

JOINT OVERSIGHT HEARING

**OVERSIGHT OF CALIFORNIA'S REGIONAL CENTERS:
ENSURING INTEGRITY, TRANSPARENCY, AND BEST PRACTICES
IN A CHALLENGING FISCAL ENVIRONMENT**

**Senate Committee on Human Services
Carol Liu, Chair
Assembly Committee on Human Services
Jim Beall, Jr., Chair**

**Room 113
State Capitol
Sacramento, California**

**November 4, 2010
9:30 a.m. – 12:00 p.m.**

BACKGROUND BRIEFING PAPER

1. Introduction

With enactment of the Lanterman Developmental Disabilities Services Act (Lanterman Act; Welfare & Institutions Code § 4500 *et seq.*) the California Legislature established a comprehensive statutory scheme to provide services and supports to people with developmental disabilities. In its landmark opinion in *Association for Retarded Citizens-California v. Department of Developmental Services (ARC v. DDS)* (1985) 38 Cal.3d 384, 388, the California Supreme Court noted that "[t]he purpose of the [Lanterman Act] is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community ... and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community."

Direct responsibility for implementation of the Lanterman Act service system is allocated between the Department of Developmental Services (DDS) and 21 Regional Centers (RCs). RCs are private nonprofit entities established pursuant to the Lanterman Act that contract with DDS to carry out many of the state's responsibilities under the Act. See, e.g., Welf. & Inst. Code § 4620. RCs are to "assist persons with developmental disabilities and their families in securing those services and supports which maximize opportunities and choices in living, working, learning and recreating in the community." Welf. & Inst. Code § 4640.7(a). The main roles of RCs include intake and assessment, individualized program plan development, case management, and securing services through generic agencies (e.g., school districts, In-Home Supportive Services) or by purchasing services provided by vendors. Approximately 40,000 vendored service providers deliver a wide range of services to consumers, such as respite care, transportation, day treatment programs, residential placements, supported living services, work support programs, and various social and therapeutic activities.

Lanterman Act services are intended to meet the needs and choices of each person with developmental disabilities,¹ regardless of age or degree of disability, and to promote his or her integration into the mainstream of the community. Welf. & Inst. Code § 4501. Such services must protect the personal liberty of the individual, be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services or supports, and enable the individual to approximate the pattern of everyday living available to people without disabilities of the same age. Welf. & Inst. Code §§ 4501,

¹ The term "developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. It includes mental retardation, cerebral palsy, epilepsy, and autism. It also includes disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but does not include other handicapping conditions that are solely physical in nature. Welf. & Inst. Code § 4512(a).

4502(a)(b), 4750.

Under the Lanterman Act, each Californian with a developmental disability is legally *entitled* to “treatment and habilitation services and supports in the least restrictive environment.” § 4502. The California Supreme Court explained that this “entitlement” consists of a “basic right and a corresponding basic obligation: the right which it grants to the developmentally disabled person is to be provided with services that enable him to live a more independent and productive life in the community; the obligation which it imposes on the state is to provide such services.” *ARC v. DDS*, 38 Cal.3d at 391.

Services provided to people with developmental disabilities are determined through an individual planning process. E.g., Welf. & Inst. Code §§ 4418.3, 4512(j), 4646, 4646.5, 4647. Under this process, planning teams—which include, among others, the person with a developmental disability, referred to in the Act as “consumers” (Welf. & Inst. Code § 4512(d)), his or her legally authorized representative, and one or more regional center representatives—jointly prepare an Individual Program Plan (IPP) based on the consumer’s needs and choices.

The Lanterman Act requires that the IPP promote community integration. Welf. & Inst. Code § 4646(a). To this end, DDS and RCs must ensure that planning teams develop goals that maximize opportunities and teach skills needed for each person to develop relationships, be part of community life, increase control over his or her life and acquire increasingly positive roles in the community. Welf. & Inst. Code § 4646.5. The IPP must give the highest preference to those services and supports that allow minors to live with their families and adults to live as independently as possible in the community. E.g., Welf. & Inst. Code § 4648(a)(1), (2).

2. DDS oversight of RCs

DDS' oversight responsibilities arise primarily under the Lanterman Act and through the state's responsibilities under the federal Medicaid Home and Community-Based Services (HCBS) Waiver. Under state law, DDS is the designated state agency with "jurisdiction over the execution of the laws relating to the care, custody, and treatment of developmentally disabled persons" Welf. & Inst. Code § 4416. Accordingly, it is charged with (1) monitoring the RCs to ensure that they comply with federal and state law, and (2) taking action to support the RCs in achieving compliance and in providing "high quality services and supports to consumers and their families." Welf. & Inst. Code §§ 4434(a), (b); 4500.5(d); 4501; see, *Capitol People First v. DDS* (2007) 155 Cal.App.4th 676, 683.

DDS has performance contracts with RCs through which DDS monitors progress and follows up when an RC fails to maintain an acceptable level of compliance with performance objectives or make progress toward meeting them. DDS may impose corrective actions on an RC, additional contract provisions, and levels of probation. DDS also performs biennial (or annual, if warranted) fiscal audits of RCs. Additionally, for the purpose of ensuring the RC is meeting federal requirements pursuant to the HCBS

waiver, DDS staff visit each RC every other year and review records, interview consumers and staff, and visit program sites. DDS must also review RC purchase of service policies to prevent an RC from utilizing a policy that violates the Lanterman Act.

ARC v. DDS

In *ARC v. DDS*, the California Supreme Court addressed the respective roles of DDS and RCs under the Lanterman Act. "Broadly," the Court held, DDS "'has jurisdiction over the execution of the laws relating to the care, custody, and treatment of developmentally disabled persons,' while 'regional centers' ... are charged with providing developmentally disabled persons with 'access to the facilities and services best suited to them throughout their lifetime.'" 38 Cal.3rd at 389 (citations omitted). The Court further noted that "it is regional centers, not DDS, that provide services to developmentally disabled persons and determine the manner in which those services are to be rendered." *Id.* DDS, on the other hand, "is responsible for developing uniform systems of accounting, budgeting and reporting, setting the rates for out-of-home care, and auditing and paying funds to the regional centers." *Id.* DDS' authority "is basically limited to promoting the cost-effectiveness of the operations of the regional centers, and does not extend to the control of the manner in which they provide services or in general operate their programs." *Id.* at 389-90. In the *ARC v. DDS* case the Supreme Court invalidated DDS priorities that categorically denied certain services and would, therefore, "have vitiated the IPP procedure." *Id.* at 392.

3. Funding for services and recent budget actions

Services for people with developmental disabilities are funded through a combination of federal and state funds.² The 2010-11 budget for DDS and RCs is approximately \$4.8 billion to provide services to over 240,000 individuals.³

Like all areas of state government, DDS and RCs have had to take steps to deal with the state's fiscal crisis. With limited exceptions, most community provider rates have been frozen since fiscal year 2003-04. The limited cost-of-living and other rate adjustments granted by the Legislature for residential and day programs in the past two decades have been far outstripped by inflation. The FY 2008-09 and FY 2009-10 budgets included an additional 3% reduction in provider rates. The FY 2010-11 budget continues the 3% reduction and includes an additional 1.25% reduction. DDS and RCs have been required

² Approximately 90,000 consumers living in the community receive services funded through the federal Medicaid HCBS Waiver, which funds 50% of the costs of allowable services. The number of consumers who are funded through the HCBS Waiver is capped, but increases by 5,000 each year. In fiscal year 2009-10 the cap was 90,000, and will be 95,000 in federal fiscal year 2010-11.

³ Diagnostic and demographic information about the population served by regional centers is available on DDS' website: <http://www.dds.cahwnet.gov/FactsStats/Home.cfm>.

to institute numerous other cost-savings measures over the last 2 years, including the following:

The 2008-09 Budget

AB 5 X3 (Budget Committee), Chapter 3, Statutes of 2008 Third Extraordinary Session:

- Changed the intake and assessment timelines from 60 days to 120 days.
- Prohibited RCs from paying providers at a rate greater than the rate in effect on or after June 30, 2008.
- Provided authority for DDS to freeze rates for all negotiated-rate services for residential facilities.
- Froze rates for all Specialized Residential Facilities including Habilitation, Health, and the Adult Residential Facility for Persons with Special Health Care Needs.
- Limited starting rates for new Specialized Residential Facilities and for new service providers to either the RC's average rate for similar services or the statewide average rate for similar services, whichever is lower, starting July 1, 2008.
- Indefinitely restricted the use of purchase of service funds for starting new programs except extraordinary circumstances or to protect consumer health and safety.
- Included early start consumers (children less than three years of age) under the Family Cost Participation Program.

AB 1183 (Budget Committee), Chapter 758, Statutes of 2008.

- Required RCs to establish an internal review process of IPPs and individualized family service plans to ensure conformity with federal and state law and regulations.
- As part of this internal process, RCs are to consider a family's responsibility for providing similar services and supports for a minor child without disabilities in identifying a consumer's service and support needs as provided in the least restrictive and most appropriate setting as noted.

The 2009-10 Budget

SB 6 X3 (Ducheny), Chapter 13, Statutes of 2009 Third Extraordinary Session: In response to RC operations budget reductions, suspended RC contract requirements specifying average service coordinator-to-consumer ratios, certain staff expertise requirements, and specified fiscal reporting requirements.

AB 5 X3 (Evans), Chapter 20, Statutes of the 2009 Third Extraordinary Session: Required that DDS work with stakeholders to submit a plan to the Legislature that identified specific cost containment measures to achieve up to \$100 million in General Fund (GF) reductions for the 2009-10 Fiscal Year.

May Revise. Due to a worsening economy, the Governor's May Budget Proposal required an additional \$234 million in reductions from DDS, which, unlike the first \$100 million, could come from the entire DDS budget, including developmental centers.

DDS Proposals. In response to the Legislature's call for DDS to work with stakeholders to identify \$100 million in GF reductions, DDS held three stakeholder public forums and established a workgroup that included representatives from statewide stakeholder groups and legislative staff. After the Governor's May Revise, DDS received input from the workgroup and identified an additional \$234 million in reductions.

The adopted cost savings measures included, among others, the following, related to RC provider selection and the IPP process⁴:

- Establishing new standards for RCs to use in authorizing services, including preventing purchase of experimental treatments, prohibiting funding for any service available through a more generic service such as IHSS or Medi-Cal, and requiring selection of the least costly vendor who is able to meet the consumer's needs;
- Maximizing cost-effective transportation services;
- Ensuring that all eligible individuals access IHSS hours before receiving Supported Living Services (SLS);
- Expanding neighborhood preschools as an alternative to specialized services;
- Reducing costs for in-home behavior intervention services by requiring parents to complete group instruction on behavioral intervention prior to receiving in-home behavioral services;
- Establishing specific standards to be used by RCs in purchasing behavioral services, including requiring that services be evidence-based, evaluated regularly, not used solely as respite, and discontinued if the consumer's goals have been achieved;
- Restricting eligibility for Early Start services for children entering the program at 24 months of age or older to only those toddlers who have a 50% or greater delay in one domain or 33% or greater in two domains (currently criterion is 33% in one domain regardless of age);
- Restricting Early Start programs from purchasing services not required under the federal Early Start grant program, establishing a Prevention Program at each RC for infants and toddlers who do not meet the federal Early Start or Lanterman Act eligibility requirements, and providing services to infants and toddlers who are "at

⁴ More detailed information on the 2009-10 budget savings measures is available at: <http://www.dds.cahwnet.gov/Director/BudgetReductionSummary.cfm>. A number of the 2009-10 budget savings measures were enacted as budget trailer bill language, in AB 9 X4 (Evans), Chapter 9, Statutes of 2009 Fourth Extraordinary Session.

- risk" for developing a developmental disability with services through these Prevention Programs rather than through Early Start programs;
- Requiring families of children 0-3 years of age to use private insurance for services other than intake and assessment (already required for children 3 years and older);
 - Expanding the scope of services performed by non-licensed respite workers to include routine skilled services, such as medication administration and diabetic care;
 - Establishing temporary specific standards for RCs to use in authorizing respite services, including prohibiting use of day care services in place of respite services and restricting respite services to no more than 21 days of out-of-home respite services in a fiscal year or 90 hours of in-home respite services in a three-month period; and,
 - Temporarily suspending services such as social/recreation activities, camping services, educational services for school-aged children, and non-medical therapies such as specialized recreation, art, dance, and music.

4. Recent review of DDS oversight of regional centers

In addition to the development of cost-savings measures through the budget process, the state's fiscal crisis has also brought attention to RC fiscal and management practices and DDS' general oversight of RCs.

Assembly Accountability and Administrative Review (AAR) Committee hearing

In June 2010, the Assembly AAR Committee held a public hearing on regional center accountability and oversight. The committee focused on a lack of transparency, noting in a background paper prepared for the hearing that "[RCs] are not required to provide information about their operations or expenditures to the public." The paper also noted that "[t]here is currently no way to make . . . reports or complaints to the [RC], DDS, the Attorney General, or any other oversight agency in an anonymous manner because Whistleblower protections are not applicable." The paper concluded, based on input gathered by Committee staff, that, while "several [RCs] were cited as well-run organizations which operate in accordance with high standards of transparency and accountability," other RCs "were fraught with allegations of conflict of interest, over-billing, refusals to provide information, and retaliation towards those who raised concerns about the way their local [RC] operates."

The AAR Committee made several recommendations, including recommending that the protections of the California Whistleblower Protection Act be extended to RC employees, and that an audit be conducted of selected RCs. The AAR Committee also introduced a bill (AB 1589) that required RCs to disclose specified "related persons transactions" and

established whistleblower protections for RC employees modeled on the California Whistleblower Protection Act.⁵

California State Auditor Report

In response to a request from the Joint Legislative Audit Committee (JLAC), the Bureau of State Audits (BSA) examined fiscal policies and practices, and DDS' oversight of select RCs.

Scope

JLAC directed BSA to:

- Examine DDS' oversight responsibilities for the RCs and determine the extent to which DDS performs oversight with respect to the RCs selected for review.
- Select a sample of paid invoices and determine whether the activities described were reasonable and/or allowable under the law.
- Review a sample of service provider contracts, evaluate the policies and procedures used to award contracts, and determine what factors the regional centers considered when awarding contracts.
- Survey past and current service providers to determine if they were reluctant to file complaints for fear of retaliation or believed they experienced retaliation from the RCs.

In August 2010, BSA issued a report entitled, *Department of Developmental Services: A more uniform and transparent procurement and rate-setting process would improve the cost-effectiveness of regional centers*, California State Auditor, Bureau of State Audits, Report: 2009-118 (August 2010) (BSA Report).⁶ The report includes numerous recommendations, including that DDS should provide more oversight and issue more guidance to RCs for preparing and adhering to written procedures regarding rate-setting, vendor selection, and procurement processes to ensure consumers receive high-quality, cost-effective services that meet the goals of the consumers and the program. It was also recommended that DDS monitor RCs' adherence to laws, regulations, and new processes by enhancing the level of reviews to include examining rate-setting, vendor selection, and procurement practices at the regional centers and to adhere to its newly documented

⁵ AB 1589 was held in the Assembly Appropriations Committee and, thus, did not pass out of the Assembly. Late in the legislative session, the whistleblower provisions of AB 1589 were substituted for the provisions of another bill, already in the Senate, AB 435. After substantial further amendments, AB 435 was passed by the Senate Human Services Committee but was not further referred to a policy or fiscal committee prior to the final bill deadline.

⁶ A summary of the BSA Report is available on line at <http://www.bsa.ca.gov/reports/summary/2009-118>. The complete BSA Report is available at <http://www.bsa.ca.gov/pdfs/reports/2009-118.pdf>.

process for receiving, tracking, and investigating complaints from regional center employees.

Surveys of RC providers and employees

As part of its review, BSA surveyed a sample of past and current service providers, both to address the question of whether providers were reluctant to file complaints and to select the sample of RCs for purposes of auditing RC fiscal practices. While mass-mailed or e-mailed survey sampling of this type is convenient for reaching large numbers of people with minimal cost, the validity and reliability of the results of such surveys are often questionable. Because the surveys are not completed in a contained environment, for example, the sample needs to be motivated in order to respond and send it back, a factor which often results in a low completion rate and a response bias.

BSA's survey sample consisted of a random sample of approximately 3,000 past and current vendors who were not family members or consumers.⁷ The response rate was low: only approximately 8.5% (i.e., approximately 255) responded to *at least one question*. BSA Report, p.14. Because providers who have had negative experiences with a RC would likely be more motivated to respond, particularly with the low completion rate, a response bias cannot be ruled out.

BSA also examined the "tone" of the 6 RCs selected for the audit, including management's philosophy and operating style. Information for this portion of the review was obtained by administering a survey sent to employees of each of the 6 RCs. While the number of employees receiving the survey is not noted, 503 responded to at least some of the survey questions. The response to individual items was often much lower. As with the vendor survey, it is possible that employees who have had complaints or concerns with RC management would be more motivated to complete the survey than those who are more satisfied.

JLAC did not specifically direct BSA to survey the end-users and intended beneficiaries of RC services—consumers and family members. Therefore, BSA's review did not address such matters as consumer or family member satisfaction with the case management and other services provided by the 6 selected RCs, including whether needs were being met, concerns were being addressed, and non-cost-related factors—for example, least restrictive setting and consumer choice—were being adequately considered and respected in the IPP process. Consumer and family advocates contend that such input would have been useful in the context of the BSA review in evaluating the process used for selecting among service providers—particularly in light of concerns that have been raised with how some RCs have interpreted and implemented some of the recently adopted cost-savings measures, and with DDS' oversight in this area.

⁷ The BSA Report does not give a breakdown of how many current versus former providers were sent surveys or the response rate for each category.

Summary of Results

The BSA Summary of its report (see footnote 6) notes the following with respect to RC procedures:

Although the regional centers could improve their documentation of procedures in a few areas, most of the expenditures we reviewed for the purchase of services appeared allowable and were supported by proper vendor invoices. However, the regional centers do not document how rates are set, why particular vendors are selected to provide IPP-related services to consumers, or how contracts are procured, nor are they required to do so. As a result, the regional centers could not consistently demonstrate the rationale behind their rate-setting and vendor-selection decisions. In some cases, the ways in which the regional centers established payment rates and selected vendors had the appearance of favoritism or fiscal irresponsibility and did not demonstrate compliance with recent statutory amendments attempting to control the costs of purchased services.

...

[T]he lack of a formal, transparent rate-setting and vendor-selection process invites criticism that regional centers display favoritism toward certain vendors and makes it difficult, if not impossible, for [DDS] to ensure that the regional centers comply with a July 2009 amendment to state law requiring them to select the least costly available provider of comparable services.

In summarizing the results of the employee survey, the BSA Summary notes the following:

Employees at six locations we visited identified several problems in the working environment at the regional centers. Responses to a survey we conducted of these six regional centers' employees indicated that almost half of the roughly 400 regional center employees who responded to the questions concerning this topic do not feel safe reporting suspected improprieties to their management. ...

Regional center employees responding to our survey also frequently indicated that communication with management was not always positive and that rising caseloads reduce their ability to provide the highest-quality service to consumers. Although the Lanterman Act specifies that service coordinators should provide case management to an average of 66 consumers, depending on the type of consumer, the governor and the Legislature temporarily suspended this requirement effective February 2009 through June 2011. As a result, one respondent indicated that her unit averages 80 cases per service coordinator. Another respondent said that caseloads had increased by 20 percent. A program manager indicated

that these rising caseloads prevent service coordinators from building and maintaining relationships with the consumers and families they serve.

With respect to DDS' process for responding to RC employee complaints, the BSA Summary says:

We could not systematically evaluate [DDS'] process for responding to complaints from regional center employees, because, at the time of our fieldwork, [DDS] did not centrally log or track complaints from these employees and did not have a written process for handling such complaints. ... After we discussed these concerns with the department, in July 2010, [DDS] formally documented procedures that describe when and how it will investigate complaints from regional center employees, and informed the regional centers of this process.

Recommendations

Following are the BSA Report recommendations as set forth in the BSA Summary:

1. [DDS] should require that the regional centers prepare and follow written procedures for their purchase of services that detail what documents will be retained for payment of invoices.
2. To ensure that negotiated rates are cost-effective, [DDS] should:
 - a. Require regional centers to document how they determine that the rates they negotiate or otherwise establish are reasonable for the services to be provided.
 - b. Follow and refine, as necessary, its newly established fiscal audit procedures requiring a review of a representative sample of negotiated rates as part of its biennial fiscal audit of each regional center.
3. Unless rescinded by the Legislature, [DDS] should carry out its newly developed fiscal audit procedures for ensuring compliance with provisions of the Legislature's July 2008 rate freeze.
4. To ensure that consumers receive high-quality, cost-effective services that meet the goals of their IPPs, as required by state law, [DDS] should do the following:
 - a. Require the regional centers to document the basis of any IPP-related vendor selection and specify which comparable vendors (when available) were evaluated.
 - b. Follow the newly established fiscal audit procedures and review a representative sample of this documentation as part of its biennial waiver

reviews or fiscal audits to ensure that regional centers are complying with state law, and particularly with the July 2009 amendment requiring selection of the least costly available provider of comparable services.

5. To ensure that regional centers achieve the greatest level of cost-effectiveness and avoid the appearance of favoritism when they award purchase-of-service contracts, [DDS] should require regional centers to adopt a written procurement process that:
 - a. Specifies the situations and dollar thresholds for which contracts, requests for proposals, and evaluation of competing proposals will be implemented.
 - b. When applicable, requires the regional centers to notify the vendor community of contracting opportunities and to document the competitive evaluation of vendor proposals, including the reasons for the final vendor-selection decision.
6. To ensure that regional centers adhere to their procurement process, [DDS] should review the documentation for a representative sample of purchase-of-service contracts during the department's biennial fiscal audits.
7. To ensure that regional center employees have a safe avenue for reporting suspected improprieties at the regional centers, [DDS] should follow the process for receiving and investigating these types of allegations that it put into writing in July 2010 and should continue to notify all regional centers that such an alternative is available.
8. To ensure that appropriate action is taken in response to allegations submitted by regional center employees, [DDS] should centrally log these allegations and track follow-up actions and the ultimate resolution of allegations, as required by its new procedures.

DDS response

In its response to the BSA Report (pp. 77-83), DDS does not take issue with most of the recommendations. DDS describes steps it has taken or is in the process of taking (including issuing directives) to address the recommendations. In the case of specific instances of improprieties or noncompliance with statutory or waiver requirements identified in the BSA Report, DDS indicates that it has taken steps or will be following up with the individual RCs to ensure that appropriate corrective actions are taken.

With respect to employee complaint procedures and whistleblower protections, DDS says that it has already implemented the BSA recommendation by documenting its existing processes for receiving, logging and investigating whistleblower complaints, posting the process on its website, and instructing RCs to do the same. DDS has also instructed RCs to provide notification to employees, board members, consumers/families, and vendors about the complaint process and the right to make reports of improper activity to DDS.

DDS also says it will pursue contract amendments with the RCs requiring them to develop whistleblower policies and processes. The BSA Report (p. 85) notes that these changes were implemented too recently to evaluate for the report.

ARC v. DDS redux

An issue of contention between BSA and DDS is the extent to which DDS is authorized under the Lanterman Act to monitor and direct RC compliance with July 2009 budget trailer bill language requiring selection of the least costly available provider of comparable service. See, Recommendations 4.a. and 4.b., above; Welf. & Inst. Code § 4648(a)(6)(D).⁸ The issue is a significant one, not only as it relates to the specific statutory language at issue here but also related to DDS' monitoring and oversight responsibilities and authority with respect to RCs' implementation of the Lanterman Act, generally, and with respect to RC responsibility under other state and federal laws, including the integration mandate of the Americans with Disabilities Act as discussed in the U.S. Supreme Court opinion in *Olmstead v. L.C.* (1999) 527 U.S. 581.

DDS cites legal concerns related to its authority (as addressed in *ARC v. DDS*), and concerns with singling out this one factor in the vendor selection process without taking into account other legally required considerations in the IPP process and the selection of providers—including a provider's success in delivering quality services or supports, whether services or supports are provided in the least restrictive and integrated setting, and consumer choice. The BSA recommendation, according to DDS, would require it to improperly intercede in the IPP process and subject the state to litigation. BSA Report, pp. 80-82. DDS also cites practical concerns, stating that:

If DDS required extensive documentation of one factor and not all factors considered in the IPP process, the likely response would be litigation that DDS has overstepped its authority. If all factors are required to be documented, unnecessary delays in the provision of services could result. Additionally, this would exacerbate the issue cited by BSA of increased [RC] caseloads.

BSA Report, p. 81.

In response to DDS, BSA asserts that its recommendation falls within DDS' authority to promote cost-effectiveness in providing services. Moreover, BSA says, the statutory amendment requiring selection of "the least costly available provider of comparable service" was made after the Supreme Court's *ARC v. DDS* decision. BSA Report pp. 85-86. According to BSA:

⁸ The budget trailer bill language at issue says: "The cost of providing services or supports of comparable quality by different providers, if available, *shall be reviewed, and the least costly available provider of comparable service ... shall be selected*" (italicized language added in July 2009).

Although it is true that the Lanterman Act does describe other factors that should be considered when developing an [IPP], for only one of these factors—the least costly available provider of comparable services—does it specifically state "shall be selected." Thus, it is the Lanterman Act, as amended in July 2009, that expressly requires planning teams to consider the costs of comparable providers' services and expressly requires selection of the least costly provider. ... Additionally, because we do not believe our recommendation requires [DDS] to intercede in the [IPP] process, we fail to understand how requiring regional centers to document a duty that current law already requires would result in litigation.

Consumer and family advocates have expressed concerns with interpretations of the "least costly available provider of comparable services" provision that would prioritize cost over the other complex, interrelated considerations that go into the selection of providers of services and supports, which are also required under the Lanterman Act. They note that, in the context of the entire statutory provision from which the new language comes, and in the context of the Lanterman Act scheme as a whole, the selection of provider is not simply a matter of comparing costs and selecting the least costly provider.⁹

Thus, for example, the section in question also provides that the RC and consumer (or consumer representative, where appropriate) "*shall consider all of the following* when selecting a provider of consumer services and supports: (A) A provider's ability to deliver quality services or supports which can accomplish all or part of the consumer's [IPP]. (B) A provider's success in achieving the objectives set forth in the [IPP]. (C) Where appropriate, the existence of licensing, accreditation, or professional certification." Further, the July 2009 amendment to Paragraph (D), which contains the "least costly" language, also says that: "In determining the least costly provider, the availability of federal financial participation shall be considered" and "[t]he consumer shall not be required to use the least costly provider if it will result in the consumer moving from an existing provider of services or supports to more restrictive or less integrated services or supports."¹⁰

⁹ Consumer and family member input could provide valuable information on how RCs are interpreting and applying the "least costly provider of comparable service" provision, including whether cost is being considered to the exclusion of other factors.

¹⁰ The Lanterman Act also mandates, for example, the following (emphases added):

It is the intent of the Legislature that persons with developmental disabilities *shall* have rights including, but not limited to, the following:
(a) A right to treatment and habilitation services and supports in the least restrictive environment. ... Such services *shall* protect the personal liberty of the individual and *shall* be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services, or supports.

Welf. & Inst. Code § 4502.

The right of individuals with developmental disabilities to make choices in their own lives requires that all public or private agencies receiving state funds for the purpose of serving persons with developmental disabilities, including, but not limited to, regional centers, *shall* respect the choices made by consumers or, where appropriate, their parents, legal guardian, or conservator.

Welf. & Inst. Code § 4502.1.

The determination of which services and supports are necessary for each consumer *shall* be made through the [IPP] process. The determination *shall* be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and *shall* include consideration of a range of service options proposed by [IPP] participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option.

Welf. & Inst. Code § 4512(b).

The regional center *shall* secure services and supports that meet the needs of the consumer, as determined in the [IPP], and within the context of the [IPP], the planning team *shall* give highest preference to those services and supports which would allow minors with developmental disabilities to live with their families, adult persons with developmental disabilities to live as independently as possible in the community, and that allow all consumers to interact with persons without disabilities in positive, meaningful ways.

Welf. & Inst. Code § 4648(a)(1).

In implementing individual program plans, regional centers, through the planning team, *shall* first consider services and supports in natural community, home, work, and recreational settings. Services and supports *shall* be flexible and individually tailored to the consumer and, where appropriate, his or her family.

Welf & Inst. Code § 4648(a)(2).

No service or support provided by any agency or individual *shall* be continued unless the consumer or, where appropriate, his or her parents, legal guardian, or conservator, or authorized representative, ... is satisfied and the regional center and the consumer or, when appropriate, the person's parents or legal guardian or conservator agree that planned

Of note, the comparison required by the 2009 trailer bill language is only among providers of "comparable services"; however, comparable service is undefined. In the context of the Lanterman Act, such a determination would potentially include consideration of the other mandated factors listed in Section 4648(a)(6)(D), as well as those specified throughout the act (see, e.g., footnote 10, above), such as individual need, consumer/family member/conservator choice and satisfaction, service quality, progress in achieving objectives, and least restrictive setting.

DDS has not issued and apparently has no plans to issue further directives or other guidance on implementation of this provision. This issue exemplifies the broader issue of the nature and extent of DDS' authority to direct RCs—not only with respect to fiscal practices but also, in general, with respect to RCs' compliance with the requirements of state and federal law. It is an area that may require legislative clarification.

5. Conclusion

The Lanterman Act service system is large and complex, with responsibility for providing services to over 240,000 individuals shared among tens of thousands of public and private entities. Particularly in the current challenging fiscal environment, ensuring integrity, accountability, and transparency in the system is critical.

The purpose of this hearing is to share information on oversight of the RCs, and to begin a discussion of ways to increase efficiency and cost effectiveness within the system while achieving the underlying purpose and keeping the promise of the Lanterman Act. Questions that may be addressed include, among others, the following:

- Whether DDS is sufficiently monitoring RCs to ensure their compliance not only with respect to required fiscal policies and practices but also with respect to the law related to the development and implementation of IPPs consistent with consumer choice and the provision of services in least restrictive settings.
- Whether DDS has sufficient authority under the Lanterman Act to ensure that RCs are complying with their obligations to consumers as set forth in the Lanterman Act and federal law, and are doing so in a cost-effective manner.
- Whether there are ways to increase DDS' ability to monitor RCs' fiscal and other policies and practices that will not impinge on the integrity of the IPP process.
- Whether RC fiscal practices—particularly with respect to rate-setting and provider selection—are sufficiently transparent to ensure accountability and cost-effectiveness in their use of public funds.

services and supports have been provided, and reasonable progress toward objectives have been made.

Welf. & Inst. Code § 4648(a)(7).

- Whether the right balance has been struck between allowing flexibility in the operation of RCs, on the one hand, and establishing statewide standards and guidelines for RC fiscal practices and the IPP process, on the other hand.
- Whether there is adequate communication—including training and information sharing—between DDS and RCs, among RCs, and between RC management and employees—on efficient and cost-effective practices and procedures related to such matters as rate-setting, provider selection, resource development, the IPP process, and employer-employee relations.
- Whether policies and procedures are in place to ensure that RC employees are adequately protected against retaliation when raising issues concerning improper or inefficient RC policies and practices.

This hearing is intended to be the beginning not the end of a discussion. It is hoped that one result will be more voluntary collaboration and cooperation among RCs and between RCs and DDS to share ideas and best practices. The other anticipated outcome of this hearing will be ideas and recommendations for ways to address issues and concerns related to RC oversight, including through, as appropriate, administrative directives, contract provisions, regulations, and/or legislation.