the clients in the facility.

2. *Non-Negotiated Rate Community-Based Programs* – Day programs, independent living services, in-home respite agencies, and some other services had their rates set by the Department of Developmental Services (DDS) based on a cost statement the provider completed and submitted to the regional center. The cost statement reflected the anticipated costs of operating the business. Initially, a temporary rate was set, based on aggregate projections. After six months, a permanent rate was set based upon actual costs.

3. *Statutorily Set* – Supported employment rates are the only statutorily established rates in the developmental services system. The rate for all providers is the same, regardless of actual service costs. Neither DDS nor the regional centers have the authority to modify the rate.

4. *Negotiated Rates* – Some service providers are paid a rate negotiated with the regional center, based on cost data submitted to the regional center. The ability of regional centers to negotiate rates has been almost completely eliminated by the establishment of the median rate, which sets an upper limit that cannot be exceeded, regardless of the provider's cost of operation.

5. *Usual and Customary* – Some categories of service providers are paid their “usual and customary” rate, which is what they charge the general public for their services, such as counseling. This option is available only when at least 30% of their customers are not regional center clients.

6. *Schedule of Maximum Allowances (SMA)* – Service providers who provide services that are reimbursable under the Medi-Cal program, such as nurses, are paid the SMA rates. These rates are established by the Department of Health Services (DHS).

Since usual and customary rates are the current market rates, and DHS sets the SMA rates, these rates will not be addressed in this paper. This paper will address the first four types of rates, various changes that have affected them, the implications for

individuals with developmental disabilities and service providers, and providers' ability to provide ongoing quality services.

RATE SETTING PROCESSES

Alternative Rate Model (ARM)

History and Foundation of Rate-Setting Procedure

Community Care Facilities (CCFs) are defined in Title 17 regulations. They serve children, adults, and the elderly. Payment rates are set by DDS in accordance with the ARM, which was developed in the late 1980s. The ARM rates were introduced in a pilot program conducted from 1985 to 1987. By January 1, 1991, all CCFs were converted to the ARM rates.

The ARM system set rates based on the level of support provided by the CCF. Those levels range from 1 to 4, with level 4 being subdivided from 4a through 4i. Level 1 CCF residents require the least intensive supports, while Level 4i CCFs serve clients with the most complex needs. The current ARM rates range from \$993 (Level 1) to \$5,159 per month per resident (Level 4i) (see Appendix B: Community Care Facility Rates for more information). As the facility levels (and resident needs) increase, so do the mandated levels of staffing hours, staff training, and outside consultation in areas such as medical and behavioral supports. Generally, regional center clients do not live in Level 1 facilities, as they require more support to meet their needs. Some individuals' needs can be met with basic supervision, while others require staff who have specialized training in medical or behavioral management, and lower staff-to-client ratios. The ultimate aim of the ARM model was to base reimbursement for service providers on the intensity of the support needs of the individuals within the facility.

Rate Adjustments, Reductions, and Freezes

Since July 1, 2000, the ARM rates have been increased three times:

1. In FY 2001-02 the ARM rates were increased for the Supplemental Security Income-State Supplementary Payment (SSI/SSP) pass-through of 1.5%.

2. In FY 2002-03 the ARM rates were again adjusted for the SSI/SSP pass-through of 1%.

3. In FY 2006-07 all service providers whose rates are set by DDS were granted a 3% rate increase. Some CCFs (Levels 2 and 3) also received a 3.7% increase due to the minimum wage increase. Other CCFs, which provide increased levels of service, did not receive the 3.7% increase, even though many of them had employees qualifying for the minimum wage increase. Those levels of service are classified as 4a through 4i.

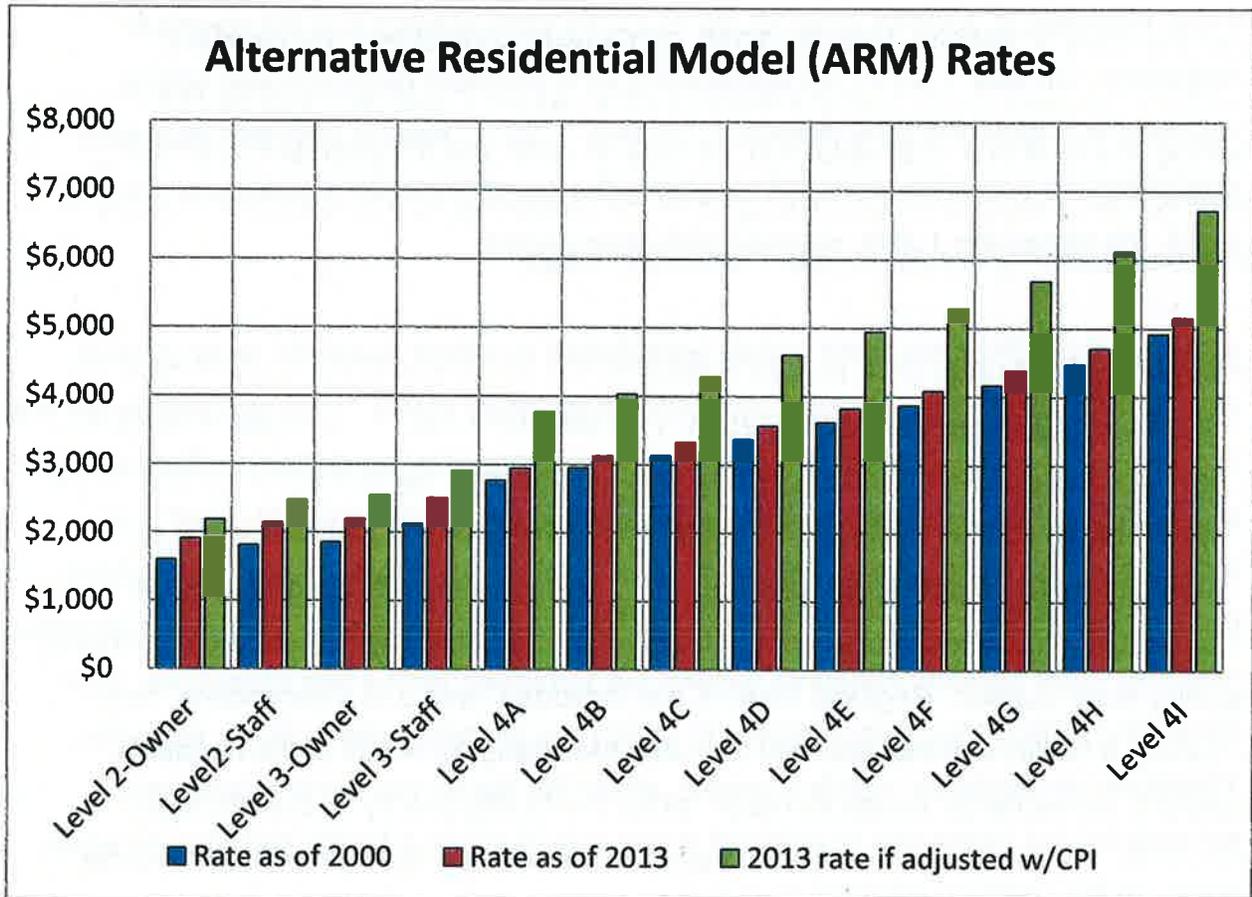
From February 1, 2009 to June 30, 2010, CCFs were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total of 4.25% reduction. On July 1, 2012, the 3% payment reduction ended but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

Although the ARM rates were initially established to reflect residents' level of need, statute froze CCF rates on June 30, 2008. That statute states "...no regional center may approve any service level for a residential service provider, as defined in Section 56005 of Title 17 of the California Code of Regulations, if the approval would result in an increase in rate to be paid to the provider...."^{viii} Many individuals become long-term (and, often, life-long) residents in these facilities. As residents age, their needs increase, requiring more support. Regional centers are forbidden, with a few exceptions, from increasing a facility's reimbursement to match the changing needs of the residents. Therefore, as residents' needs increase, either the facility can try to provide more services for the same rate to maintain these individuals in a facility that they consider home, or the resident will have to move.

Rates and Inflationary Growth

In comparing the current ARM rates to those in effect on July 1, 2000, the rates for Level 2 homes have increased by 19.3%, whereas the rates for Level 4i homes (meeting the most complex needs), have increased by only 4.9%. Since July 2000, the Consumer Price Index (CPI) for California has increased 36.6%. Although the CPI is an important indicator in the stagnation of rates, it still does not reflect all of the additional costs of doing business that have occurred.

The chart below illustrates the ARM rates as of July 1, 2000, the current ARM rates, and what the ARM rates would be if they had kept pace with inflation.



Source: DDS Rates Lists.

New Philosophy, Old Rates

In recent years, regional centers have moved towards providing clients with more home-like living arrangements. To achieve this type of living environment, regional centers have requested providers to develop homes with four beds or fewer. This philosophy is driven by the guidelines issued by the Centers for Medicaid and Medicare Services (CMS) for establishing home-like environments that qualify for the home and community-based waiver. The ARM rates were established using a six-bed model that spread the fixed costs over the first five residents, with the sixth resident providing a profit margin. Consequently, care providers find it difficult to develop these smaller homes with the current ARM rates, as fixed costs make it more expensive to operate a facility with fewer residents. This is beginning to result in an inadequate supply of this resource.

Non-Negotiated Rate Community-Based Programs

Day Service Categories, Service Codes, and Client-Staff Ratios

| | | |
|--|--|--|
| Activity Centers <ul style="list-style-type: none">•Service Code 505•Ratios - 1:8, 1:7, 1:6 | Adult Development Centers <ul style="list-style-type: none">•Service Code 510•Ratios - 1:4, 1:3 | Behavior Management Programs <ul style="list-style-type: none">•Service Code 515•Ratios - Variable |
| Independent Living Programs <ul style="list-style-type: none">•Service Code 520•Ratios - 1:3, 1:2, 1:1 | Social Recreational Programs <ul style="list-style-type: none">•Service Code 525•Ratios - Variable | Infant Development Programs <ul style="list-style-type: none">•Service Code 805•Ratios - 1:3, 1:2, 1:1 |

Ratios are defined in Regulations and/or within the program design

Source: Title 17 Regulations.

History and Foundation of Rate-Setting Procedure

Five types of day programs are defined in Title 17 regulations, with a sixth, for infants and their families, defined in Welfare and Institutions Code § 4693. In 1984, per Welfare

and Institutions Code § 4691, DDS established program standards, and developed a rate-setting procedure delineated in the 'Rate Procedure Manual.' But in 1987, the California Association of Rehabilitation Facilities (CALARF) and others took legal action seeking to compel DDS to make regulations establishing a new set of standards and rate-setting procedures. A settlement of the case, along with additional legislation (AB 877, Chapter 1396, Statutes of 1989), eventually resulted in the adoption of rate-setting regulations for community-based day programs that are in use today. ^{ix}

DDS set day program providers' rates based on their cost statements. The cost statement calculated a rate of reimbursement for the program, and DDS set the rate depending on where that rate fell within the schedule of "Allowable Range of Rates." That schedule was established by averaging the costs for all the types of like programs throughout the State. Based upon the prescribed calculations in regulations, a lower and upper limit was set, and the average became the temporary rate. New programs received the temporary rate for six months, and then they submitted a cost statement documenting their actual costs for assignment of a permanent rate. If a program's calculated rate was between the upper and lower limits of the "Allowable Range of Rates", then DDS set the provider's rate at their calculated rate. But even if the program's calculated rate was above the upper limit of the "Allowable Range of Rates", DDS would only set the rate at the upper limit. Providers whose calculated rate fell below the lower limit were compensated at the lower limit of the range. In the past, programs would submit cost statements every two years to DDS, which would update the "Allowable Range of Rates" based on the new data. The biannual cost statements would be the driving force for adjustment to the range of rates, which ensured the rate range realistically reflected contemporary costs.

Closely related to day programs are work activity programs, which are defined in Welfare and Institutions Code § 4850.2 (g). Work activity programs assist individuals with increasing their time in paid work, productivity rate, attendance level, and work-appropriate behavior, with the aim of developing the skills necessary for competitive

employment. Similar to day programs, temporary rates are assigned by DDS, but in the case of work activity programs, the permanent rate is set after there are at least three months of cost data.

Rate Adjustments, Reductions, and Freezes

A California Bureau of State Audits report, released in October 1999, stated “if the State had increased funding, providers would have received a rate adjustment every two years; however, there were no rate increases between fiscal years 1992-93 and 1997-98. [In] September 1998 the State granted \$33 million in additional funding. Although the increase allowed these providers to receive adjustments, it was only enough to fund rates based on their fiscal year 1995-96 costs... Furthermore, their rates will remain at this level until the department revises its current rate-setting process or receives additional state funding.”^x

The “Allowable Range of Rates” was last updated in FY 1998-99, when that report was written, which means the rates were already substantially outdated and stagnant even prior to the 2003 rate freeze, under AB 1762.

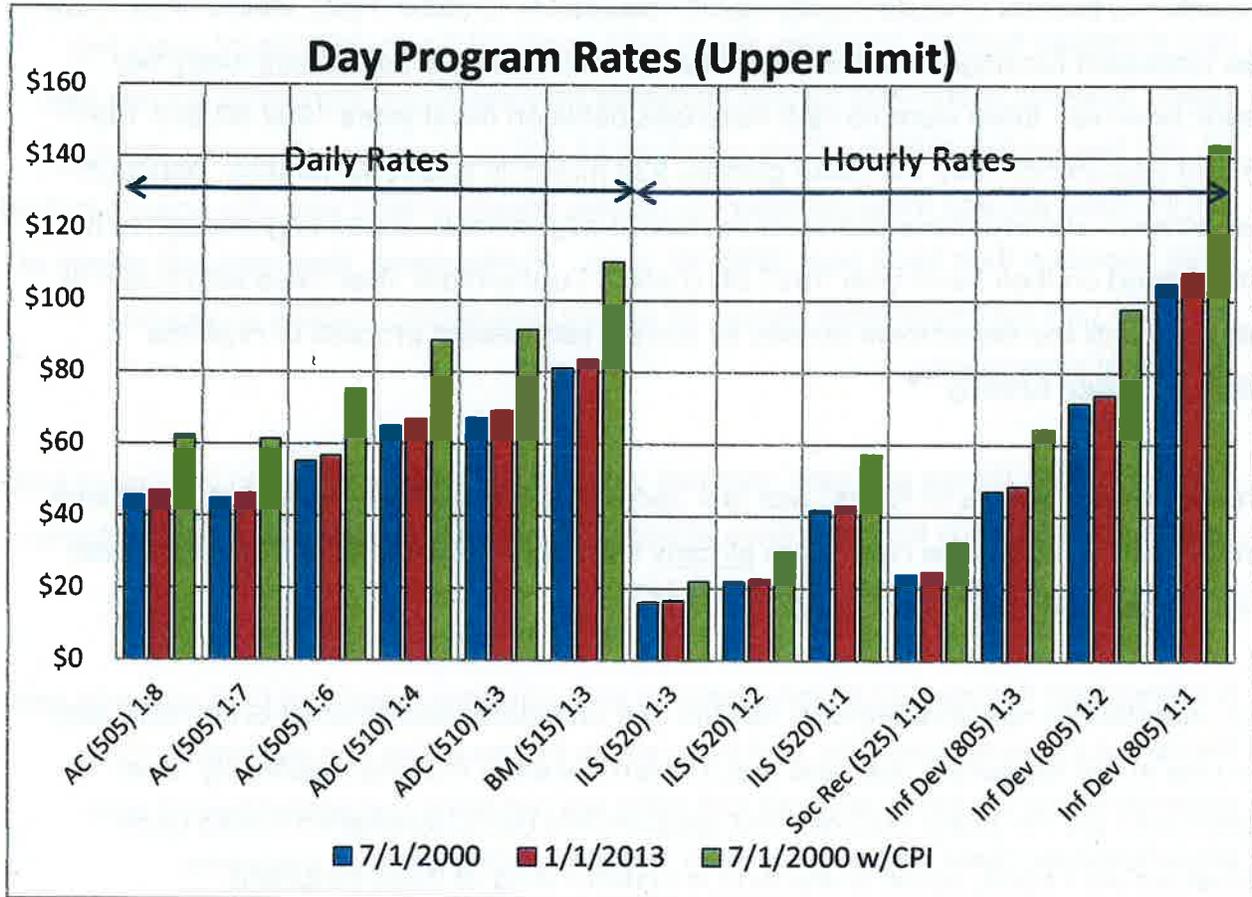
It is important to note that regional centers and providers report that DDS currently sets the rate at the temporary rate, and they remain frozen at this rate indefinitely. Cost statements are not being required and rates are not being considered based upon actual provider costs, which is resulting in underfunding of these programs.

Since FY 2000-01, day program rates were increased in FY 2006-07 by 3%, and then again via an adjustment for the raise of the minimum wage in that same year.

From February 1, 2009 to June 30, 2010, day programs were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total reduction of 4.25%. On July 1, 2012, the 3% payment reduction ended, but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

Rates and Inflationary Growth

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The chart below compares the upper limit rates as of July 1, 2000, the current upper limit rates, and what the upper limit rates would be if the rates had kept pace with inflation.



Source: DDS Rates Lists.

New Philosophy, Old Rates

Day programs have evolved and expanded the scope of their services. Day programs now include behavioral skills training. People moving out of the developmental centers, as well as those in the community with challenging needs, create demands that day programs have to address. Day programs are also being limited to 30 to 45 participants, rather than the larger traditional model, in order to provide more innovative,

individualized, and outcome-driven services. The new smaller model, while preferred, does not work financially for providers given the current rates.

Many programs now place a strong emphasis on pre-vocational skills - helping an individual prepare for the workplace. Some of the needed skills include dexterity, attention span, time management, compliance, and attention to detail. To assist in their success, regional centers work with providers to supply individual or group supports in their place of employment through supported employment.

Supported Employment

History and Foundation of Rate-Setting Procedure

Supported employment provides individuals with the opportunity to work in the community in integrated settings, either in individual or group job placements. Support services are provided to enable individuals to learn job skills needed in order to maintain employment. The services were originally vendorized and authorized by regional centers, but the program later became the responsibility of the Department of Rehabilitation. During this period, the rates were statutorily established, with an aim of balancing overall costs with program outcomes and demand. In 2004, responsibility for the program transitioned back to the regional centers, but the statutory determination of rates continued. This is the only service category which has statutorily-defined rates.

Rate Adjustments, Reductions, and Freezes

Rates for supported employment have risen and fallen with more volatility than rates that are established by DDS. In 1998, the rate for both group and individual supported employment job coaching hours was set at \$27.50 per hour (AB 2779). In 2000 it was increased to \$28.33 (AB 2876) and reduced in 2003 to \$27.62 (AB 1752). In 2004 the rate was again increased to \$28.33 when the program was returned to the purview of the regional centers (SBX1 24). In 2006, as a result of too few individuals securing employment, the rate was increased to \$34.24 (AB 1807), only to be reduced two years later to \$30.82 (AB 1781), a rate that remains in effect today.

| Supported Employment Reductions | | | | |
|---|---|--|--|---|
| Hourly rate for individual Reduced from \$34.24 to \$30.82 | Hourly rate for group services Reduced from \$34.42 to \$30.82 | Intake fees Reduced from \$400 to \$360 | Job Placement Reduced from \$800 to \$720 | 90-day Retention fee Reduced from \$800 to \$720 |

Source: AB 1183 (2008)

Rates and Inflationary Growth

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The rate for supported employment services has increased only 8.8% in that same timeframe.

New Philosophy, Old Rates

Supported employment provides the most integrated work option for individuals served by regional centers. In spite of the increased focus on this outcome, the service has not expanded to meet the needs of a population increasingly interested in it. Consistent with national trends and the passage of recent legislation (AB 1041), the movement of individuals from day programs or directly from school into employment settings is expected to increase. Regional centers work with providers to supply individual or group supports in the person's place of employment through supported employment.

Negotiated Rates

History and Foundation of Negotiated Rates

Negotiated rates, per Section 57300 of Title 17 of the California Code of Regulations, were paid for many services, based on negotiations between a service provider and the regional center (see Appendix D: Service Codes for more information). Regional centers can negotiate rates for services that meet individuals' unique needs.

Title 17 regulations prescribe the service categories that allow for negotiation in order to meet these needs. But "...there [was] little regulatory guidance on how these negotiations [were] to be conducted and few parameters governing how the rates [were] set and adjusted. In an effort to better understand and control costs in areas where

rates are negotiated, DDS embarked on a multi-year project. The first step in this project involved developing and distributing three rate surveys to the regional centers.”^{xi} The surveys, conducted during FY 2007-08, reviewed the negotiated rates paid by regional centers and the vendors who qualify for negotiated rates.

Rate Adjustments, Reductions, and Freezes

As a result of the review, negotiated rate services were changed to a median rate system – which had the effect of simultaneously being an adjustment, a reduction, and a rate freeze.

A median is determined by arranging data set in numeric order. The middle of the array has an equal number of points above and below it – even if some points are the same. This middle value is called a median. The “median rate” is determined by finding the median among all the rates paid to providers of a particular service code.

Examples:

| | | | | | | |
|---------|---------|---------|---------|---------|---------|---------|
| \$2,400 | \$2,500 | \$2,800 | \$3,000 | \$4,900 | \$5,000 | \$5,600 |
|---------|---------|---------|---------|---------|---------|---------|

The median rate in the example above is \$3,000

| | | | | | | |
|---------|---------|---------|---------|---------|---------|---------|
| \$10.75 | \$10.75 | \$11.38 | \$11.38 | \$12.99 | \$18.78 | \$33.95 |
|---------|---------|---------|---------|---------|---------|---------|

The median rate is \$11.38 (although the mathematical average, or “mean,” is \$15.71, and there are several duplicate rates. The middle remains the middle.)

After the study was completed, DDS set the median rates based on the 2007 data in the regional centers’ rate tables. Those rates included the median rates at both the regional center and state level. The former reflected the median paid for each service within each regional center’s catchment area. The latter was the median of each service’s rates across the state. 77 service code categories were impacted by the introduction of the median rates. Commencing July 1, 2008, with few exceptions, existing negotiated rates were frozen at the rate in effect as of June 30, 2008.

Median rates for all new negotiated rate services/providers, inclusive of specialized residential facilities and supported living services, were established. Once the rates were set, they were frozen (AB 5, Welfare and Institutions Code § 4691.9). Median rates require the vendoring regional center to use either their median rate or the statewide median rate, whichever is lower (AB 5 and AB 1183, Welfare and Institutions Code § 4681.6 and § 4689.8). In many cases, the statewide median is much lower than the regional center's median and is inconsistent with other similar programs vendored by that regional center. This creates a wide disparity in rates between existing and new providers, and creates difficulty in obtaining new providers. Service providers in regions with particularly high costs of doing business are immediately short-changed by this methodology. Some statewide median rates are lower than the current minimum wage. In 2011, median rates were reviewed and recalculated based on updated data from regional centers, resulting in some median rates being decreased.

From February 1, 2009 to June 30, 2010, negotiated rate services were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total reduction of 4.25%. On July 1, 2012, the 3% payment reduction ended, but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

When median rates were established by DDS, regional centers and service providers raised a number of concerns. Two of them, explained below, illuminate the severe constraints the median rate places on the service system.

Some service codes, called "miscellaneous service codes," can be used by a regional center for multiple types of services. For example, socialization training is used for social skills training provided by a licensed therapist, which requires a higher rate based on a therapist's expertise and training. This rate was also used for various after-school socialization opportunities or activities receiving much lower rates. Therefore, this particular service code could have varying hourly rates of \$10.00, \$12.50, \$28.75, \$70.00, or \$95.00, resulting in a median rate set at \$28.75. Individuals with the

diagnosis of autism frequently require this type of service. Yet with this low rate, the opportunity to expand the availability of new, licensed and skill-intensive providers has been extremely difficult, if not impossible.

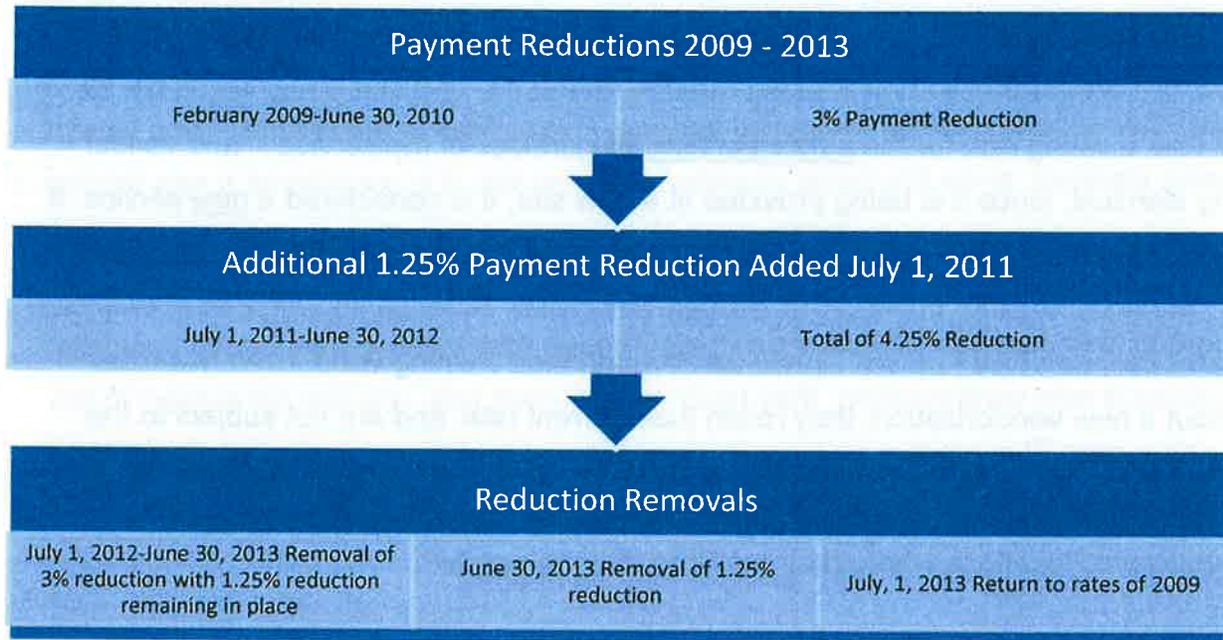
Another important issue is the start-up of new facilities. A vendor with a long track record of excellent work may wish to expand their services to meet regional needs. If they provide those services at a facility (a "site-based" program) and decide to open a new site, they would be subject to the median rate at the new site. They would not be paid their existing rate for the same service. Regardless of the service – and vendor – being identical, since it is being provided at a new site, it is considered a new service. If a vendor does not have a site, because their services are offered within the community (e.g., services helping an individual actively participate in the community), then they can expand their services to more individuals through their existing vendorized business. Without a new vendorization, they retain their current rate, and are not subject to the median rate. This creates an inequity between vendors. It also makes it difficult for those providers who are subject to the median rate to expand services to other geographic locations where their services may be needed.

CALIFORNIA BUDGET CRISES AND THEIR EFFECTS ON SERVICE PROVIDERS

Since 2000, there have been recurring budget crises impacting the rates of services for persons with developmental disabilities. In response to these crises, and in attempts to contain costs, over several years various legislation was passed that eroded services. In 2003, many service rates were frozen at their already inadequate rates, and these rates remain frozen. Also in 2003, there was a restriction placed on regional centers preventing the use of POS funds to start up new programs. Service providers were subject to payment reductions from 1.25% to 4.25% from 2009 to 2013. Other factors affecting services were the implementation of an ongoing uniform holiday schedule (FY 2009-2010), a requirement for independent reviews and audits, and an administrative cap of 15% for providers (2011).

Payment Reductions and Freezes

From 2009 through 2013, regional centers were required to implement payment reductions for most services (Sec. 10 of Chapter 13 of the third Extraordinary Session of the Statutes of 2009, as amended by Section 16 of Chapter 9 of the Statutes of 2011). Two separate reductions, of 3% and 1.25%, were put in place.



Although on July 1, 2013, those reductions were ended, rates still remain low and far behind where they should be, due to lack of adjustments and rate freezes. The additional effect of this payment reduction, although time-limited, took its toll on many of the providers.

Aside from small rate increases and an adjustment for the minimum wage to three of the service categories (residential levels 2 and 3, day programs, and in-home respite) in FY 2006-07, rates have remained stagnant, while inflationary pressures have increased (*i.e.*, fuel costs and worker's compensation).

In 2003, many service rates were frozen, and continue to remain so by virtue of an annual renewal of this freeze (initially set forth by AB 1762, Chapter 230, Statutes of 2003. Welfare and Institutions Code §§ 4648.4, 4691.6, and 4681.5). The services in the table below were initially subject to the rate freeze, but additional services' rates were frozen by subsequent legislation, to be discussed later in this paper (see Appendix A: Glossary for more information).

| | |
|---------------------------|--|
| Supported Living Services | Transportation, including travel reimbursement |
| Socialization Programs | Community Integration Programs |
| Mobile Day Programs | Behavior Intervention Programs |
| Creative Arts Programs | Supplemental Day Service Program Supports |
| Adaptive Skills Trainers | Independent Living Specialists |
| Community Care Facilities | Day Programs |
| Respite Agencies | |

Source: AB 1762, Chapter 230, Statutes of 2003.

Decrease in Available Service Days

During FY 2009-2010, Trailer Bill language (ABX4 9, Chapter 9, Statutes of 2009) added § 4692 to the Welfare and Institutions Code. Called the “uniform holiday schedule,” it imposed fourteen total unpaid/non-service (furlough) days each year on work activity programs, activity centers, behavior management programs, social recreation programs, and infant development programs. In addition to day and work programs, it also impacted a number of other services: adaptive skills trainers; socialization training programs; client/parent support behavior intervention programs; community integration training programs; community activities support services; program support groups (day service); and creative arts programs. It was effectively a 1.6% reduction in funding for these programs. It also placed burdens on family members and residential providers who had to provide care on these additional

holidays. The uniform holiday schedule was implemented August 1, 2009 and remains in place today.

Independent Reviews and Audits

On March 24, 2011, Welfare and Institutions Code § 4652.5 required an independent review of vendors who receive regional center funding in excess of \$250,000, and an independent audit of vendors who receive regional center funding in excess of \$500,000. Vendors are reporting that the cost of these reviews and audits can run between \$4,000-\$15,000. The threshold for these reviews and audits is low; many small providers meet this threshold. For example, the owner of a single Level 4i home with five of their six beds filled could be funded at over \$300,000 annually, requiring an independent review. As previously indicated, the ARM rate was based on the fixed costs spread over five beds, with the sixth bed as a profit margin. Given this scenario, the residential provider may barely cover their fixed costs, yet is responsible for the additional expense of an independent review. These reviews/audits do not yield useful information for the regional centers from a quality assurance (QA) perspective. The focus is fiscal, not programmatic, and does not examine utilization of funds as intended within their program design. The audits do not provide the regional centers with information relevant to determining if the provider is using the money appropriately for direct services to the individuals served. This requirement places an additional financial burden on many providers, and negatively impacts the ability to provide direct services to the individuals they serve.

Administrative Cap of 15%

Trailer Bill Language (SB 74, effective March 24, 2011) added § 4629.7 to the Welfare and Institutions Code, requiring all regional center contracts or agreements with service providers to expressly require that not more than 15% of regional center funds be spent on administrative costs. Direct service expenditures are those costs immediately associated with the services provided to clients. Administrative costs include, but are not limited to, any of the following:

- Salaries, wages, and employee benefits for managerial personnel whose primary purpose is the administrative management of the entity, including, but not limited to, directors and chief executive officers
- Salaries, wages, and benefits of employees who perform administrative functions, including, but not limited to, payroll management, personnel functions, accounting, budgeting, and facility management
- Facility and occupancy costs, directly associated with administrative functions
- Maintenance and repair
- Data processing and computer support services
- Contract and procurement activities, except those provided by a direct service employee
- Training directly associated with administrative functions
- Travel directly associated with administrative functions
- Licenses directly associated with administrative functions
- Taxes
- Interest
- Property insurance ^{xiii}

Some providers report that California has a tremendous amount of employment and tax regulations that require expertise that they do not have as a clinician, for example. The providers must hire or contract for payroll, human resource department or staff (HR), data and computer services, and office staff for scheduling. These employed/contracted individuals stay apprised of employment laws, workers' comp issues, taxes, disciplinary issues, quality assurance, and finance.

Providers now must also participate in E-billing requiring data entry to submit billings to regional centers. They have to have the expertise and manpower for billing insurance companies and regional centers for services and co-pays. In an attempt for providers to become more productive and responsive in case reporting to regional centers, they are becoming more automated, allowing staff to do electronic scheduling and online report

writing, etc. Automation results in requiring Information Technology (IT) assistance for protection of information as related to the Health Insurance Portability and Accountability Act (HIPAA).

The cost of insurance and workers' compensation is increasing dramatically. Providers who work with the more challenging individuals state that their workers compensation increases with injuries occurring during the course of doing business.

Providers are also reporting that they will be affected by the Affordable Care Act (ACA), but the state currently does not allow for adjustments to rates in response to legislative changes/mandates.

Restriction on Start-up Funding

Initially set forth by AB 1762 (Stats. 2003, Ch. 230), Welfare and Institutions Code §§ 4781.5 & 4781.6 restricted regional centers from using POS funds to start new programs. Before this, regional centers could use POS funds to help start programs to serve unmet needs. But AB 1762 limited start-up funding to just two circumstances – the protection of client health and safety, or “extraordinary circumstances.” The regional center must receive prior written approval from DDS in either case.

There are a number of different reasons start-up funding is helpful in establishing services within a given geographic area (as indicated by a needs assessment). The ability to establish services closer to where individuals live improves access to services in their own communities, and can be more cost-effective by decreasing the need for an extensive transportation network and its related costs.

Separately, regional centers have the ability to utilize Community Placement Plan (CPP) budgets to offer start-up funds for specialized services for individuals moving from the developmental centers, and for those at risk of placement in a developmental center. These factors limit the ability of regional centers to offer specialized services and maintain long-term viability within the community.

Changing Needs For a Changing Population

The Center for Health Policy Studies reports that “today’s complex, community-based service delivery is comprised of thousands of different providers... Requirements for providers have also grown in sophistication as federal and state laws have changed. Expectations of the community service delivery system have also become more rigorous as knowledge and information about best practices are more readily shared through conferences, resource libraries, internet webpages and listservs...

To a large extent, our sense of successful service provision has been focused on the quantity of services provided....The reports of workgroups recognize the importance of requiring and gathering information on the quantity of services provided and compliance with law and needed regulations. However, they recommend an additional focus that asks: Is anyone better off? ...In the past ten years, there has been a nationwide movement toward outcome-based service delivery that links quality assurance processes for providers to the achievement of consumer and family outcomes.”^{xiv}

Changing Demographics’ Effect on Service Needs

A 2004 study by Braddock and Hemp found a quartet of factors driving demand for services. Youth aging out of special education programs, increased longevity (coupled with aging caregivers), and a general trend out of institutional, and into community, settings.^{xv}

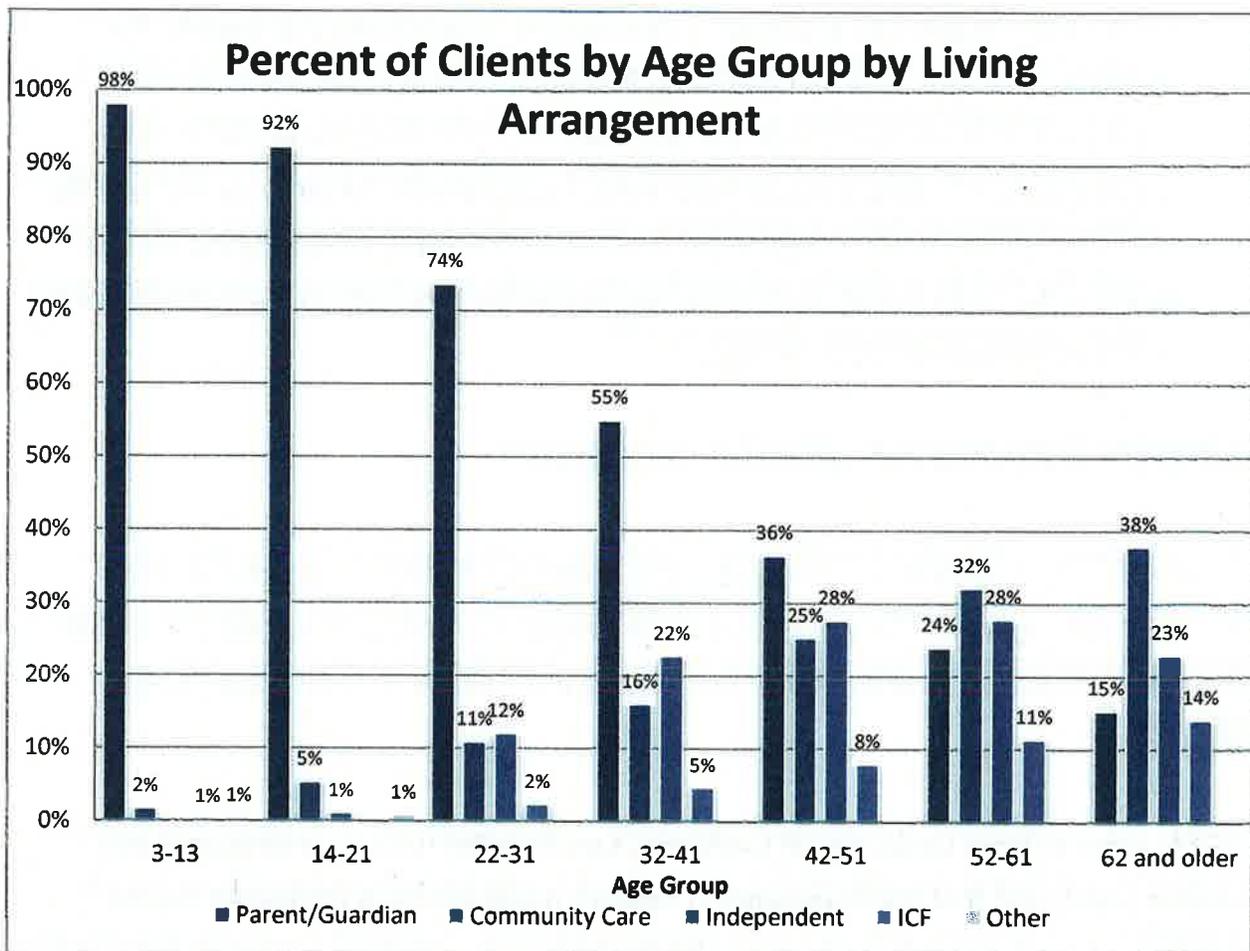
In 2011, a report from University of California, Los Angeles (UCLA) reiterated those concerns and found that improvements in modern medicine have increased the life expectancy of persons with developmental disabilities. In a lifetime-service system, this translates to more years of service needs and needs that grow more intense as individuals age. As they age, the caregiving provided by aging parents must often be

supplemented or replaced by more formal services. And “when a caregiver dies, a DDS consumer likely requires an alternative residential setting at a high cost.”^{xvi}

Current data bears out the timeless truth and growing relevance of the core findings of those two studies.

Living Arrangements

As indicated in the chart below, individuals 21 years and younger primarily live with their parent or guardian, but this begins to shift significantly from the age of 22 on.



Source: DDS Quarterly Report – September 30, 2013.

It is projected that individuals served by the regional center system, ages 42-62 and older, who are currently living with their parent(s) or guardian(s) will require residential and day/work services in the coming years to support them in the community.

Aging Caregivers

“An aging caregiver may require an increased level of services and supports to maintain their family member in the home. When these caregivers die, or are no longer able to support their loved ones, alternative living arrangements must be developed or located. Almost all forms of out-of-home care are more costly than supporting a person in their own home. The Department’s data clearly shows that the percentage of consumers living out-of-home increases as they age.”^{xvii}

Individual choice and needs change over time

The data indicate that almost 90% of 18-21 year-olds still live with their parent(s) or guardian(s). Among 22 to 31-year-olds, roughly 74% have such living arrangements. In short, as with the population as a whole, as the adult child ages, they move from the parent/guardian’s home to another living arrangement. There are different reasons for this movement, such as the choice to live in another setting as an assertion of independence or an aging parent being unable to continue to care for them. The new living arrangement is not always a community care facility, but there will still be a need for services and supports, such as independent living skills, to help them to maintain that new situation.

With increasing age, individuals’ needs expand to require community care facilities, supported living, personal assistance, transportation, medical services, or medical equipment. With individuals’ increased needs, it can be projected that those in independent living may require personal assistance, medical assistance, community care, or ICF or SNF placement, dependent upon their age and/or health-related variables.

Given the need for these additional services and supports, the system needs to be prepared to have an array of alternative living arrangements and other support services available. This requires an assessment of need and the proactive development of resources. To facilitate this, an adequate rate structure needs to be in place to encourage providers to expand their services to address the growing need.

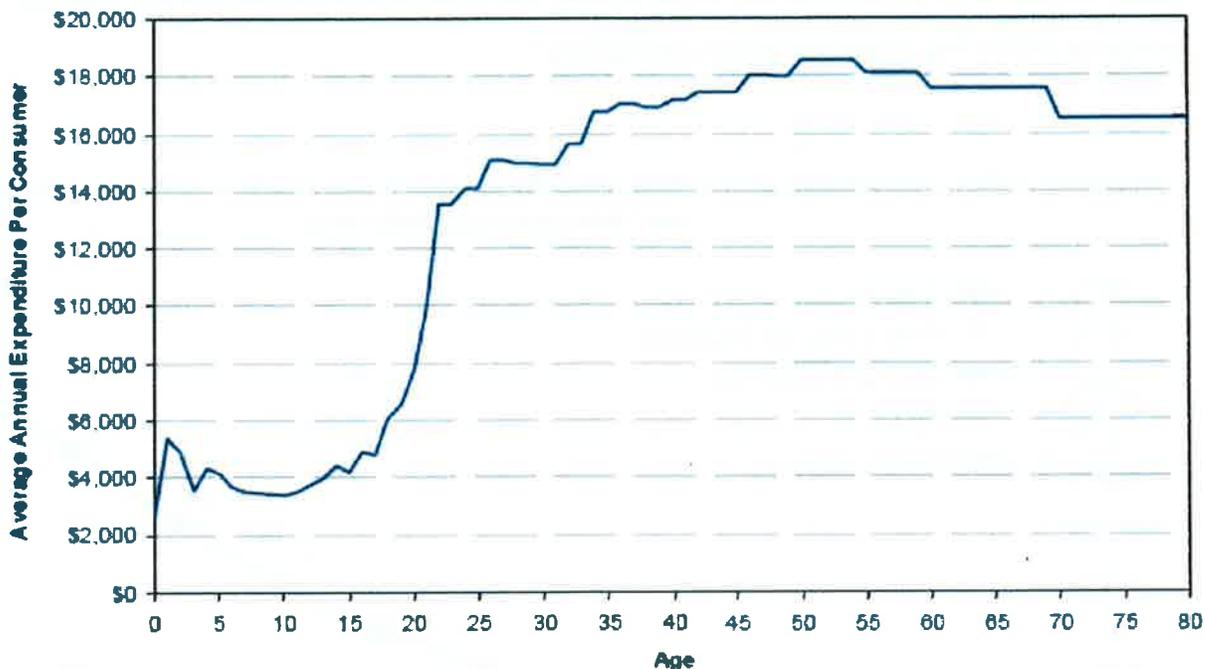
As of September 2013, there are 5,427 individuals 52-62 years and older still living with their parents, 2,096 who are 62 years and older living independently, and 1,422 individuals still residing in the developmental centers. Regional centers will have to develop community services for up to 8,945 individuals in the next five to ten years.

Individuals Aging Out of the Public School System

The number of young adults who will be transitioning out of the public education system in the next decade is significant. There is an increase in regional center costs when this happens because those individuals require day or work programs, independent living skills training, residential services, or other supports to assist them to work and live as independently as possible. Additionally, young adults with autism typically need a higher intensity and number of services. This issue has been compounded in recent years by the sharp decrease in funding for adult education programs which once funded services to many adults without cost to the regional centers. This shift in funding from a generic resource to the regional centers creates additional pressures for development and sustainability.

Per-client expenditures by age

Average Expenditures by Age in FY 2005-06



Source: "Controlling Regional Center Costs." ^{xix}

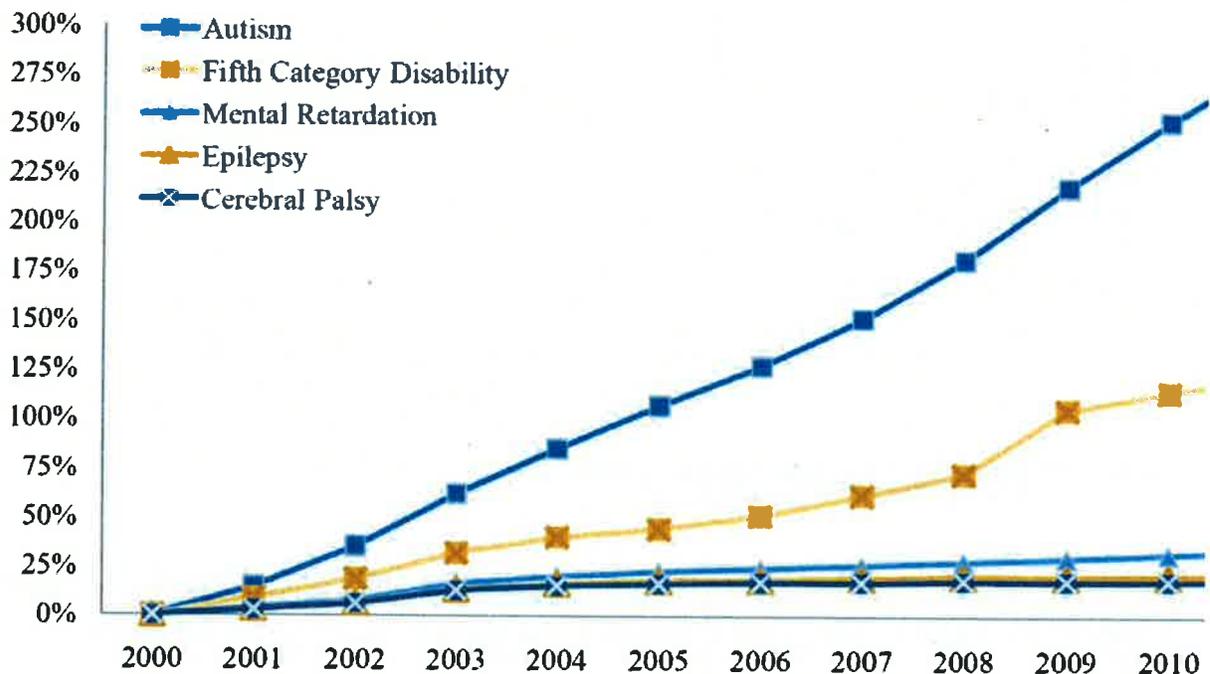
The DDS quarterly report of September 2013 indicates that the number of children with an eligible developmental disability between the ages of 10-21 years (regardless of diagnosis) are:

- 10-13 years - 24,758
- 14-17 years - 22,452
- 18-21 years - 23,924

From the statistics in the report, it can be projected that community-based services will need to be developed to meet the needs of 71,134 young adults in the next twelve years, and of them, almost 24,000 will need services in the next three years alone.

The majority of children with developmental disabilities aging out of the school system have autism. As indicated in the chart below, the growth has exceeded the number of persons with other developmental disabilities.

Growth in California population with autism versus three other major developmental disabilities and the "fifth category," 2000–2010



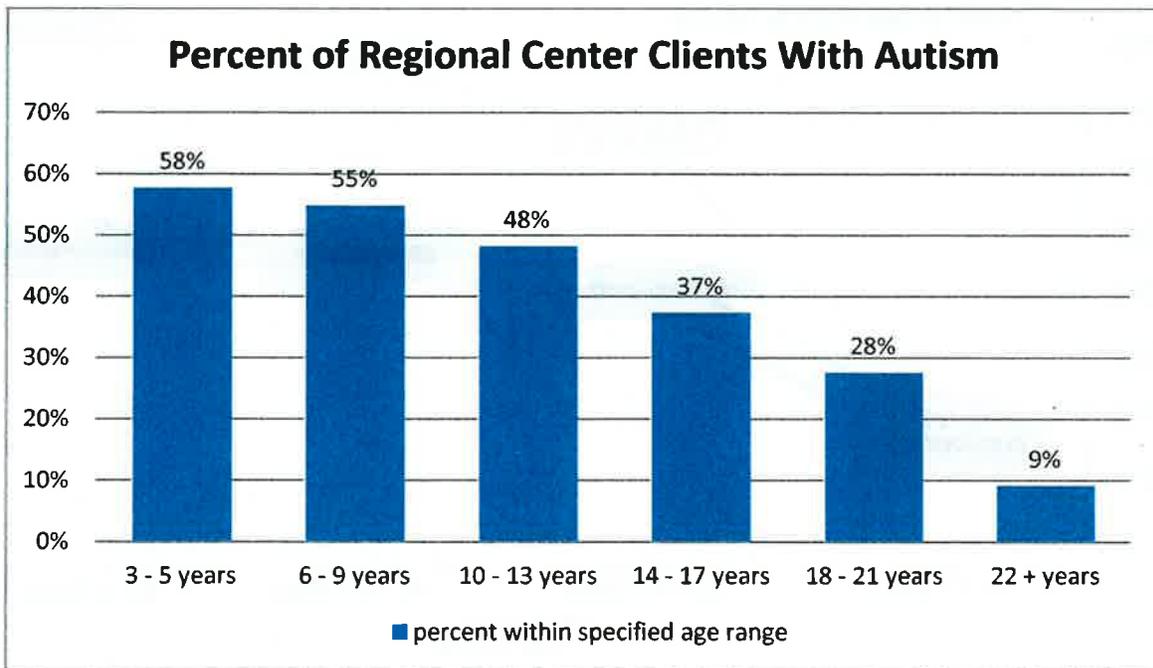
Notes: Developmental disability groups are not mutually exclusive, due to potential duplication of individuals across diagnostic categories. The "fifth category" refers to disability conditions found to be closely related to mental retardation or to require similar treatment (Welf. & Inst. Code §4512).

Source: Authors' analysis of data provided by Department of Developmental Services Data Extraction Unit; 2011.

Source: "Challenges to Sustaining California's Developmental Disability Services System." xviii

Most persons with autism are in the younger age ranges. There are many services offered to younger children with autism, but the cost of services is usually shared with schools and private insurance. Also illustrated in the chart below, only 9% of adults older than the age of 22 served by regional centers have a diagnosis of autism. In spite

of this low percentage, the development of services to meet their needs associated with aging is a significant challenge as well.



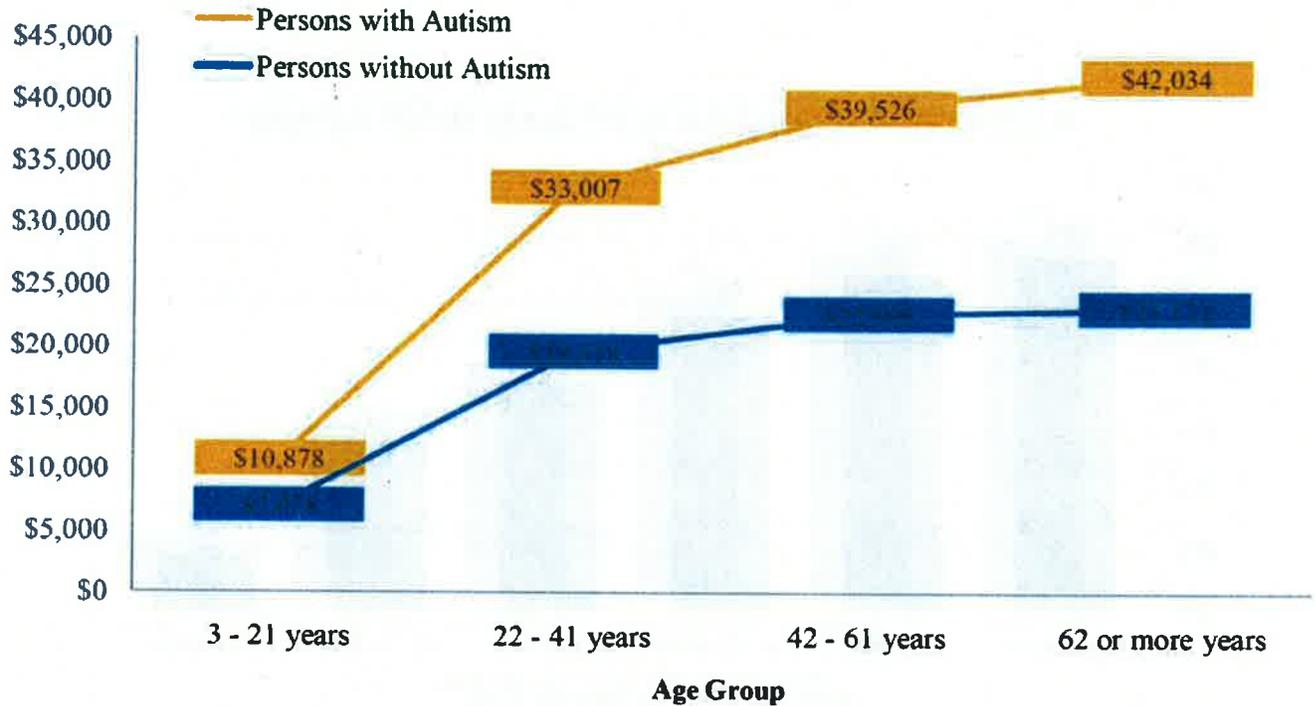
Source: DDS Quarterly Report – September 30, 2013.

The DDS quarterly report as of September 2013, indicates:

- Individuals ages 10-13 years (11,926) have a diagnosis of autism
- Individuals ages 14-17 years (8,382) have a diagnosis of autism
- Individuals ages 18-21 years (6,599) have a diagnosis of autism

Community-based services and supports to meet the specialized needs of almost 27,000 young adults with autism will need to be developed over the next 12 years. Those services and supports are generally more expensive than for persons with other diagnoses. The challenge the median rate creates for regional centers is an inability to negotiate adequate rates, not only for the establishment and expansion of the needed services, but also to sustain these services.

Average annual expenditure per Regional Center client by age group for those with autism and those without (FY 2006-07)



Source: Department of Developmental Services, *Factbook, 11th Edition, 2008*, State of California, Department of Developmental Services.

Source: "Challenges to Sustaining California's Developmental Disability Services System." ^{xx}

Individuals with Challenging Needs

Many negotiated rate services address severely challenging needs, whether medical, psychiatric, forensic, or a combination thereof. Supporting individuals with complex needs requires staff with extensive training and experience in the individual's particular area of need. Staff-to-client ratios, as well as staff skills, are the primary drivers of service cost for this population. The table below illustrates the number of individuals served in forensic or psychiatric facilities and out-of-state placements.

In 2012, Trailer Bill language (AB 1472), created Welfare and Institutions Code § 4648(a)(9)(B) and (C), which prohibits regional centers from purchasing residential services from facilities that are not eligible for federal funding. The law went into effect

July 1, 2012. All residents are to be moved out of those facilities by June 30, 2014. To develop appropriate community settings to meet those individuals' unique and intensive needs it is commonly acknowledged as taking up to three years. Only two years were provided in law and regional centers were expected to begin transition almost immediately without sufficient resources. More fundamentally, the services required are subject to the median rate, making it extraordinarily difficult to find service providers to meet those needs.

| Type of Facility | Number of Individuals (Statewide) |
|-------------------------------|-----------------------------------|
| Criminal Justice System | 208 |
| Facilities Ineligible for FFP | 149 |
| Out-Of-State | 24 |
| Total: 381 | |

Source: Department of Developmental Services, Individuals with Challenging Needs, November 2013.

There are hundreds of individuals who need specialized services to meet their medical, psychiatric, and forensic needs who are not currently in these facilities. These individuals remain in the community accessing a patchwork of available services. This patchwork frequently costs more than if a specialized, holistic service with an adequate rate structure was able to be developed.

The Health and Human Services Agency convened a Task Force on the Future of the State's Developmental Centers. Its report, released at the end of 2013, identified 445 individuals with complex medical needs, 315 of whom will require specialized medical homes in the community. The Task Force also identified 227 residents with complex and challenging behaviors and approximately 200 other residents with involvement in the criminal justice system. All of these individuals will most likely require more

specialized negotiated-rate living arrangements and day programs to meet their needs in the community.

REPORTS AND STUDIES

1997: Department of Developmental Services (DDS) Report to the Legislature

As part of the 1996 Budget Act, DDS was required to review existing methodologies in use, survey other possibilities, and gather stakeholder input. In November 1996, DDS met with stakeholders to review current, and recommend new, rate-setting practices. In summary, DDS said “retaining the existing system would involve no disruptions of current practices and trends, and allows continued use and evaluation of the several alternatives, and particularly the AB 637 proposal process discussed...that are designed to increase the flexibility and creativity of regional centers in meeting local needs. It is undesirable to alter the system before the efficacy of present and anticipated practices can be assessed.”ⁱⁱⁱ

1998: Senate Bill 1038

Welfare and Institutions Code § 4681.1, enacted by SB 1038, states that the department shall adopt regulations that specify rates for community care facilities. As a result, DDS contracted with the Center for Health Policy Studies to examine the rate system and identify a methodology for payment to providers that would support the achievement of the desired outcomes for clients and family.

| <u>Reports and Studies</u> |
|--|
| 1997 Department of Developmental Services Report to the Legislature |
| 1999 Bureau of State Audits Report |
| 2000 DDS May Revise |
| 2001 Center for Health Study Policies report in response to SB 1038 |
| 2007 DDS Report to the Legislature on Controlling Costs |
| 2011 UCLA Study on Challenges to the System |

1999: Bureau of State Audit Report

The BSA found “the State’s system was designed to provide optimal service to adult consumers, yet insufficient funding hampers providers’ and regional centers’ ability to appropriately supply services and retain staff. Inadequate state funding often forces centers to pay providers rates that do not reflect current economic conditions, which increases the chance that consumers will receive fewer or inferior services and increases the difficulty providers have in retaining staff.” ^{iv}

2000: May Revise to the Governor’s Budget:

In comments submitted with its request for rate increases for several services, DDS stressed the importance of adequate funding. “Without funding sufficient to recruit, train, and retain a skilled labor force, the Department puts at significant risk the health, safety, and well-being of consumers. Specialized knowledge results from a long-term relationship with consumers, families, and the surrounding community. Turnover issues are amplified in the lives of consumers and families when the knowledge, skills, and abilities of the experienced direct support professional gains over time is lost. The transfer of knowledge to newly hired workers is incomplete, and results in a reduction in service quality. Without sufficient funding, we jeopardize the long-term investment value of a skilled workforce.” ^v

2001: Center for Health Policy Studies

As a result of 1998 legislation, DDS contracted with the Center for Health Policy Studies (CHPS) to develop a cost-modeled rate system. The two-phase contract ran from February 1, 2000, through July 31, 2001. The first phase was to develop a residential rates model. The second phase was to apply the model to other services. The model developed was built around client outcomes. From that baseline, it allowed for the incorporation of different variables, such as current economic trends, changes in law (*i.e.*, minimum wage), and other elements to be accounted for, thereby making rate adjustments fair and equitable among providers. The conclusion was that cost-modeled systems, if funded adequately, and if developed for all service types, would promote consistency and fairness among providers. ^{xiv}

2007: DDS Report to the Legislature

DDS completed a report in response to “legislation chaptered on August 24, 2007, [that] required the Department of Developmental services to ‘develop a plan of options for consideration by the Administration and the Legislature to better control regional center costs of operating and providing state-supported services.’” This report contains an extensive review of the developmental services system. The report concludes by stating “there are no simple solutions for reducing regional center expenditures. However, it is critical that discussions about cost containment are informed by an understanding of the existing system so that fiscally responsible decisions can be made while ensuring quality services for [clients] and their families.”^{vi}

2011: UCLA Study

A UCLA report, published almost ten years after the 2001 CHPS study, reiterated CHPS’ conclusion: *“Establishing a fee schedule that is informed by thorough cost-based analysis and that incorporates adjustments for the increasing cost of service provision would allow vendors to sustainably maintain operations by limiting undue fiscal strain. A cost-based analysis recognizes the inherent variability in consumer needs -- where more severe conditions require more intense and expensive services -- and it also engages stakeholders in the rate-setting process.*

Furthermore, the cost statements required for rate setting should reflect the true costs of providing efficient and high-quality services, as required by the California Welfare and Institutions Code § 4690. This would allow for the consideration of any mechanisms that have been employed by vendors to reduce costs in a rate-restricted environment in order to maintain solvency. The inclusion of an explicit adjustment for input price inflation, such as the Consumer Price Index (CPI), would mitigate threats to access by recognizing the ongoing cost increases faced by vendors.”^{vii}

SUMMARY

From a policy perspective, California's developmental services system is poised to promote better service outcomes for more than 265,000 individuals with developmental disabilities. Services will be more individualized and will lead to greater levels of community participation, employment, and independence. Unfortunately, long-standing underfunding of the service system undermines this potential forward progress and the adequacy of the community-based provider network.

The concepts in this paper are not new. Studies dating back many years speak to the same point, but it bears repeating now. Even though client outcomes are directly tied to the quality and availability of services, the rate structure inhibits their quality – or makes it impossible to provide them. Acknowledging the problem with a passive response does not help the people we serve to progress. The challenge before us looms large only because it has been ignored for so long.

The provision of services has changed dramatically in recent years, owing to the shift in client population and advances in knowledge and methods of intervention. Accompanying these changes has been an evolution of services and service categories, as existing models were not flexible enough to meet emerging needs. The ability to negotiate rates for more innovative or individualized service models makes them viable. It is critical that all service codes be considered for rate-setting review. As the philosophy of the developmental services system evolves, and better outcomes are expected, there needs to be a renewed commitment to develop and sustain service models to meet the needs of individuals both today and in the future.

Over fifty years ago, California made a promise to the state's most vulnerable residents. The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to the people with developmental disabilities as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an

obligation to them which it must discharge..." Absent effective intervention, the health and well-being of clients and their families, for whom the state has accepted responsibility, are at risk. ^{xxi}

ENDNOTES

- ⁱ "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 14.
- ⁱⁱ "Supporting Californians with Developmental Disabilities," CPRC/CPAC Briefing Paper, California Policy Research Center, University of California, Berkley, 2006, p. 4-5.
- ⁱⁱⁱ "Rate Setting Alternatives for Community-Based Day and Residential Services," Report to the Legislature, Department of Developmental Services, Community Services Division, February 27, 1997, p. 19.
- ^{iv} "Department of Developmental Services: Without Sufficient Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults," Bureau of State Audits, California State Auditor, October 1999, p. 14.
- ^v "Rate Increase for Day, Infant, and Respite Programs," State of California May Revision Proposal, Fiscal Year 2000-2001, Department of Developmental Services, April 2000, p. 4.
- ^{vi} "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 98.
- ^{vii} "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 7.
- ^{viii} Welfare and Institutions Code § 4681.5 (*Amended by Stats. 2008, 3rd Ex. Sess., Ch. 3, Sec. 6. Effective February 16, 2008.*)
- ^{ix} "Department of Developmental Services Detail of Proposed Changes," 2001 May Revise to the Governor's Budget.
- ^x "Department of Developmental Services: Without Sufficient Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults," Bureau of State Audits, California State Auditor, October 1999, p. 15.
- ^{xi} "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 52.
- ^{xii} "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 12.
- ^{xiii} "Additional Clarification on Implementation of Statutory Requirements in SB 74, Chapter 9, Statutes of 2011," Department of Developmental Services, Letter of Regional Center Executive Directors, September 16, 2011, p.4.
- ^{xiv} Draft Report to the Service Delivery Reform Committee, Center for Health Policy Studies, May 15, 2001.
- ^{xv} "Analysis of California's Commitment to Developmental Disabilities Services," David Braddock, Ph.D. and Richard Hemp, M.A., January 23, 2004, p. 8.

^{xvi} "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 4.

^{xvii} "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 23.

^{xviii} "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 3.

^{xix} "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 26.

^{xx} "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 4.

^{xxi} WIC § 4501

APPENDIX A

GLOSSARY

GLOSSARY

1. **Adaptive skills trainers**
These are providers who have the skills, training and education to enhance the existing skills of the individual with a developmental disability. The trainer may also assist with training to address skill deficits in communication, social function, and other related areas, such as safety awareness. This instruction is later transitioned to the parent or caregiver for ongoing reinforcement and works at ensuring the deficits in these areas don't become barriers to the individual's ability to "function" in everyday life.
2. **Behavior intervention programs**
Use of applied behavioral analysis. No more than 40 hours per week depending on the individual's needs and progress. It can be one-to-one or in groups settings. (Government Code 95021 per AB 9, Statutes of 2009)
Applied behavioral analysis is the design, implementation, and evaluation of interventions to promote positive social behavior and reduce behaviors that interfere with learning and social interaction.
3. **Community integration training programs**
These are considered "look-a-like" day programs (i.e. similar to traditional day programs) but are provided within the community rather than at a facility, as center-based day programs are. Individuals participate in the community and sometimes work-related activities to learn the skills necessary to actively participate within the community.
4. **Community-based day programs include the following:**
 - **Activity Centers (AC) (Service Code [SC] 505)** which may have direct a care staff-to-client ratio of 1:8, 1:7, or 1:6.
 - Activity centers serve adults who have most of the basic self-care skills (eating, toileting, dressing, etc.), some ability to interact with others, and can make their needs known. Focus is on the development and maintenance of the skills required for self-advocacy, community integration (participation in natural/community environments) and employment. Requires licensure.
 - **Adult Development Centers (ADC) (SC 510)** which may have staff-to-client ratios of 1:4 or 1:3.
 - These programs serve adults who are still acquiring some of their self-help skills and so need the support of, and direction from staff

to interact with others, respond to directions, and make their needs known. The focus is on continued acquisition of self-care skills as well as self-advocacy, community integration, and employment. Requires licensure.

- Behavior Management Programs (SC 515)
 - These programs serve adults with severe behavior disorders and/or co-occurring diagnoses of a mental health disorder and developmental disability. Due to their behavior problems they are unable to participate in other types of day programs. Utilizes a consultant, such as a behaviorist. Requires licensure.
- Independent Living Programs (SC 520) which may have staff-to-client ratios of 1:3, 1:2 or 1:1.
 - These programs provide the functional skills training to secure an independent living situation in the community (i.e. an apartment, accessing transportation and health related services) and may provide the support to maintain those skills. Some of these functional skills would be doing laundry, paying bills, shopping, and cooking.
- Infant Development Programs (SC 805) which may have staff-to-client ratios of 1:3, 1:2 or 1:1.
 - This is a “day training and activity program where infants, and their families are provided training individually and in groups...these programs are designed to encourage the development and adjustment of the infants in the community and their homes, and to prepare the infants for entrance into classes of local schools or other appropriate facilities.” (Welfare and Institutions Code 4693)
- Social Recreation Programs (SC 525).
 - Provide community integration and self-advocacy training as they relate to recreation and leisure pursuits.

5. Creative arts programs

A program that facilitates self-expression through art, which includes art classes, and the development of vocational skills.

6. Independent living specialists

Individuals who are qualified to teach individuals with developmental disabilities the skills needed to live independently and/or assist them in

maintaining an independent living situation. In addition to bill-paying, cooking, etc. the individuals are assisted with securing housing, accessing transportation, community inclusion, recreation and health services, etc.

7. **Miscellaneous Services**

Miscellaneous services are services which are not similar to any services specified within regulations. A new miscellaneous service code must be requested by a regional center and approved by the Department of Developmental Services. Once a miscellaneous service code is approved it can be utilized by any of the 21 regional centers.

8. **Mobile day programs**

Services provided to clients who are unable to attend day programs outside of their homes.

9. **Program Design** is a document the vendor provides to the regional center per regulations and contains detailed information regarding the service such as, the description of the service, the purpose, the staffing ratios, the location, the hours of operation, etc.

10. **Rates**

ARM – Alternative Residential Model rates are set by the Department of Developmental Services. The rate reflects the level of care for which the provider has been vendorized.

Community–Based Day Programs – Rates are set by the Community Services Section of the Department of Developmental Services and are based upon the submission of a cost statement and if they fall within the “allowable range of rates”.

Negotiated – These rates are based upon submission of cost data information, review by the regional center, and a mutually agreed upon rate by the vendor and the regional center and documented in a contract.

SEP – Supported Employment Program rates are set by statute.

SMA - Schedule of Maximum Allowances are also known as Medi-Cal rates developed by the California Department of Public Health. It is the maximum rate of reimbursement for services under the Medi-Cal program. By regulation, regional centers cannot pay more than the Medi-Cal rate (SMA) for the same service.

U&C - Usual and Customary is the rate of reimbursement for vendors who serve the general public and regional center clients. If more than 70% of the

individuals served are regional center clients, the vendor must negotiate a rate with the regional center.

WAP – Work Activity Program rates are based upon cost data and size. The rates are assigned to small (0-30 clients), medium (31-100) clients, and large (101 or more clients). Their assigned temporary rate is the same regardless of the size of the program.

11. Ratios

Ratios indicate how many staff are assigned to a particular number of clients. The staff to client ratios are defined by regulation and/or in the negotiated contract and program design agreed upon by the regional center and the provider.

12. Respite agencies

Intermittent or regular non-medical care and supervision in the individual's home, providing the type of basic care and supervision family members do around-the-clock. This service helps the family to be able to keep the individual living at home and ensures safety in the absence of family members. It also relieves the family briefly from the demands of caring for the individual and during this time assures the family that the needs and daily activities of the individual are being maintained.

13. Service Codes

Service codes are numbers attached to a service type as defined in regulation or in the definition set forth for miscellaneous services. The service code clearly identifies the service and the expectations as set forth in regulation.

14. Socialization programs

These programs allow children to learn to build relationships with peers through participation in meaningful activities. The programs also offer opportunities to interact with peers who do not have a developmental disability, for the purpose of modeling and learning age-appropriate skills and behavior. Most programs primarily serve individuals with autism but are open to individuals who meet entrance criteria.

15. Specialized Residential Facilities

Specialized residential facilities were developed to meet the needs of individuals requiring 24 hour care but whose needs cannot be met within the array of other community living options available. These facilities may include various therapeutic social and recreational programming and other staffing to meet the unpredictable needs of the individuals and ensuring the health and safety of the residents.

16. Supplemental day service program supports

Some individuals temporarily require additional staffing at day programs or within residential care due to behaviors, or for assistance with self-care skills such as eating or toileting, beyond what is normally required in these settings. These additional supports are put in place temporarily to address the issues to help make the participation successful for the individual. The utilization of this service is defined specific to that individual and their needs.

17. Supported employment

A service that provides a job coach to support and maintain an individual in an employment situation. Must also be contracted with the Department of Rehabilitation.

18. Supported living services

These services provide support to the individual to live in their own "home" and assists them in participating in community activities as appropriate to each individual's interests and ability. The goal is to maximize their potential to live integrated and productive lives. The amount and intensity of support is based upon the individual's need.

19. Transportation, including travel reimbursement

Most commonly this service is provided through contracts with transportation companies or as an add-on to an existing service such as residential care or day program. Transportation is normally provided to assist an individual in getting to and from their work or day program. Sometimes it is made available to assist individuals and their families to get to needed medical appointments.

APPENDIX B
COMMUNITY CARE FACILITY RATES

**DEPARTMENT OF DEVELOPMENTAL SERVICES
COMMUNITY CARE FACILITY RATES
EFFECTIVE JANUARY 1, 2013**

| Service Level | Monthly Payment Rate Per Consumer Effective 1/1/2013 ¹ |
|---------------|--|
| 1 | \$993 |
| 2-Owner | \$1,910 |
| 2-Staff | \$2,146 |
| 3-Owner | \$2,194 |
| 3-Staff | \$2,502 |
| 4A | \$2,941 |
| 4B | \$3,134 |
| 4C | \$3,326 |
| 4D | \$3,567 |
| 4E | \$3,825 |
| 4F | \$4,082 |
| 4G | \$4,386 |
| 4H | \$4,707 |
| 4I | \$5,159 |

The Personal and Incidental expenses associated with the January 1, 2013, SSI/SSP payment standard increased from \$128 to \$129.

¹ Includes the SSI/SSP pass through effective January 1, 2013.

APPENDIX C
COMMUNITY-BASED DAY PROGRAMS AND IN-HOME
RESPIRE ALLOWABLE RANGE OF RATES

COMMUNITY-BASED DAY PROGRAMS AND IN-HOME RESPITE AGENCIES

ALLOWABLE RANGE OF RATES AND TEMPORARY PAYMENT RATES

2007/08 FISCAL YEAR
Effective January 1, 2008

| Service Category | Staff Ratio | Lower Limit | Upper Limit | Temporary Payment Rate |
|--|-------------|-------------|-------------|------------------------|
| Daily Rates | | | | |
| Activity Center (505) | 1:8 | \$26.83 | \$46.91 | \$36.39 |
| | 1:7 | 28.52 | 46.20 | 36.54 |
| | 1:6 | 32.68 | 56.76 | 45.09 |
| Adult Dev. Center (510) | 1:4 | 36.14 | 66.94 | 53.86 |
| | 1:3 | 45.43 | 69.22 | 58.87 |
| Behavior Management (515) | 1:3 | 49.97 | 83.49 | 72.42 |
| Hourly Rates | | | | |
| Independent Living (520) | 1:3 | 10.64 | 16.54 | 14.31 |
| | 1:2 | 17.45 | 22.68 | 20.66 |
| | 1:1 | 22.42 | 43.00 | 31.62 |
| Social Recreation (525) | 1:10 | 13.12 | 24.74 | 16.36 |
| Infant Development (805) | 1:3 | 28.66 | 48.34 | 38.72 |
| | 1:2 | 42.58 | 73.65 | 59.17 |
| | 1:1 | 60.07 | 108.05 | 78.29 |
| In-Home Respite (862) | 1:1 | 14.16 | 20.68 | 17.53 |
| In-Home Respite (862) (eff. 1/1/08) | 1:1 | 14.75 | 21.27 | 18.12 |

Revised January 2008

APPENDIX D
RATES OF REIMBURSEMENT FOR NON-RESIDENTIAL,
MISCELLANEOUS AND SUPPORTED LIVING SERVICES

**RATES OF REIMBURSEMENT FOR
NON-RESIDENTIAL, EXCLUDING TRANSPORTATION,
MISCELLANEOUS AND SUPPORTED LIVING SERVICES**

| <i>Service Code</i> | <i>Service Description</i> | <i>Basis for Rate</i> |
|---------------------|--------------------------------|---|
| 605 | Adaptive Skills Trainer | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 855 | Adult Day Care | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 691 | Art Therapist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 610 | Attorney | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 612 | Behavior Analyst | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 615 | Behavior Management Assistant | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate), not to exceed the rate of reimbursement for the licensed professional with whom the Behavior Management Assistant is registered. |
| 620 | Behavior Management Consultant | Based on the method of reimbursement established for an individual with the same licensed classification. |
| 850 | Camping Services | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 851 | Child Day Care | Usual & Customary or Negotiated rate. (Negotiated if vendor has no Usual & Customary rate.) |
| 625 | Counseling Services | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 692 | Dance Therapist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |

| | | |
|------------|---|--|
| 405 | Day Care—Family Member (Voucher) | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 670 | Developmental Specialist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 410 | Diaper and Nutritional Supplements—Family Member (Voucher) | Supplier's Usual and Customary Rate. |
| 627 | Diaper Service | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 720 | Dietary Services | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 630 | Driver Training | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 672 | Educational Psychologist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 800 | Genetic Counselor | Reimbursed according to the Medi-Cal Schedule of Maximum Allowances (SMA), if applicable. If not, vendor shall be reimbursed at their Usual and Customary (U&C) Rate or, if no U&C exists, at a rate negotiated with the regional center. |
| 858 | Homemaker | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 860 | Homemaker Service | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 635 | Independent Living Specialist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 810 | Infant Development Specialist | Reimbursed according to the Medi-Cal Schedule of Maximum Allowances (SMA), if applicable. If not, vendor shall be reimbursed at their Usual and Customary (U&C) Rate or, if no U&C exists, at a rate negotiated with the regional center. |
| 864 | In-Home Respite Worker | Rate not to exceed \$8.98 per hour, including fringe benefits. See Title 17, Section 58140 if family has more than one consumer in home authorized to receive respite services. |

| | | |
|-----|--|---|
| 642 | Interpreter | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 742 | Licensed Vocational Nurse | Reimbursed in accordance with the Schedule of |
| 645 | Mobility Training Services Agency | Maximum Allowances (SMA) for Home and Community-Based Services, In-Home Medical Care Waiver Program. Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 650 | Mobility Training Services Specialist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 693 | Music Therapist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 743 | Nurse's Aide or Assistant | Reimbursed in accordance with the Schedule of Maximum Allowances (SMA) for Home and Community-Based Services, In-Home Medical Care Waiver Program. |
| 415 | Nursing Service—Family Member (Voucher) | Reimbursed in accordance with the Schedule of Maximum Allowances (SMA) for Home and Community-Based Services, In-Home Medical Care Waiver Program. |
| 868 | Out-of-Home Respite Services | <ul style="list-style-type: none"> •Day care homes providing out-of-home respite services shall be reimbursed at the Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). •Licensed residential facilities providing out-ofhome respite services for whom the Dept. of Social Services or the Dept. of Health Services have set a rate shall be reimbursed at the rate established by that department. •Licensed residential facilities providing out-ofhome respite services for whom the Dept. of Social Services has not established a rate shall be reimbursed at 1/21 of the rate established by the regional center. |
| 655 | Out-of-State Manufacturer or Distributor | <ul style="list-style-type: none"> •Products reimbursable under the Medi-Cal program shall be reimbursed at the Schedule of Maximum Allowances (SMA). •All other products shall be reimbursed at the vendor's Usual and Customary rate. |

| | | |
|------------|--|---|
| 790 | Psychiatric Technician | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 694 | Recreational Therapist | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 744 | Registered Nurse | Reimbursed in accordance with the Schedule of |
| | | Maximum Allowances (SMA) for Home and Community-Based Services, In-Home Medical Care Waiver Program. |
| 869 | Respite Facility | Either 1/21 of the established approved monthly rate or the agreed-upon level of payment for a service contract negotiated pursuant to Title 17, Section 57540(b) through (f), not to exceed \$8.98 per hour, including benefits. |
| 420 | Respite Services—Family Member | Reimbursement shall not exceed \$8.57 per hour, including benefits. |
| 660 | Retail/Wholesale Stores | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 896 | Supported Living Service | Negotiated with regional center. |
| 894 | Supported Living Service Vendor Administration | Negotiated with regional center. |
| 674 | Teacher | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 678 | Teacher of Special Education | Usual & Customary or Negotiated rate. (Negotiated if vendor has no Usual & Customary rate.) |
| 676 | Teacher's Aide | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 643 | Translator | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| 680 | Tutor | Usual & Customary or Negotiated rate (Negotiated if vendor has no Usual & Customary rate). |
| | Multiple Miscellaneous Services | <ul style="list-style-type: none"> • The Schedule of Maximum Allowances (SMA) • The vendor's Usual and Customary rate if the SMA does not apply. • A Negotiated rate if the vendor does not have an established Usual and Customary rate and the SMA does not apply. |

APPENDIX E
WORK ACTIVITY PROGRAM (WAP) AND SUPPORTED
EMPLOYMENT PROGRAMS (SEP) RATES

**Work Activity Program (WAP)
Service Code 954
Upper Limits for WAP
Effective 7/1/2006**

| | | |
|--------------------|-----------------------|------------------------------|
| Small vendors: | 0 to 30 consumers | \$58.86 per consumer per day |
| Medium vendors: | 31 to 100 consumers | \$42.30 per consumer per day |
| Large vendors: | 101 or more consumers | \$31.50 per consumer per day |
| <hr/> | | |
| Statewide average: | Temporary Rate | \$35.29 per consumer per day |

**Supported Employment Programs (SEP)
Service Codes 950 & 952
Effective 10/1/2008**

The hourly rate shall be \$30.82 as per Welfare and Institutions Code 4860 (a) (1).

Item 8

LPPC PRIORITIES FOR 2015

BYLAWS OF THE STATE COUNCIL- SECTION RE: THE ROLE OF THE LPPC:

(e) The charge of each of these committees shall be as follows:

(3) Legislative and Public Policy Committee

The Legislative and Public Policy Committee shall implement the California State Strategic Plan on Developmental Disabilities objectives as assigned by the Council. The Committee shall:

- [a] Be composed of at least seven (7) members.
- [b] Review, comment and recommend positions on significant proposed legislation and/or proposed regulations.
- [c] Recommend legislation consistent with Council's responsibilities and objectives.
- [d] Recommend initiatives and policies consistent with Council responsibilities and objectives.
- [e] Provide testimony and recommendations to the Legislature with regard to matters pertaining to people with developmental disabilities.
- [f] Respond to other responsibilities as assigned by the Council or Council Chairperson.

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FEBRUARY

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MARCH

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APRIL

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MAY

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| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 5 Legislature **reconvenes** (J.R. 51(a)(1)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12 (a)).

Jan. 19 Martin Luther King, Jr. Day.

Jan. 30 Last day to submit **bill requests** to the Office of Legislative Counsel.

Feb. 16 Presidents' Day.

Feb. 27 Last day for bills to be **introduced** (J.R. 61(a)(1), (J.R. 54(a)).

Mar. 26 **Spring Recess** begins at end of this day's session (J.R. 51(a)(2)).

Mar. 30 Cesar Chavez Day.

Apr. 6 Legislature reconvenes from **Spring Recess** (J.R. 51(a)(2)).

May 1 Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(a)(2)).

May 15 Last day for **policy committees** to hear and report to the Floor **non-fiscal** bills introduced in their house (J.R. 61(a)(3)).

May 22 Last day for **policy committees** to meet prior to June 8 (J.R. 61(a)(4)).

May 25 Memorial Day.

May 29 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61 (a)(5)). Last day for **fiscal committees** to meet prior to June 8 (J.R. 61 (a)(6)).

| | | | | | | |
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| 28 | 29 | 30 | | | | |

61(a)(7)).

June 5 Last day for bills to be **passed out of the house of origin** (J.R. 61(a)(8)).

June 8 Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget must be passed by **midnight** (Art. IV, Sec. 12(c)(3)).

| JULY | | | | | | |
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| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

July 3 Independence Day observed.

July 17 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)).
Summer Recess begins at the end of this day's session, provided Budget has been enacted (J.R. 51(a)(3)).

| AUGUST | | | | | | |
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| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

Aug. 17 Legislature reconvenes from **Summer Recess** (J.R. 51(a)(3)).

Aug. 28 Last day for **fiscal committees** to meet and report bills to the Floor (J.R. 61(a)(11)).

Aug. 31 – Sept. 11 Floor Session only. No committees, other than conference committees and Rules Committee, may meet for any purpose (J.R. 61(a)(12)).

| SEPTEMBER | | | | | | |
|-----------|----|----|----|----|----|----|
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| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |

Sept. 4 Last day to **amend** bills on the Floor (J.R. 61(a)(13)).

Sept. 7 Labor Day.

Sept. 11 Last day for **each house to pass bills** (J.R. 61(a)(14)).
Interim Study Recess begins at end of this day's session (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM STUDY RECESS

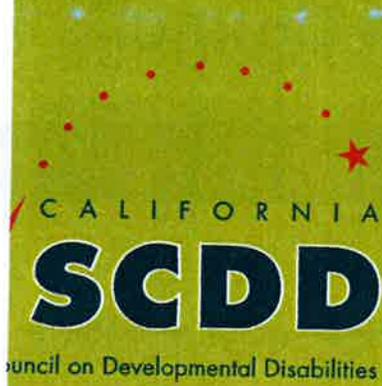
2015

Oct. 11 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 11 and in the Governor's possession after Sept. 11 (Art. IV, Sec.10(b)(1)).

2016

88 Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature reconvenes (J.R. 51 (a)(4)).



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 Termerman 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.



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 control 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

ular job with competitive pay gives people an opportunity to contribute and be valued at a work site; it gives the 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 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

Community center services and supports must be distributed equitably so all individuals receive culturally and linguistically competent services and supports that meet their needs, regardless of their race, ethnicity, or gender. 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 measurable 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

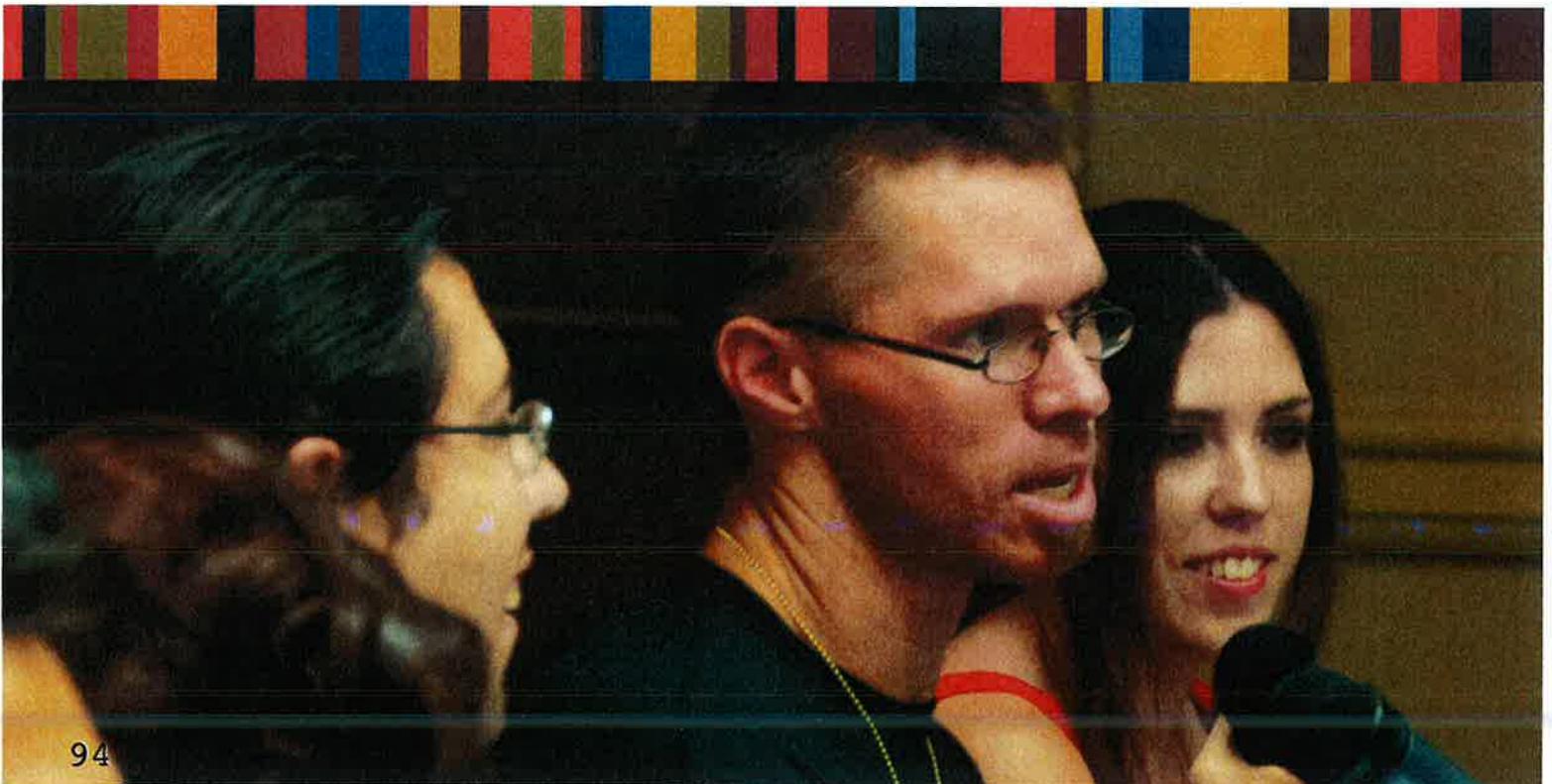
Individuals with IDD must be supported to exert maximum control over their lives. They must be provided the opportunity and support to assume their rightful leadership in the service system and society, including voting and other civic responsibilities. Self-advocates must have access to enhanced training,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

TIMS OF CRIME

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 and how 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.



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Main Office (Headquarters)

1507 21st Street, Suite 210

Sacramento, CA 95811

(916) 322 8481

(866) 802-0514

TTY (916) 324-8420

Draft



State Council on Developmental Disabilities

www.scdd.ca.gov

2015 LPPC Legislative Priorities Setting Exercise

Our goal today is to develop a “playbook” of the LPPC priorities for 2015. A playbook has a strategy with clear and measurable goals and objectives while identifying the process/means necessary to get there. In order to accomplish the development of the playbook for the LPPC, we are asking each committee member to develop 3 priorities based on the LPPC platform (included in this agenda packet). This exercise asks you to take 3 platform statements that you feel should have the highest priority and turn them into 3 goals specific to the work of the LPPC. It then asks you to develop the objectives (or steps necessary) to accomplish each of the 3 goals and to identify some of the process/means to succeed in each of the objectives. While you are filling out the three sheets, think about potential collaborative partners needed to succeed in each of the objectives and what targets and approaches/activities would be needed for each stage. Use this handout to help you identify what each of the “bubbles” in the attached worksheets refers to. Use one worksheet per goal.

Platform Statements as Goals, Objectives and Process/Means

Each member of the LPPC is expected to complete the worksheets before coming to the meeting. At the meeting, we will review each committee member’s top 3 platform statements and the group will then pick the top 3 most often picked statements. This way we can collectively work on what the group feels are the top 3 statements. It is from those statements that we will begin to develop the LPPC Goals and Objectives for this coming year along with the process/means that we will need to put in place to succeed.

Goals

Your legislative advocacy goal builds on your issue described in the platform statement by adding specifics. For **example**, if I select Housing from our LPPC Platform: my goal may be to increase the number of affordable housing units for people with intellectual and other developmental disabilities by 10% across the state.

Objectives

Your goal should be broken down into a few short-term objectives that will directly contribute to achieving your goal. Objectives are the smaller steps you must complete in order to reach your overall goal. They should be clear and focused, and should include: the change you want to see, who (e.g., person, institution, office) will make the change, and when it will be achieved. They should be limited in number (no more than 3). Note: If your objective is likely to

take longer to achieve than your goal, it is not a good objective. For our housing **example**, one objective for the housing goal above might be to introduce legislation that would require local housing authorities to increase their capacity for people with intellectual and other developmental disabilities by 10%.

Identify Process/Means along with Partners & Alliances to help accomplish objectives

One part of the of the process/means to reach our objectives is in forming strong **partnerships** with other groups/organizations is essential to a successful legislative advocacy strategy. We need to identify partners who will bring helpful, unique skills and contributions to our efforts. Make sure SCDD and potential partners are in agreement about the issue and its potential solutions. A stakeholder forum may be necessary to build consensus. For the exercise, please identify 2 or 3 potential partners and what they can contribute to our legislative advocacy initiative. For our housing **example** above, we may identify local housing authorities as collaborative partners (after all, if they are in support of the legislation that we propose, it is more likely to succeed). Another partner may be the California Independent Living Centers.

Another part of the process/means to reach our objectives is in identifying our **targets**. Primary targets are the people that have the power to make the change we are advocating for. When you cannot influence your primary targets, choose secondary targets. A secondary target is the person/group/etc. you can influence who can then, in turn, influence your primary target. The targets must be specific (e.g., a person, newspaper, department, committee) —“the public” or “the government” are too general and, therefore, are not good targets. For your exercise, identify at least 2 targets (primary or secondary) that could help us accomplish what you identified as the objective. For our housing **example** above, we may identify the Chair of the Senate Transportation and Housing Committee and/or all of its members (since these are primary targets).

Finally as part of the process/means, we always consider the activities. It is also important for us to think at each stage about who may be supportive, neutral or oppose our goals and objectives. It also important for us to think about the timing of the process/means and the related activities. For example, when is the right time to propose the legislation or to advocate on the issue? We often refer to these as “windows of opportunity”. And most importantly, what types of approaches and activities should we take? There are four types of approaches: Public (highly visible), Private (less visible with a few key partners behind the

scenes), Direct (directly asking policymakers to take action) or Indirect (influencing the public opinion through media etc). For our housing **example** above, we may decide to take an indirect approach by putting together a media clip for a public service announcement on the need for housing.

Advocacy activities should be designed to help us achieve our individual objectives, moving us toward our goal. Below is a list of common advocacy activities. Consider pursuing a combination of them for each objective. Do not be afraid to use your imagination as well, but be selective. You cannot and should not do everything. Think about your expertise, capacity, what will have the greatest impact on your target, and your funds.

Examples of activities:

- Arrange site visits or study tours
- Hold educational briefings & events
- Conduct advocacy trainings
- Launch public awareness campaigns
- Hold policy dialogues & forums among key stakeholders
- Document problems for policymakers (e.g., commission a report)
- Engage the media to cover your issue
- Hold face-to-face meetings with policymakers
- Mobilize groups (community members, public interest groups, etc.) in support of policy change
- Provide technical information and recommendations to policymakers
- Utilize email, phone calls, letters, petitions, and social media to mobilize constituents to contact policymakers

Finally, think “outside of the box”. Legislative advocacy often requires strong relationships and creative approaches to fix the problem.

Please complete the 3 attached sheets (one for each Goal) and bring them with you to our meeting on December 8, 2014 – we will be using them as part of our “Priority Setting Exercise”. Start with filling in the goal and work backwards to the objectives and then the process/means. There is an example to help you.

Adapted From “Straight to the Point: Mapping an Advocacy Strategy” by Pathfinder International. Retrieved from: <http://www.pathfinder.org/publications-tools/pdfs/Straight-to-the-Point-Mapping-an-Advocacy-Strategy.pdf>

The Problem Now

The Process/ Means to achieve the Objectives

The Objectives to achieve the Goal

The Goal

Example

seek collaboration with local Housing Authorities and Indept living centers

meet with Chair of Senate Transp & Housing Committee

Introduce regulation requiring local Housing Auth to increase capacity by 10%

Increase number of affordable housing units by 10% for people with Intellectual & other develop. disabilities

Example

not enough housing available for indell. people with disabilities & other

Platform Statement (Circle only one):

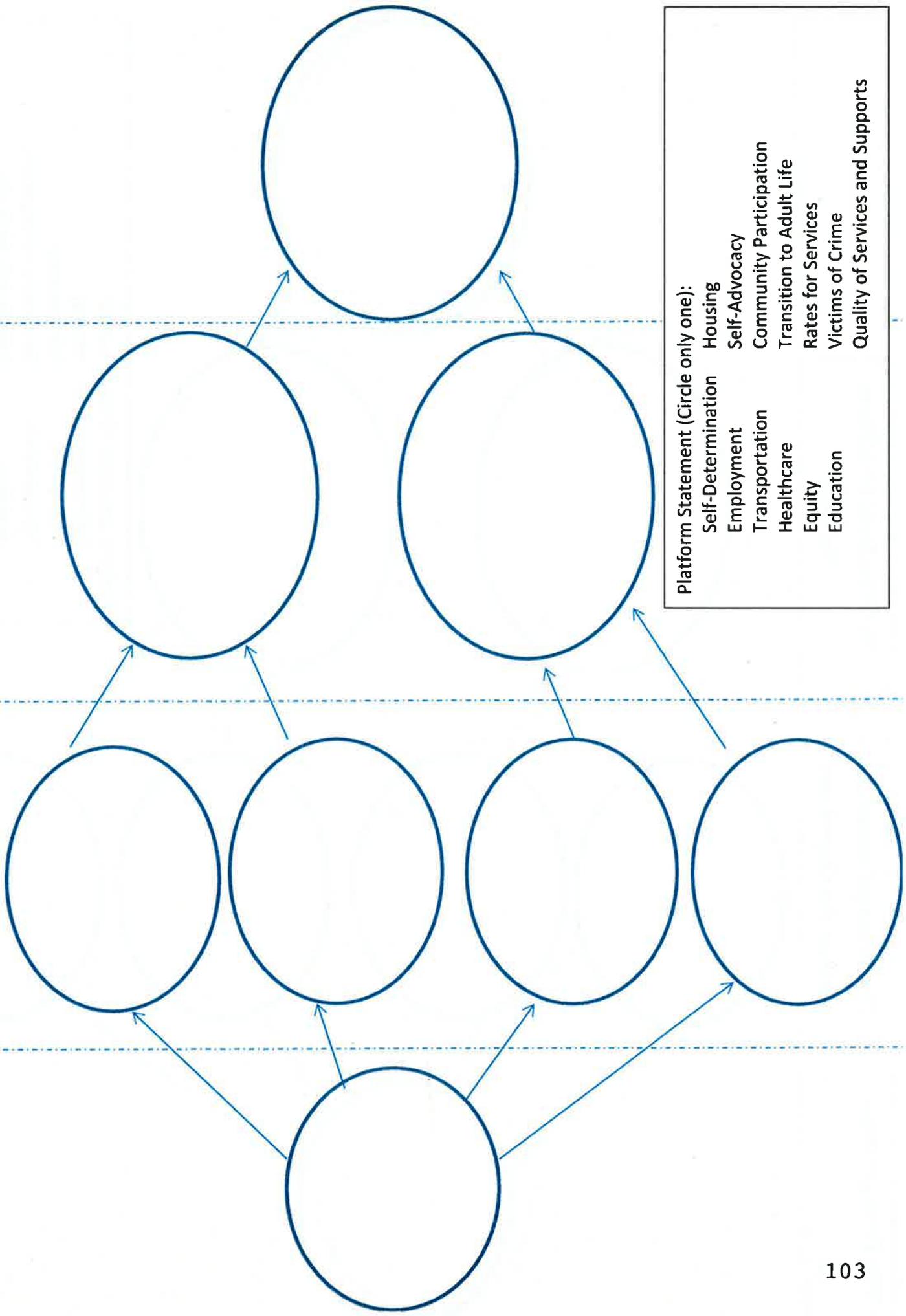
- Self-Determination
- Employment
- Transportation
- Healthcare
- Equity
- Education
- Housing
- Self-Advocacy
- Community Participation
- Transition to Adult Life
- Rates for Services
- Victims of Crime
- Quality of Services and Supports

The Problem Now

The Process/ Means to
achieve the Objectives

The Objectives to achieve
the Goal

The Goal



Platform Statement (Circle only one):

Self-Determination
Employment
Transportation
Healthcare
Equity
Education

Housing
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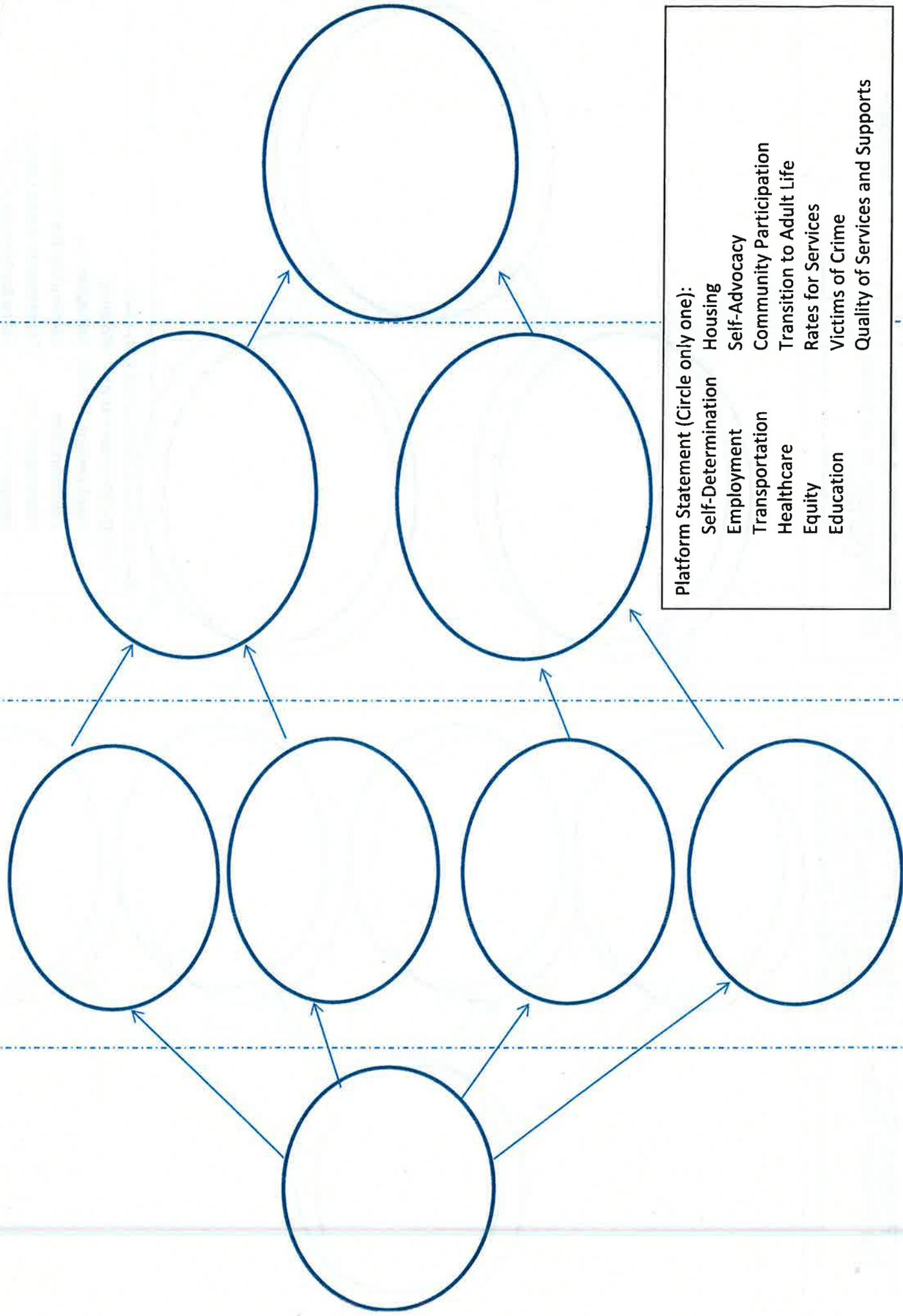
The Problem Now

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The Process/ Means to achieve the Objectives

The Objectives to achieve the Goal

The Goal

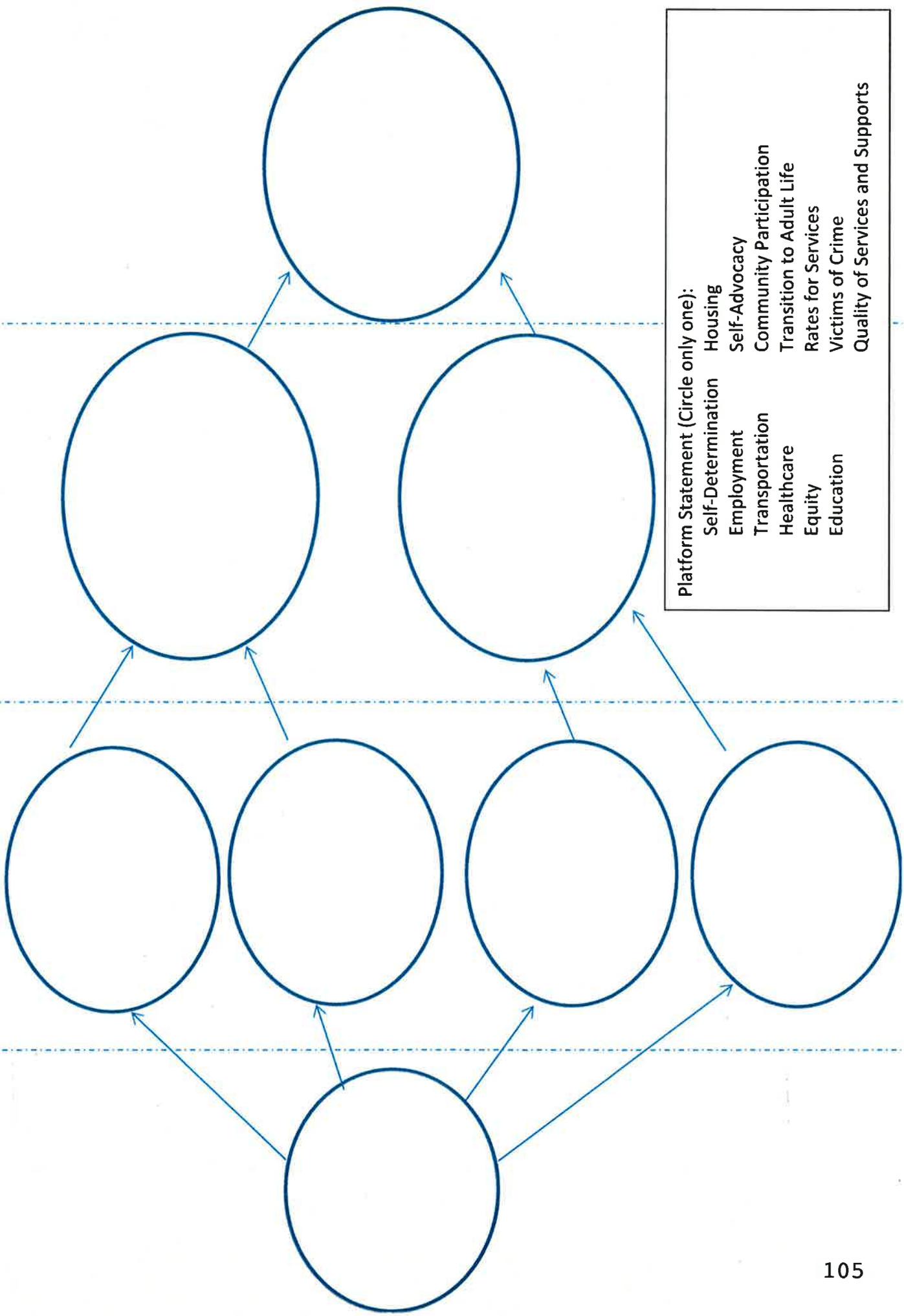


The Problem Now

The Process/ Means to achieve the Objectives

The Objectives to achieve the Goal

The Goal



Platform Statement (Circle only one):

- Self-Determination
- Employment
- Transportation
- Healthcare
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