Case No. 04-15228

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STEPHEN SANCHEZ, et al.

Plaintiffs-Appellants,

v.

GRANTLAND JOHNSON, et al.,

Defendants-Appellees

On Appeal from the United States District Court
for the Northern District of California
No. CV-00-01593-CW
Honorable Claudia Wilken, Presiding

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INTRODUCTION

Plaintiffs alleged that California's programs for delivering services to over 180,000 developmentally disabled persons violate the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act (§ 504) and Title XIX of the Social Security Act (Medicaid Act). Plaintiffs sought an order "enjoining defendants at least to double current community direct care wages and benefits . . ." a remedy they conceded would cost California $1.4 billion annually. The district court properly concluded that not one of the named Plaintiffs was unjustly institutionalized, that the proposed modification was unreasonable, ineffective and would fundamentally alter the California's programs. (Appellants' Excerpts of Record on Appeal ("ER"), Vol. 10, Tab 253, pp. 38-39, 42-45 ("Vol. #/Tab #/P. #").) The evidence is also undisputed that California is committing millions of dollars statewide – as much as $200,000 per person per year – to the highly individualized task of developing programs that assure that those persons in institutions can find appropriate community placements. (Appellees' Supplemental Excerpts of Record ("SER"), Vol. 1, Tab 4, at p. 96.) The district court thus found that California has a comprehensive, effectively working plan for deinstitutionalization. (ER 10/253/45.) The court also correctly found that Plaintiffs had no right to enforce their Medicaid claim under 42 U.S.C. § 1983, and dismissed the remainder of Plaintiffs' case. (ER 10/507/9.)

STATEMENT OF ISSUES

1. In an action seeking injunctive relief on behalf of a statewide class of persons with developmental disabilities, on the theory that class members have been institutionalized in violation of the ADA, may the court issue injunctive relief if it finds that none of the named Plaintiffs have been improperly institutionalized?

2. In the action described above, where the Plaintiffs contend that the class is improperly institutionalized because of a disparity in wages between state employees and employees of private agencies who provide community care, did the district court abuse its discretion in finding that the Plaintiffs' proffered evidence was insufficient to warrant the requested class-wide injunction because the evidence failed to establish a widespread pattern of illegal institutionalization?

3. In the action described above, was summary judgment properly granted to Defendants under *Olmstead v. L.C.*, 527 U.S. 581 (1999) where the evidence:

   a. showed no causal relationship between increasing the wages of employees in private agencies and increasing the rate of deinstitutionalization; or

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b. established that the state has a comprehensive, effectively working plan to move persons with developmental disabilities from institutions into community settings; or

c. failed to demonstrate that their proposed accommodation – increasing wages to employees of private agencies at an additional annual cost of $1.4 billion per year – is reasonable and the Defendants demonstrate the accommodation would result in a fundamental alteration to the state's program of services?

4. Does 42 U.S.C. § 1396a(a)(30)(A) unambiguously confer a right on Medicaid recipients enforceable under § 1983?

STATEMENT OF THE CASE

Except as follows, Defendants agree with the Plaintiffs' Statement of the Case.

The district court denied Plaintiffs' motion for summary judgment in its entirety and granted in part and denied in part the Defendants' motion for summary judgment. (ER 10/253/1-59.) Plaintiffs' first cause of action under the ADA and § 504 alleged that Defendants had discriminated against Plaintiffs by permitting wages in state-operated institutions to be higher than wages paid to employees of community-based private providers. The court ruled that Plaintiffs

failed to establish that increasing wages would significantly reduce the numbers of persons allegedly subject to unjustifiable institutionalization, (*Id.* at 40-41); the relief proposed by Plaintiffs – a $1.4 billion increase in wages for direct-care community-service workers – would constitute a fundamental alteration of Defendants' programs (*Id.* at. 43); Plaintiffs failed to overcome California's showing that it has in place a comprehensive, effectively working plan for placing persons in the community (*Id.* at 45); and, Plaintiffs' evidence suggesting some unjustified institutionalization is "isolated" and "sporadic" and does not warrant class-wide relief. (*Id.* at 46.)

SUMMARY OF ARGUMENT

The district court correctly granted Defendants' motion for summary judgment on two grounds: Plaintiffs' failure to demonstrate material factual disputes that if resolved in their favor would establish certain elements of their prima facie case, and the insufficiency of plaintiffs' evidence to support the issuance of class-wide relief.

The district court correctly held that Plaintiffs do not have a private right of action under § 1983 because § 1396a(a)(30)(A) does not establish an unambiguous congressional intent to confer a private right of action on Medicaid recipients.

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STATEMENT OF FACTS

1. California's Statutory Scheme for Providing Services for the Developmentally Disabled.

In 1977, California enacted the Lanterman Act, a comprehensive statutory framework to provide a "pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life." Welf. & Inst. Code, §§ 4500-4846.[1]

> The purpose of the statutory scheme is...to prevent or minimize the institutionalization...and their dislocation from family and community (§§ 4501, 4509, 4685), and to enable them to approximate the pattern of everyday living of nondisabled persons...to lead more independent and productive lives in the community (§§ 4501, 4750-4751).

ARC v. Department of Developmental Services, 38 Cal. 3d 384, 388 (1985).

The Department of Developmental Services ("DDS") "has jurisdiction over the execution of the laws relating to the care, custody, and treatment of developmentally disabled persons" (often called "consumers"). § 4416. These services are provided through a unique administrative structure incorporating private and public institutions. The Act creates 21 Regional Centers ("RCs"), operated by private, nonprofit community agencies under contract with DDS. RCs

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[1] Statutory references are to provisions in the California Welfare & Institutions Code unless otherwise stated, and attached in Tab A of the Addendum.

are charged with providing consumers "access to the facilities and services best suited to developmentally disabled persons throughout their lifetime." § 4620.

RCs coordinate services provided to consumers from assessment and diagnosis to 24-hour-out-of-home care and every level-of-care in between. §§ 4620, 4630, 4648. (ER 7/187/ 3-4.) Each consumer is assigned a service coordinator who helps develop an Individual Program Plan ("IPP") for services, and assists the consumer and their family in obtaining services. § 4646. (ER 7/187/4.)

RCs determine the services to be rendered and arrange their delivery. §§ 4620, 4630, 4648, 4651. DDS is responsible for developing uniform systems of accounting, budgeting, and reporting (§ 4631(a)), setting rates for out-of-home care (§ 4681,) auditing, and funding RCs. § 4780.5. DDS "is basically limited to promoting the cost-effectiveness of the operations of RCs, and does not extend to the control of the manner in which they provide services or in general operate their programs." *ARC*, 38 Cal. 3d at 390.

2. The Scope of Services Provided to Consumers.

DDS administers a system providing extensive services in a variety of settings. Most consumers live in their own homes. DDS provides a number of residential alternatives for consumers living out-of-home that are either operated or funded by DDS. (ER 7/187/5-8.)

The DDS directly operates five large Developmental Centers ("DCs") and two smaller facilities located throughout California. These facilities provide services to individuals who have been determined by RCs to require programs, training, care, treatment and supervision in a structured health facility on a 24-hour basis. (ER 7/187/13.)

Other living situations include: (1) Intermediate Care Facilities ("ICF/DDs"), licensed health facilities providing 24-hour-per-day services; (2)Community-Care Facilities ("CCFs"), licensed facilities providing 24-hour non-medical community-based residential care to individuals who are in need of personal services, supervision, and/or assistance essential for self-protection or sustaining activities of daily living; (3) Family-Home Agencies, approved family homes for up to two adult consumers per home to reside with a family; and (4) Supported Living Services ("SLS"), which consist of a broad range of services to adult consumers choosing to live in their own homes. (ER 7/187/6-8.)

In addition to residential services, DDS funds many non-residential programs to assist consumers in achieving maximum independence, including day-programs, vocational programs, transportation, healthcare, respite services, community integration training, community activities support, adaptive skills training, behavior management, tutors, special education, recreation therapists, counselors, infant development specialists, and speech pathologists.

(ER 7/187/9-10.)

3. The Funding Structure.

The services provided under the Lanterman Act are a statutory entitlement. California is the only state that makes services to persons with developmental disabilities an entitlement regardless of family income. (SER 1/2/36.) For consumers receiving care in the community, his or her RC, with the agreement of the consumer, selects vendors to provide services. In most cases, DDS sets the rate at which vendors are reimbursed by the state for their services. (ER 7/187/10.)

The reimbursement rates paid by the state depend on the nature of the service provided. For instance, ICFs are reimbursed at rates established by the Department of Health Services under the Medi-Cal program. The rates for CCFs are specified in regulations of DDS and vary depending on the level of care. Day programs receive a daily or hourly-rates based on vendor cost-statements. SLS agencies negotiate contracts with RCs on an individual basis for each consumer. (ER 7/187/10-11.)

Some services are eligible for reimbursement from federal sources. Recipients must essentially be indigent to be eligible. The Medicaid agency provides matching funds equal to 50% of the expenditures for these services. (ER 7/187/11.)

California is aggressively seeking to enhance federal matching funds. However, California will never obtain federal matching funds for all services currently provided. While all consumers are legally entitled to services funded by state general funds, some consumers will not qualify for matching funds. Assuming that all of the prerequisites for full participation were satisfied, the Department calculated in 2002 that it could receive $115,068,000 in additional federal funds out of a total DDS budget of $2.2 billion. (ER 7/187/11-12; ER 6/184/3.)[2]

4. The Current Developmental Center Population.

The remaining population in the DCs consists primarily of consumers who: (1) oppose discharge, or whose families are opposed to discharge if that opposition would prevent successful placement; (2) require significant skilled medical care and whose community placement has to be made cautiously to avoid health and safety risks; and (3) those who exhibit extreme self-injurious, assaultive or anti-social behavior. (ER 7/187/2; SER 1/141.)

DC residents present very significant challenges to placement in the community. In general, DC residents suffer from more profound levels of

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[2] Plaintiffs improperly contest Ms. Marquez' testimony with the transcript of her deposition taken after the order granting summary judgment. Defendants have filed a motion to exclude this evidence from Appellants' Excerpts of Record on appeal.

retardation, more serious health conditions and difficult-to-manage behaviors. (ER 6/186/4-5; ER 6/183/4-6; SER 1/142.) The management of DC residents is further complicated by the fact that many present both significant medical needs and very difficult behaviors. (ER 6/186/6; SER 1/151-152.)

The severe conditions that DC residents exhibit do not automatically prevent community placement. They do, however, represent significant challenges to staff seeking living arrangements with the right mix of services to assure stability and safety. Because needs vary widely, residents require many different types of services in order to live successfully in the community. (ER 7/18714; ER 6/1834.)

5. The Community Placement Plan: California's Program to Place DC Residents in Community-Based Settings.

DDS collaborates with RCs to develop strategies specifically designed to encourage the development of community-based care. (ER 7/187/14.) As part of this effort, DDS developed a system of Community Placement Plans ("CPP") that moves residents from DCs to community residential settings on a carefully planned and individualized basis. (*Id.*; ER 6/183/8.)

The RCs identify needed services for each consumer in the CPP and identify available community services. It may be necessary for the RC to develop resources that do not yet exist. Services may include insuring the proper level-of-

care, one-on-one behavioral or program support in residential and/or day programs, extended pre-placement activities, facility visits, and specialized supports to address cultural, physical and mental health needs, and social and day program needs. DDS provides substantial funding for development of services necessary to implement individual CPPs. The CPP can also fund one-time start-up costs to assist the development of new services. §4469.2. (ER 6/183/9.)

Resource development is time-consuming and complex. The cost of services identified in the CPP is highly individualized. The 2002/2003 CPP allocates as much as $286,000 for the first year that a consumer is discharged from a DC. The budget also estimates the costs for the second year following community-placement. The 2003/2003 CPP allocates $18,662,000 for 183 consumers – an average of nearly $102,000 per year per consumer to maintain the community placements after the first year. (ER 6/183/10.)

Once the resources are developed, additional planning and preparation are necessary to achieve a successful placement. Consumers identified as ready for community placement follow a specific plan for transition and discharge from the DC. (ER 6/183/13.)

DDS commits substantial resources to the task of encouraging the development of support services in the least-restrictive setting possible. (ER 7/187/15.) The 2002-2003 budget increased CPP funding well over 60%,

from $29,777,000 to $50,220,000. (SER 1/150.) This sum includes $1,462,000 to conduct assessments on an estimated 260 consumers and $3,302,000 to develop 42 new CCFs and 10 new ICFs. (ER 6/183/9.)

DDS is continuing efforts to reduce the DC population, and expects the closure of another DC by 2007. Two DCs have already closed due to community-placements of over 3300 consumers since 1993. The Lanterman Act promises whatever services are necessary, so DCs serve as a kind of "safety net" for consumers in behavioral, medical or psychological crises. (ER 7/187/13-16.)

6. Declines in DC Population and Increases in Caseload and Expenditures for Community-Based Care.

As a result of California's policies and efforts, the population in the DCs has fallen dramatically in the last 10 years, from 6% to 2% of the total population. (ER 6/186/3-4.) During this period, the state has increased the level of funding to community-based services that far exceeds the rapid growth in caseload and, as a result, the statewide network of community-based services has grown substantially. (ER 6/186/2; ER 6/186/3; SER 2/10/441.) There has been a steady growth in the numbers of agencies providing every type of service. (ER 6/186/20-21; ER 7/188/3; SER 1/3/51-68.) Plaintiff-organizations admit that their programs have grown dramatically. (SER 2/10/357; SER 2/10/350.)

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California's record of placing consumers in the community exceeds the national average with regard to residential placements, SLS, family-support programs, and the percentage of consumers living in small community facilities. The percentage of consumers living in large institutions is less than the national average. (SER 2/10/438-441.)

7. The Named Plaintiffs and Purported Class Members.

The district court described the situations of each of the seven named plaintiffs, which Defendants hereby incorporate. (ER 10/253/29-33.) The court found no evidence of unjustified institutionalization and only a hypothetical risk of institutionalization for the five individuals living in the community. (ER 10/253/38-39.) Plaintiffs **do not** challenge those factual findings on appeal.

With regard to unnamed plaintiffs, Plaintiffs submitted five *In Re Hop*[3] Orders and 23 IPPs of DC residents. (ER 5/6/48, 48-66, 83-159, 160-211; ER 3/170/1-177.) These records describe people whose medical and/or behavioral conditions require specialized services, making community placement very challenging. Medical conditions include history of choking, seizures, tracheostomy, cerebral palsy with spastic diplegia, macerated hands, and tinea corpora. Severe behaviors include self-injurious behavior, aggressive behavior

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[3] Pursuant to *In Re Hop* 29 Cal. 3d 82 (1981), a placement hearing and annual review is conducted whereby the court determines the appropriateness of an individual's placement in a DC.

that has resulted in emergency psychiatric admissions, lack of safety awareness, suicidal ideation, and AWOL.

ARGUMENT

I. PLAINTIFFS CANNOT PROVE THEIR ADA AND SECTION 504 CLAIMS

A. Plaintiffs' Theory of Liability under the ADA and Section 504.

Plaintiffs' theory of liability begins with two propositions. First, they allege that large numbers of persons with developmental disabilities are being subjected to or are at risk of unnecessary institutionalization. (ER 1/1/ 22.) Second, they contend employees of private community-based programs that serve disabled persons earn less than civil service employees who work at the state-operated DCs. (ER 1/1/23.) Plaintiffs then hypothesize that improper institutionalization is caused by the wage differential. (ER 1/1/25-28.) Their proposed remedy would establish wage parity at an annual cost of $1.4 billion, which would, under Plaintiffs' theory, permit private community-based facilities to hire and retain more and better employees, who will create additional community-based programs, which will, in turn, allow more persons to be moved to community settings.

B. The Standard of Review on Plaintiffs' ADA and Section 504 Claims.

The district court granted summary judgment for Defendants on Plaintiffs'

claims under the ADA/Section 504 on two separate grounds. A separate standard of review applies for each ground.

The court found that Plaintiff' evidence did not warrant class-wide injunctive relief because the evidence did not support a finding of 'systemwide' violations of the ADA. (ER 10/253/45-46.) This ruling is reviewed for abuse of discretion. "We review a summary judgment granting or denying a permanent injunction for abuse of discretion and application of the correct legal principles." *Midgett v. Tri-County Metropolitan Transportation District of Oregon*, 254 F. 3d 846, 849 (9th Cir. 2001).

The court also granted summary judgment on the ground that Plaintiffs had failed to raise factual disputes, which if resolved in their favor, would establish certain elements of their prima facie case. This ruling is reviewed *de novo*. *Weyer v. Twentieth Century Fox Film Corp.*, 198 F. 3d 1104, 1108 (9th Cir. 2000).

C. The District Court Did Not Abuse Its Discretion in Granting Summary Judgment Because Plaintiffs' Evidence Does Not Support System-Wide Injunctive Relief.

1. Standards for issuance of class-wide injunctive relief.

Plaintiffs sought injunctive relief mandating wage increases for each direct-care employee of each community-based provider in California. Plaintiffs must therefore advance evidence that this remedy is necessary to prevent widespread, wholesale violations of the ADA. *Hodgers-Durgin v. De La Vina*, 199 F. 3d 1037,

1042 (9th Cir. 1999). Plaintiffs do not meet this standard merely by arguing they are "subject to a governmental institution that was not organized or managed properly." *Id.*, quoting *Lewis*, 518 U.S. at 349-50 (1996). Furthermore, Plaintiffs "must contend with the well-established rule that the Government has traditionally been granted the widest latitude in the dispatch of its own internal affairs." *Midgett*, at 254 F. 3d at 850, quoting *Rizzo v. Goode*, 423 U.S. at 378-79.

Two principles governing the issuance of class-wide injunctive relief apply in this case. First, to obtain class wide injunctive relief, the **named** Plaintiffs must show that they personally have been injured, not that injury has been suffered by unidentified class members. *Lewis*, 518 U.S. 343, quoting *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 40 n. 20 (1976); *Hodgers-Durgin*, 199 F. 3d at 1045. Second, to obtain class-wide injunctive relief, plaintiffs' evidence must establish *systematic* discrimination. Proof of sporadic acts of discrimination is not sufficient. See *Franks v. Bowman*, 424 U.S. 747, 751 (1976); *International Brotherhood of Teamsters v. United States*, 431 U.S. 324, 357-360 (1967); *Armstrong v. Davis*, 275 F. 3d 849, 861 (9th Cir. 2001). To make this showing, plaintiffs must establish that the state has either a "written policy" or a "pattern of officially sanctioned . . . behavior" of involuntary institutionalization of disabled persons, and that this unjustified institutionalization of disabled people is "widespread enough to justify system-wide relief." *Id.* at 861 (citations

omitted); at 870 (quoting *Lewis*, 518 U.S. at 359).

2. Plaintiffs are not entitled to systemwide injunctive relief on behalf of the class because they failed to demonstrate that the named Plaintiffs have been subjected to unjustified institutionalization.

The district court found that none of the named Plaintiffs were unjustifiably institutionalized or at risk of being unjustifiably institutionalized in violation of the ADA and Section 504. (ER 10/253/38.) Five of the named Plaintiffs were currently living in the community and there was no "more than a hypothetical risk that these individuals may be institutionalized." (ER 10/253/39.) Only two of the named plaintiffs resided in institutions, but because of the "States's ongoing, active efforts to place these individuals in the community in situations that meet their individualized needs," the court concluded that "their current institutionalization cannot be deemed 'unjustified.'" (*Id.*) **On appeal, Plaintiffs do not challenge this finding**. Instead, Plaintiffs rely exclusively on evidence concerning the circumstances of unnamed class members. (Appellants' Opening Brief ("AOB"), pp. 14, 50.) Such evidence, as a matter of law, is insufficient to support a claim for class wide injunctive relief:

> Unless the named plaintiffs are themselves entitled to seek injunctive relief, they may not represent a class seeking that relief. Any injury unnamed members of this proposed class may have suffered is simply irrelevant to the question whether the named plaintiffs are entitled to the injunctive relief they seek.

Hodgers-Durgin, 199 F. 3d at 1045.

3. Plaintiffs failed to provide sufficient evidence of systematic violations of the ADA to support issuance of a class-wide injunction.

The district court found that "[t]he evidence of unjustified institutionalization provided by Plaintiffs is "isolated" and "sporadic," and therefore does not warrant class-wide relief." (ER 10/253/46.) Plaintiffs do not dispute that under *Lewis v. Casey*, *supra* and *Armstrong v. Davis*, *supra*, they are entitled to class-wide injunctive relief only if the prove widespread and systematic unjustified institutionalization. On appeal, they contend that they have raised material issues of fact, which if resolved in their favor, would meet this burden. (AOB, pp. 48-50.) However, it is not sufficient for Plaintiffs to argue that district court "improperly resolved factual disputes." (*Id.*) It is Plaintiffs' burden to demonstrate that the trial court abused its discretion. (See section I.B. above.) An abuse of discretion occurs if the district court bases its decision on an erroneous legal standard or on clearly erroneous findings of fact. *U.S. v. Alisal Water Corp.*, 370 F. 3d 915, 921 (9th Cir. 2004). A finding is clearly erroneous when "although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." *Anderson v. City of Bessemer City*, 470 U.S. 564, 573 (1985). A review of he evidence cited by Plaintiffs demonstrates that the district court did not abuse its

discretion in finding Plaintiffs' evidence insufficient.

Plaintiffs rely heavily on evidence that the pace of deinstitutionalization is slower now than in the early 1990s. (AOB, p. 49.) However, it is undisputed that the state depopulated its institutions by first placing in the community the least severely disabled residents. (SER 1/6/3-4.) The developmental centers now house those residents who are the most difficult to place. (ER 6/186/4-6.) Plaintiffs also cite "evidence" that some 1100 persons have been "recommended for community placement." The undisputed evidence is that the source of this data is unreliable and that the data may reflect recommendations that represent only a long term goal (SER 1/4/93-94), and the district court so found. (ER 10/253/19-20.) Plaintiffs do not produce evidence that the data upon which they rely is reliable or that it demonstrates that any of the persons identified are improperly institutionalized. Instead, Plaintiffs contend that appellees have failed to explain the meaning of "recommended for community placement." (AOB, p. 14.) In so arguing, Plaintiffs put the shoe on the wrong foot. It is their burden to show that the cited evidence will support an inference of improper institutionalization. Their failure to advance admissible evidence that the data they cite support such a conclusion is fatal to their claim.

The district court did find that Plaintiffs had marshaled enough evidence that "suggests unjustified institutionalization" as to "several" unnamed class

members. The court cited *In re Hop* reports, a declaration from one Regional Center director and some IPPs. However, these represent only a handful of the over 3000 persons living in institutions. Furthermore, the evidence only "suggests" rather than "proves" or "establishes" that the institutionalization is unjustified as to any of the cases cited. Based on this record, the district court concluded that the evidence, at best, shows sporadic and isolated instances of possible violations. "[T]hese occasional problems do not, without more, establish a violation of the ADA." *Midgett*, 254 F. 3d at 850. Accordingly, the district court did not abuse its discretion in finding that Plaintiffs' evidence insufficient to support class-wide injunctive relief.

D. Plaintiffs Failed to Show Factual Disputes, Which If Decided in Their Favor, Would Establish Certain Elements of Their Prima Facie Case.

1. The legal standards for Plaintiffs' claims under the ADA and Section 504.

Plaintiffs' complaint alleges a cause of action arising under Title II of the ADA (Title II) and Section 504 of the Rehabilitation Act (Section 504). Title II prohibits public entities from excluding a qualified individual with a disability from participating in programs or services offered by the entity. 28 U.S.C. § 12132. Section 504 imposes a similar prohibition against discrimination in any program receiving federal funding. 29 U.S.C. § 794. The elements of a cause of

action are the same under both statutes, *Rodriguez v. City of New York*, 197 F. 3d 611, 618 (2d Cir. 1999), as is the standard for summary judgment. *Zukle v. Regents of University of California*, 166 F. 3d 1041, 1054 & n.11 (9th Cir. 1999).

In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the court held that "unjustified institutional isolation of persons with disabilities is a form of discrimination." *Id.* at 600. Therefore, public entities may not discriminate against persons with disabilities by requiring that they "relinquish participation in community life they could enjoy given reasonable accommodations." *Id.* at 601; see also 28 CFR §§ 41.51(d), 35.130(d). However, the Court emphasized that responsibility imposed by anti-discrimination statutes "is not boundless." *Olmstead*, 527 U.S. at 603. Title II does not "impel States to phase out institutions, placing patients in need of close care at risk." *Id.* at 605. Some persons with disabilities may require institutional placement to stabilize acute symptoms and for others "no placement outside the institution may ever be appropriate." Therefore, "Title II provides only that qualified individuals with a disability may not be subjected to discrimination." *Id.* at 601-602.

A state may rely on the reasonable assessments of its own professionals in determining whether an individual "meets the essential eligibility requirements for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting."

Id. (internal quotations and citations omitted.) Nor does federal law require community placement of an individual who desires to remain in an institution. *Id.*

Furthermore, the statutes prohibiting discrimination on the basis of disability do not mandate immediate transfers of every individual whose treatment professionals have determined that community placement is appropriate. Title II regulations require public entities only to make "reasonable modifications in policies, practices, or procedures" and only when such modifications "are necessary to avoid discrimination on the basis of disability." 28 CFR § 35.130(b)(7). In addition, such modifications are not required if "the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." *Id.*

The *Olmstead* decision was careful to explain that a state's duty under Title II is limited by the resources available and the needs of other persons for whom the state has responsibility. In *Olmstead*, the court reversed the Eleventh Circuit which had given "an unduly restrictive" reading of the defenses available to a state and instead fashioned a defense that permits a state to take into account its obligation to all disabled persons:

> Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and

> treatment of a large and diverse population of persons with mental disabilities.

Id. at 597, 604.

As an example of how a state may meet its duty under Title II, the court explained that a state would meet the reasonable modification standard if "it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated . . . ." *Id.* at 605-606.

In light of all of these qualifications, to establish a prima facie case under Title II for discrimination based on alleged unjustified institutionalization, Plaintiffs must show: [1] the state's treatment professionals have determined that community placement is appropriate, [2] the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, [3] some act or omission of the state is causing the "unjustified instituitonalization, and [4] the placement can be reasonably accommodated, taking into account (a) the resources available to the state and (b) the needs of others with mental disabilities. *Frederick L. v. Department of Public Welfare*, 364 F. 3d 487, 492 (3rd Cir. 2004) (citing *Olmstead*, 527 U.S. at 587); see also *Wong v. Regents of the University of California*, 192 F. 3d 807, 816-17 (9th Cir. 1999).

As explained below, the district court correctly found that Plaintiffs have not raised factual issues which would defeat summary judgment on the third and fourth elements, and that the undisputed evidence establishes that Defendants have met their burden of proving that Plaintiffs' proposed $1.4 billion annual increase in wages would constitute a fundamental alteration.

In addition to not establishing elements of their claim and failing to rebut the fundamental alteration defense, Plaintiffs' analysis of Title II and § 504 is both incomplete and inaccurate. Plaintiffs' contention that "federal law mandates California deinstitutionalize developmentally disabled except in limited circumstances," (AOB, p. 45), does violence to the Supreme Court's careful analysis in *Olmstead* which strengthened a state's defense to a deinstitutionalization case. Additionally, Plaintiffs misapply the applicable burden when they argue that they must prevail unless the state can demonstrate that it has a "comprehensive plan" and that "provision of community based services will 'fundamentally alter' the nature of the services." (AOB, p. 48.)

2. Plaintiffs have not raised factual issues relating to a causal relationship between wages and institutionalization.

Plaintiffs contend that improper institutionalization has at its roots in the insufficient wages and benefits allegedly paid employees of community-based providers. Indeed, the class definition includes Plaintiffs' theory of causation.

The class is defined as 1) all persons unnecessarily placed in institutions "because the wages and benefits of community-based direct care workers are insufficient to support or make available sufficient, quality community based services . . . ," 2) all persons at "risk of unnecessary institutionalization because the wages and benefits of community based direct care workers threaten to close, terminate or render [community-based] services inadequate or of insufficient quality," and 3) all persons living with their family who are at risk of unnecessary institutionalization for the same reason. (ER 1/108/5-6.) Therefore, plaintiffs must show not only the existence of unnecessary institutionalization as a system-wide problem, but that it is caused by inadequate wages and benefits paid to community-based workers.

Certainly none of the evidence cited by Plaintiffs establishes their theory of causation. In fact, Plaintiffs have not identified to either the district court or this Court a single person who is improperly institutionalized because of "inadequate" wages. The conclusory opinion by a regional center director to that effect is insufficient to avoid summary judgment. *Lujan v. National Wildlife Federation*, 497 U.S. 871, 889 (1990); *Hal Roach Studies v. Richard Feinerand Co.*, 896 F. 2d 1542, 1550-51 (9th Cir. 1990); *Taylor v. List*, 880 F. 2d 1040, 1045 (9th Cir. 1989).

Plaintiffs misstate the record in attempt to meet their burden on causation. They contend that Defendants' CPP generates placements by "authorizing rates

which average twice the usual community service rates and concomitantly, support twice the direct care wages and benefits." (AOB, p. 52.) There is no evidence – including the declarations cited by Plaintiffs – in the record that supports this claim. Neither Mr. Shorter nor Mr. Clark, both regional center directors, had any data about wages paid by providers under the CPP process. Mr. Shorter merely *assumed* that because moving a consumer from a DC under the current CPP costs twice what it cost during the 1990's, that the wages providers pay are double those paid under the existing rate structure. Similarly, Mr. Clark confirmed that he does not have a quantitative basis for assessing the level of wages paid direct-care staff for CPP placements, and that "realistically" it would be two or three years before the regional center would have "wage information to show any difference between activities under the CPP and existing services delivery." (ER 7/213/4.) Thus, the *total* cost of a placement does not permit any conclusion about the rates paid to the provider or the wages paid to the provider's staff. Mr. Clark acknowledged that the increase of per client costs under the CPP is "being driven by the services and supports under the new CPP plan being provided to difficult to serve people in more individualized, specialized settings." (ER 7/213/4-5.) Therefore, the additional number of services needed by the difficult-to-serve persons who make up the remaining population in the DCs, and not substantially increased wages, accounts for the higher cost per placement of moving persons into the community

pursuant to the CPP process. (SER 1/142; ER 6/186/4-6; ER 7/187/14; SER 1/90.)

Moreover, just because Defendants have funded services necessary for deinstitutionalization at rates outside the existing rate structure under § 4669.2, does not establish that it is necessary in every case. The undisputed evidence is that the CPP involves many additional measures that do not require that rates be increased. Plaintiffs never identified a single consumer who was placed in a community setting due to increased rates or wages.

3. Plaintiffs cannot show that the accommodation they propose is a reasonable one.

Plaintiffs' claim also founders on the requirement that their proposed remedy be a reasonable one. The reasonableness of a particular accommodation "depends on the individual circumstances of each case" and "requires a fact-specific, individualized analysis of the disabled individual's circumstances and the accommodations that might allow him to meet the program's standards." *Wong*, 192 F. 3d at 818. Plaintiffs bear the initial burden of producing evidence that a reasonable accommodation was possible. *Vinson v. Thomas*, 288 F. 3d 1145, 1154 (9th Cir. 2002); *Wong*, 192 F. 3d at 816-17. The burden then shifts to defendants who must establish that the requested relief would require a fundamental alteration of state policy. *Frederick L.*, 364 F. 3d at 492 n. 4. Here, as explained in the preceding section and below, the district court properly found that Plaintiffs failed

to show that doubling the wages of community workers would achieve the result they seek. (ER 10/253/41) Accordingly, Plaintiffs have failed to carry their burden of "articulating a reasonable accommodation." *Id.*

The district court found that Plaintiffs failed to meet this element of their prima facie case: "Even if unjustified institutionalization is occurring, Plaintiffs have failed to show that an increase in wages and benefits for community-based direct-care workers would remedy the alleged violation." *Id.* The record does not permit any other conclusion. The history of placements demonstrate no relationship between the rate of institutionalization and the level of wages and benefits. California has placed over 40,000 persons in community settings under existing rate and wage structures. (SER 1/6/144.) Defendants significantly reduced its institutional population in the 1990's without increases in wages and benefits. (*Id.*) Under CPP, many consumers currently living in institutions will move into the community as part of individualized plans directed to the specific needs of each consumer. (ER 6/183/2-13.) Many of these consumers are being placed in existing facilities, which are under the current rate structure. (ER 6/183/19, 24, 28, 31-36, 39-46.) Plaintiffs themselves concede that thousands of persons with difficult-to-serve needs receive care in the community under existing wages and benefits. (AOB, pp. 54-55.)

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On appeal, Plaintiffs concede that doubling the wages of *every* worker is not required by the ADA. As a result, they now suggest that the reasonable accommodation they propose could be accomplished for less than $1.4 billion. They make no effort to estimate the cost, but suggest that the state need only increase the wages of those workers who would permit DC residents to move to the community in order to comply with the ADA. (AOB, p. 58.) This argument is flawed. First, they never made it to the district court and they cannot raise it for the first time on appeal.[4] Second, they do not identify these workers or explain how the state is to identify those workers who should receive pay increases and which DC residents would be deinstitutionalized if the workers wages were increased. Finally, under the state's current system, Defendants have the authority to go outside the rate structure. In short, Plaintiffs have not shown how their proposal differs or improves upon that system.

4. Plaintiffs could not defeat Defendants' showing that they have a comprehensive plan for deinstitutionalization.

The district court held that California's CPP is a comprehensive, effectively working plan for deinstitutionalization under *Olmstead*. (ER 10/253/7-9, 45.) Plaintiffs fail to mention the CPP in their 13-page "Statement of Facts" despite the

[4] In response to Appellees's argument that the remedy constituted a fundamental alteration, Plaintiffs never argued that the cost of complying with the ADA would be less than $1.4 billion per year. (ER 7/221/18-22.)

fact that the district court relied on the CPP in granting summary judgment. (AOB, p. 7-20.)

The undisputed evidence is that Defendants go to great lengths to ensure that individuals have full services and supports in place so that transfers will be successful, and to minimize the risk that placements will fail and consumers readmitted to institutions. Even Plaintiffs' witnesses describe the CPP in glowing terms. (ER 8/238/3; ER 7/213/2.) In fact, one of the agency Plaintiffs' directors testified that Defendants' policies make it "almost impossible" to admit consumers to DCs. (SER 2/354-364.) Discouraging admissions in the first instance is one reason why 98% of California's 180,000 developmentally disabled consumers reside in the community; only 2% reside in DCs.

In light of this undisputed evidence, it is ludicrous to suggest that the CPP does not meet the requirements of the *Olmstead* decision because it is not called an "Olmstead Plan." As the court in *Frederick L.*, noted:

> The issue is not whether there is a piece of paper that reflects that there will be ongoing progress toward community placement, but whether the Commonwealth has given assurance that there will be... [W]hat is needed at the very least is a plan that is communicated in some manner. The District Court accepted the Commonwealth's reliance on past progress without requiring a commitment by it to take all reasonable steps to continue that progress.

364 F. 3d at 500.

In contrast to *Frederick L.*, California has demonstrated an ongoing commitment to community placement in the CPP. California has done more than communicate their commitment, they have *codified the CPP in statue.* §§ 4418.2, 4418.25, *et seq.* Moreover, California includes as a separate item in the Governor's Budget supplemental dedicated funds which regional centers must spend only for implementing CPPs. § 4418.25; (SER 1/4/88-90; SER 1/2/35.) This funding was increased by $20.5 million in the Governor's 2002-03 budget, representing an increase of more than 60% over the previous budget specifically for the CPP. (SER 1/6/151-152.) It is difficult to conceive what additional steps Defendants could take to communicate California's commitment to ongoing progress toward deinstitutionalization.

Plaintiffs' only other criticism of the CPP is the allegedly slow pace of transferring consumers out of institutions. (AOB, p. 57.) However, Plaintiffs provide scant evidence to dispute the record relied on by the district court in showing that the recent slowdown in placements appears to be due to the complex medical and behavioral issues of those who remain in institutions. (ER 10/253/41:17-42; SER 1/6/142-143.) Their only argument is that there are large numbers of persons already in the community who have some of the same complications. The undisputed evidence is that consumers in institutions have, on average, more, and more severe disabilities and very high level-of-care needs.

(SER 1/153-154.) These residents are over four times more likely to have major medical problems or be dependent upon life-sustaining technology, and six times more likely to have severe behavior problems or unable to understand spoken words. They are ten times more likely to suffer from profound mental retardation or to have special conditions or severe behaviors. These consumers demand greater quantities of more intensive care. (*Id.*) In addition, beginning in 1998, courts began to find an increasing number of persons incompetent to stand trial due to developmental disabilities. The resulting growth of the so-called "forensic" population offsets the number of discharges being made from institutions. (SER 1/142-143.) The effect is that while total caseloads grew by 71% during the 1990s, the institutional population *declined* by 43%. (SER 1/6/142.) By 2000-2001, the statewide *rate* of institutionalization was *half* what it was ten years earlier. (SER 1/6/141/)

The district court referenced a similar finding in *Williams v. Wasserman*, 164 F. Supp. 2d 591 (D. Md. 2001). In *Wasserman*, the court held that Maryland's "progress in placing members of the [institutionalized] population into the community has been acceptable" because "the defendants' efforts to provide a stable, safe, and caring environment [ ] were genuine and commendable, if not always successful." *Id.* at 633. (ER 10/253/42.)

In *Frederick L.*, appellants there also claimed that deinstitutionalization had

slowed impermissibly. The court concluded that "cost constraints make it inappropriate for us to direct DPW to develop 60 community residential slots per year . . . ." 364 F. 3d at 500.

California committed over $50 million in 2002/2003 specifically to place institutional residents in the community. The CPP allocated as much as $286,000 for the first year that a consumer is discharged from a DC and averages nearly $102,000 per year per consumer to maintain community placements after the first year. (SER 1/ 96.) None of the evidence cited by Plaintiffs would support a conclusion that these efforts were not genuine, comprehensive and reasonable.

5. Plaintiffs have not overcome Defendants' evidence that the proposed remedy would constitute a fundamental alteration.

The district court found that Plaintiffs' remedy – a $1.4 billion per year increase in reimbursement rates -- would fundamentally alter California's service delivery system for consumers. (ER 10/253/43-44.) The court noted that "a forty percent increase in the state's total budgetary allocation for spending on programs that serve consumers – is plainly a fundamental alteration under the analysis provided by the Supreme Court . . . . Ordering such a drastic re-allocation of resources would be inequitable." (ER 10/253/43-44.)

Under *Olmstead,* courts must recognize the state's need to "maintain a range of facilities for the care and treatment of persons with diverse mental disabilities,"

and its obligation "to administer services with an even hand." 527 U.S. at 597. Thus,

> [I]n evaluating a fundamental-alteration defense, the [court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.

Id. at 604.

The district court properly assessed whether Plaintiffs' proposed accommodation constitutes a fundamental alteration of existing programs, and found that it would require a significant restructuring of the State's existing programs and services, in light of existing budgetary constraints and the competing demands of other services that the state provides. (ER 10/253/42-44.) The $1.4 billion per year "remedy" proposed by Plaintiffs, a figure that represented over 40 percent of the State's $2.2 billion annual budget for community programs that serve individuals with developmental disabilities, would impose a massive and unprecedented reallocation of the state's fiscal resources. Although the result could certainly benefit *employees* in community-based facilities serving these consumers, the funds would have to be diverted from other recipients of state funding. Such a reallocation would necessitate the elimination or reduction of many important services and programs. (SER 1/143-149.)

Unable to dispute the substantial detrimental effect of such a reallocation, Plaintiffs focused almost entirely on alleged "untapped federal dollars" in their claim that billions of dollars could be recouped from the 50% reimbursement the federal Medicaid agency pays to the Medi-Cal program. Defendants' evidence demonstrated the fallacy of Plaintiffs' claim, and Plaintiffs failed to produce contrary evidence. (ER 7/187/11-12; ER 7/184/3.) Plaintiffs' experts only testified that California relies more heavily on state funds than other states; they admitted they do not know how many of California's recipients would qualify for additional federal funding or the amount of funding that would be generated. (ER 2/166/28.) The undisputed evidence is that California's system is very different than other states in providing services that do not quality for federal reimbursement. (SER 1/2/36; SER 1/6/152.) California could match the federal reimbursement levels of other states, but only by reducing services, or the number of consumers served. (SER 1/6/152-153.)

In any event, the possibility of increased federal reimbursements is irrelevant to the analysis. As held in *Olmstead,* it is the state's budget for services to persons with mental disabilities that courts must use to determine whether an accommodation is a fundamental alteration. In *Frederick L.*, plaintiffs argued that the state could have sought additional sums from other sources to fund additional community placements. The court found review of that issue to be beyond judicial

scrutiny. *Id.* at 496-497. Accordingly, the potential for additional federal reimbursement is irrelevant as to whether Plaintiffs' proposed accommodation would fundamentally alter Defendants' programs.

II. THE DISTRICT COURT CORRECTLY HELD THAT PLAINTIFFS DO NOT HAVE A PRIVATE RIGHT OF ACTION UNDER 42 U.S.C. SECTION 1983 TO ENFORCE SECTION 1396a(a)(30)(A) OF THE MEDICAID ACT[5]

A. Plaintiffs Have Abandoned Their Argument That Medicare Providers Can Enforce Section 1396a(a)(30)(A) under 42 U.S.C. Section 1983.

The Plaintiffs in this case include providers of Medicaid services and Medicaid recipients. In the district court, Plaintiffs asserted that both could enforce § 1396a(a)(30)(A) by means of 42 U.S.C. § 1983. On appeal, the Plaintiffs have abandon their argument that providers have such a right of action. (AOB, p. 29.) Accordingly, the issue before this Court is limited to whether recipients can maintain a § 1983 claim to enforce § (30)(A).

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[5] Because the district court dismissed the Medicaid claim on a motion for judgment on the pleadings, the standard of review is de novo. *Torbet v. United Airlines, Inc.*, 298 F. 3d 1087, 1089 (9th Cir. 2002).

B. A Plaintiff Can Maintain an Action to Enforce a Federal Statue under Section 1983 Only Where Congress's Intent to Confer an Individual Right Is Unambiguous.

1. Applicable legal principles.

In 2002, the Supreme Court in *Gonzaga University v. Doe*, 536 U.S. 273 (2002) clarified the principles to be applied in determining whether a federal statute enacted pursuant to Congress's spending power confers individual rights enforceable under 42 U.S.C. § 1983. The Court began by confirming that private enforcement of Spending Clause statutes is the rare exception. "'In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.'" *Gonzaga*, 536 U.S. at 280, quoting *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 28 (1981). Therefore, "unless Congress 'speaks with a clear voice' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983. (Citation omitted.)." *Id.*

The Court next addressed the "confusion" which had led some courts to misinterpret its prior decisions, including *Blessing v. Freestone*, 520 U.S. 329 (1997), as endorsing a less stringent standard. In *Blessing*, the Court had formulated a three-factor test to evaluate whether Congress had conferred an

enforceable right: (1) Congress must have intended that the statutory provision in question to benefit the plaintiff; (2) the right must not be so "vague and amorphous" as to be "beyond the competence of the judiciary to enforce;" and (3) the statute "must be couched in mandatory, rather than precatory terms." 520 U.S. at 340-41. While not abandoning the test, the *Gonzaga* Court dispelled any suggestion that the first *Blessing* factor stood for the proposition that Congressional intent to permit enforcement under § 1983 will be found "so long as the plaintiff falls within the general zone of interest that the statute is intended to protect."[6] *Id.* at 283. That the statute "benefits" the plaintiff is insufficient – the provision must unambiguously create a right:

> We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983. Section 1983 provides a remedy only for the deprivation of "rights, privileges, or immunities secured by the Constitution and laws" of the United States. Accordingly, it is *rights*, not the broader or vaguer "benefits" or "interests" that may be enforced under the authority of that section. (Emphasis original.)

Id.

Moreover, because only *rights* may be enforced, the Court's implied right of action cases "should guide the determination of whether a statute confers rights

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[6] See *31 Foster Children v. Bush*, 329 F. 3d 1255, 1269-1270 (11th Cir. 2003) ("The Supreme Court in *Gonzaga* clarified the first of the *Blessing* requirements.").

enforceable under § 1983." *Id.*

As *Gonzaga* explains, under the private right of action cases, the "text and structure" of the statute must demonstrate that Congress unambiguously intended to grant individual rights. 536 U.S. at 286. Critical to this inquiry is whether the statutory provision uses "rights-creating" language. 536 U.S. at 287; *Alexander v. Sandoval*, 532 U.S. 275, 288-289 (2001). Such language must clearly impart an "individual entitlement," and have an "unmistakable focus on the benefitted class." *Id.*; *Cannon v. University of Chicago*, 441 U.S. 677, 692, n. 13 (1979) (text of statute must be "phrased in terms of the person benefitted.") "Statutes that focus on the person regulated rather than the individuals protected create no implication of an intent to confer rights on a particular class of person." (internal quotes and citation omitted). *Gonzaga*, 536 U.S. at 287, quoting *Alexander v. Sandoval*, 532 U.S. at 289. "If [the statute] provide[s] some indication that Congress may have intended to create individual rights, and some indication it may not have, that means Congress has not spoken with the requisite 'clear voice.' Ambiguity precludes enforceable rights." *31 Foster Children*, 329 F. 3d 1255, 1270 (11th Cir. 2003). The *Gonzaga* Court invoked as exemplars of "rights-creating" language Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d) and Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681(a). Each of those statutes provides: "No person in the United States shall . . . be subject to

discrimination." According to *Gonzaga*, this language creates individual rights because it is phrased "with an *unmistakable focus* on the benefitted class." 536 U.S. at 284 (quoting *Cannon*, 441 U.S. at 691) (emphasis original).

Additional closely related principles relevant to determining whether the text and structure of a statutory provision manifest a congressional intent to confer an enforceable right include: (1) statutes that have an "aggregate" focus rather than a focus upon whether the needs of any particular person has been satisfied do not give rise to individual rights; (2) statutes that speak only in terms of institutional policy and practice do not evince an intent to create private rights of enforcement; (3) a statutory provision that references the individual only in the context of describing the type of policy or practice that will trigger a funding prohibition, does not reflect a congressional intent to create a private right of action; and (4) a provision that allows a state entity to avoid a loss of federal funds through substantial compliance reflects a congressional intent to confer group rather than individual rights. *Gonzaga*, 536 U.S. at 288.

Application of all these principles demonstrates that § (30)(A) does not unambiguously confer rights on Medicare recipients.

2. Section (30)(A) does not contain rights-creating language.

The Medicaid Act was enacted pursuant to Congress's spending power to help states provide medical care for the poor and disabled. To be eligible for

federal Medicaid funds, 42 U.S.C. § 1396 requires that the state submit, and have approved by the Secretary, a plan for medical assistance, i.e., a "comprehensive written statement" that describes the nature and scope of the state's Medicaid Program. See 42 C.F.R. § 430.10. See *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F. 3d 908, 915, n.2 (5th Cir. 2000). The required components of a state plan are set forth in 42 U.S.C. § 1396a(a), (attached at Tab B). Section 1396a(a)(30)(A) addresses the standards the state is to employ in setting payment rates for providers of care and services under the plan:

> A state plan for medical assistance must . . . provide for such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

The district court held that § (30)(A) does not contain rights-creating language which is critical to finding the requisite congressional intent to create a private, enforceable right:

> There can be little doubt that § 30(A) fails to employ the "no person shall" language cited by the *Gonzaga* Court as the epitome of rights-creating language. *Id.* at 287. Textually, § 30(A) is phrased in terms of what a State plan for medical assistance must provide to administrators and recipients of Title XIX services. While § 30(A) benefits both recipients and

> providers of Title XIX services, the language of the statute does not clearly confer an enforceable right on either. *Gonzaga* has made clear that the effect of conferring a benefit is not enough to warrant a private right enforceable by § 1983."

Sanchez v. Johnson, 301 F. Supp. 2d 1060, 1063 (9th Cir. 2004).

The district court's analysis is correct. There is nothing in the text of § (30)(A) that speaks to individual entitlement, or that unmistakably focuses on recipients. As the district court noted, there is no language even remotely comparable in its individual focus to the "No person shall be subject to discrimination" provision in Title VI and Title IX, which the Supreme Court held out as examples of the type of language that demonstrates an unambiguous Congressional intent to confer individual rights. Instead, § (30)(A) establishes what factors are to guide the state in providing for "methods and procedures relating to" provider rates. That is, the state must set rates based on an assessment as to whether they achieve certain broad results, i.e., rates that are consistent with efficiency, economy and quality, and that ensure access to services comparable to the general population.

Thus, Plaintiffs' argument that the provisions of § (30)(A) which they seek to enforce were included in the statute "to protect the interests of service beneficiaries" ignores the text and structure of the statute. (AOB, p. 30-31.) Section (30)(A) reveals an intent to assure that states protect the sometimes

competing interests of a number of groups. For instance, the most efficient and economical system may serve the interests of taxpayers, but only to the disadvantage of medical providers. Similarly the interests of recipients in access comparable to the general population a state may be in conflict with the objective of efficiency, economy and quality. The tension between these objectives further underscores the conclusion that § (30)(A) is concerned with overall methodology rather than conferring rights on individual recipients. Furthermore, by parsing out particular words and phrases in § (30)(A) and treating them as separately enforceable obligations, Plaintiffs ignore the overall directive of the statute. The tortured reading Plaintiffs must give to the statute demonstrates that the provision does not clearly and unambiguously bestow a enforceable right on any specific group. This argument fails because, even as framed by Plaintiffs, it claims no more than that the "quality" and "access" provisions serve the interest of and benefit recipients. However, as *Gonzaga* makes abundantly clear "it is *rights*, not the broader or vaguer "benefits" or "interests" that may be enforced under the authority of [§ 1983]." (Emphasis original.) *Gonzaga*, 536 U.S. at 283.

Even if one accepts for purposes of argument that the "quality of care" and "access" provisions constitute stand-alone requirements, the fact that a statute is cast in mandatory, rather than precatory, terms does not, in itself, demonstrate a Congressional intent to confer rights on recipients. Mandatory provisions create

law binding on states choosing to accept Medicaid funding, but whether those provisions confer enforceable rights on recipients is a separate question. *Gonzaga*, 526 U.S. at 283 ("It is only the violation of *rights*, not *laws*, which give rise to § 1983 actions."); see also *Sabree v. Richman*,367 F. 3d 180, 187 (3d Cir. 2004). A finding that rights have been conferred requires a showing that the standards articulated in *Gonzaga* – most critically the use of rights-creating language – have been met. Plaintiffs have not, and cannot, make that showing.

Nor is Plaintiffs' argument, based on the supposed link between § (30)(A) and §§ 1396a(a)(8) and (a)(10), persuasive. Section (a)(10) requires that the state "provide . . . medical assistance . . . to . . . all [eligible] individuals." Section (a)(8) requires that the state "provide . . . assistance . . . with reasonable promptness to all eligible individuals." In *Sabree*, the Third Circuit held that these sections demonstrate a Congressional intent to confer individual rights because they use rights-creating language, i.e., the text enumerates entitlements available to "all eligible individuals"; they are not focused on the entity regulated; and they do not reference the individual in the context of describing the type of policy or practice that will trigger a funding prohibition. *Id.* at 190. Although the Defendants disagree with the Third Circuit finding that §§ (a)(8) and (a)(10) satisfy *Gonzaga*, the text of § (30)(A) has none of the rights-creating language and focus on enumerated entitlements to individual recipients that arguably

characterize the text of §§ (a)(8) and (a)(10). Section (30)(A) must, by its terms, confer a right; it cannot ride on the coattails of other sections of the Medicaid Act.

a. 42 U.S.C. section 1320a-2 does not provide the rights-creating language required by *Gonzaga*.

In an effort to overcome what they concede is a lack of "classic rights-creating language" in § (30)(A), Plaintiffs rely on 42 U.S.C. § 1320a-2, which they incorrectly dub "the *Suter v. Artist M.* override provision." (AOB, pp. 32-33.) This reliance is misplaced.

In *Suter v. Artist M.*, 503 U.S. 347 (1992), the Supreme Court held that a class of parents and children could not maintain an action under § 1983 to enforce provisions of the Adoption Assistance and Child Welfare Act (a portion of the Social Security Act), which requires that states have a "plan" to make "reasonable efforts" to keep children out of foster homes. See 42 U.S.C. § 617(a)(3), (15). In response to *Suter*, Congress enacted § 1320a-2[7], which states:

> In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. *This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter . . ., but not applied in prior Supreme Court decisions respecting such enforceability*; provided, however,

[7] At the same time, and probably mistakenly, Congress passed a second, identical statute, 42 U.S.C. § 1320a-10.

> that this section is not intended to alter the holding in *Suter v. Artist M.* that section 671(a)(15) of this title is not enforceable in a private right of action. (Emphasis added.)

While the language of this provision is, at best, oblique, Congress was apparently trying to achieve three objectives: (1) to ensure that enforcement under § 1983 is not foreclosed on the sole ground that the provision at issue specifies the content of a state plan, (2) to ensure that plaintiffs may seek enforcement under § 1983 to the same extent they could prior to *Suter*,[8] and (3) to confirm that there was no intent to alter the specific holding in *Suter*.

Plaintiffs assert that § 1392a-2 excuses the requirement that a statutory provision must contain rights-creating language to be enforceable via § 1983. (AOB, p. 33-34.) However, the conclusion that plaintiffs seek to draw simply does not follow logically from § 1392a-2. The fact that private enforcement is not foreclosed because a provision deals with a state plan does not lead to the conclusion that a provision is enforceable <u>because</u> it is in a state plan. Section 1392a-2 only stops a court from, in effect, saying that because § 1396a(a) governs state plan requirements, it must be concluded that Congress did not intend any of § 1396a(a)'s subsections to create private rights of action. As a matter of logic, precluding this single rationale does not excuse a court, when assessing a

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[8] See *Harris v. James*, 127 F. 3d 993, 1003 (11th Cir. 1997); *Messier v. Southbury Training School*, 916 F. Supp. 133, 144 (D. Conn. 1996) (finding "courts should apply the *Wilder* framework, unmodified by Suter").

provision of the Social Security Act relating to state plans, from applying the principles explained in *Gonzaga* in order to discern Congress's intent.[9/]

This conclusion is supported by § 1392a-2 itself. The section's second sentence affirms that the law governing rights of action under § 1983, unmodified by any grounds of decision unique to *Suter*, was to remain in effect. According to *Gonzaga*, *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), the last § 1983 enforcement case before *Suter*, found that the now-repealed Boren Amendment could be enforced under § 1983 because "Congress left no doubt of its intent for private enforcement." *Gonzaga*, 536 U.S. at 280-81. Thus, the need to show an unambiguous congressional intent to confer a right was a requirement before *Suter*. Moreover, there is nothing in § 1392a-2 which freezes the law as it existed pre-*Suter*. Thus, so long as the Supreme Court does not rely on unspecified grounds unique to *Suter*, § 1392a-2 does not stop the Court from developing and modifying the principles governing enforceability under § 1983. Therefore, even if *Gonzaga* is interpreted as altering the analysis employed in *Wilder* – a position which plaintiffs reject (AOB, p. 29) – *Gonzaga* is fully applicable here.

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[9] Apart from the district court's decision in *Clayworth v. Bonta*, 295 F. Supp. 2nd 1110 (E.D. Cal. 2003), Defendants are not aware of any case which has interpreted § 1392a-2 as affecting the application of *Gonzaga*. For example, the Third Circuit in *Sabree*, although not addressing § 1392a-2, never questioned that §§ (a)(8), (a)(10), and (a)(15) were to be analyzed under *Gonzaga*.

Finally, it is important to stress that the district court did not base its finding of unenforceability on the fact that § (30)(A) specifies the contents of a state plan. Consequently, Plaintiffs cannot, and do not, contend that the district court violated the express mandate of § 1392a-2. Instead, they are complaining that the court did not rely on § 1392a-2 as a basis for disregarding the lessons of *Gonzaga*.

3. Section (30)(A) has an aggregate rather than an individual focus.

In addition to finding no rights-creating language, the district court correctly concluded that § (30)(A) has an aggregate, rather than the required individual, focus:

> The statute speaks, not of any individual's right, but of the State's obligation to develop 'methods and procedures' of providing medical services. Indeed, the only mention of recipients of Title XIX services is in the aggregate, as "the general population in the geographic area. (Citation omitted.) A statutory provision that refers to the individual only in the context of describing a State policy or practice does not reflect a congressional intent to create a private right of action. *Gonzaga*, 536 U.S. at 287.

Sanchez, 301 F. Supp.2d at 1064.

The district court was certainly correct in emphasizing that the focus on "methods and procedures" coupled with the virtual absence of language directed at recipients supports the conclusion that § (30)(A) is framed in aggregate terms. This is obviously true for the "efficiency, economy, and quality of care" portion of

§ (30)(A). Likewise, the court, in assessing the language relating to "access," correctly found that although there is a reference to "recipients," that reference is not reflective of a congressional intent to create private rights because it is made in the context of describing the state's policy objective of achieving access for recipients comparable to the general population in the geographic area.

Plaintiffs contend that the district court's analysis "overlooks the similarity of § (30)(A) and the [now-repealed] Boren Amendment at issue in *Wilder*" (AOB, p. 34). However, even the *Clayworth* decision, upon which Plaintiffs so heavily rely, rejects this comparison. 295 F. Supp. 2d at 1121-22 (finding that "[t]he language of Section 30(A) is not the same as that of the Boren Amendment."). Likewise, the Fifth and Third Circuits have rejected plaintiffs' argument. See *Pa. Pharmacists Ass'n v. Houstoun*, 283 F. 3d 531, 538 (3d Cir. 2002) (en banc); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F. 3d 908, 926-928 (5th Cir. 2000). These decisions are correct. The Boren Amendment, unlike § (30)(A), explicitly conferred objective monetary entitlements upon individual health providers. *Gonzaga* at 536 U.S. at 280. This fact persuaded the Court that the Amendment was enforceable. *Id.* Section (30)(A) does not confer comparable, objectively ascertainable entitlements on individual recipients.

Plaintiffs also rely on *Clayworth*'s erroneous conclusion that § (30)(A) is "not phrased in aggregate or indirect terms – such as requiring a general policy or

requiring substantial compliance – that might suggest that no single beneficiary is entitled to quality care or equal access." (AOB, p. 35, citing *Clayworth*, 295 F. Supp. 2d at 1122.) The reasoning of the district court in this case on the "aggregate" issue is better reasoned. Contrary to *Clayworth*, § (30)(A) does have an aggregate focus in that it establishes general policies and objectives for setting rates for all Medicaid providers. As the district court noted, there is no affirmative language directed at providing benefits to recipients in their individual capacity. Moreover, *Clayworth* is incorrect in finding that § (30)(A) is not satisfied by the state's substantial compliance with its requirements. 42 U.S.C. § 1396c authorizes the Secretary of HHS to suspend payments to a state if the state fails to "comply substantially" with the requirements of Title XIX:

> If the Secretary, after reasonable notice and opportunity for a hearing to the State agency administering or supervising the administration of the State plan approved under this title finds . . . that in the administration of the plan *there is a failure to comply substantially with any such provision*; the Secretary shall notify such State agency that further payment will not be made to the State . . ., until the Secretary is satisfied that there will no longer be any such failure to comply.

42 U.S.C. §1396c (emphasis added).

As explained in *Blessing*, the substantial compliance standard "is simply a yardstick for the Secretary to measure the systemwide performance of a state's . . . program. Thus, the Secretary must look to the aggregate services provided by the

state, not to whether the needs of any particular person have been satisfied." *Blessing v. Freestone*, 520 U.S. at 343; see also *Gonzaga*, 536 U.S. at 281-82. Accordingly, the "substantial compliance" provision here, as in *Gonzaga* and *Blessing*, counsel against a finding of an unambiguously conferred individual right.

4. Plaintiffs' Other Arguments Do Not Support the Conclusion that Section (30)(A) is enforceable.

Plaintiffs also argue that the lack of an administrative review procedure to challenge alleged violations of § (30)(A) supports the existence of an enforceable right. (AOB, p. 28.) *Gonzaga* had cited the fact that FERPA established an administrative process as buttressing the conclusion that Congress meant to preclude private enforcement. 536 U.S. at 289. However, whether an administrative procedure exists is not determinative of whether a provision is privately enforceable. See *31 Foster Children*, 329 F. 3d 1272-73 (finding that "lack of an enforcement mechanism by which an aggrieved individual can obtain review is but one of the factors" to be considered, and that this factor was outweighed by the fact that the pertinent provisions of the Adoption Act did not have individually focused, rights-creating language and employed a substantial compliance standard.). The same reasoning applies here.

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Plaintiffs' argument based on purported legislative history must also be rejected. The cited legislative does not relate to § (30)(A). (AOB, p. 35-36, citing House of Representatives Report 97-158, Vol. II at 312-313.) This history was erroneously cited by the Third Circuit in *Pennsylvania Pharmacists* and the district court in *Clayworth* to support the conclusion that § (30)(A) was intended to confer rights on Medicaid recipients. Although Congress did amend § (30)(A) in 1981, the passage cited by Plaintiffs actually relates to a proposed amendment to the "freedom of choice" provision, 42 U.S.C. § 1396a(a)(23).[10] Plaintiffs cited this same passage in their opposition to Defendants' motion for reconsideration in the district court, and Defendants' addressed the error in their reply brief. (SER 5/31/1404-1412.) Plaintiffs do not respond to this point in their brief to this Court, but instead continue to cite this legislative history instead of acknowledging that it is not applicable.

Plaintiffs cite numerous pre- and post-*Gonzaga* cases, claiming that no appellate court has held that recipients cannot privately enforce § (30)(A) under §

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[10] The passage referred to is a section of the report entitled "Competitive Arrangements for Payment for Laboratory Services, Medical Devices and Drugs" and proposed amendments to the "freedom of choice" requirement. The House version of the amendment was later amended in conference committee. H.R. Conf. Rep. 97-208 at p. 936. The final version was enacted in section 2174 of Public Law 97-35. The committee report to the actual amendment of § (30)(A) appears at 312-313 and makes no reference to its enforceability. In fact, the amendment had to do with deleting certain language to "remove administrative burdens" and "increase flexibility for the States.

1983. While this is technically accurate with regard to the First Circuit decision in *Long Term Care Pharmacy Alliance v. Ferguson*, the court's reasoning regarding why § 1396a(a)(30)(A) does not create a private right of action in providers applies equally to recipients. 362 F. 3d 50 (1st Cir. 2004). "[S]ubsection (30)(A) has much broader coverage [compared to current subsection (13)(A)], sets forth general objectives, and mentions no category of entity or person specially protected." *Id.* at 56. In rejecting plaintiff's suggestion that failure to provide a private right of action would render the provision a "nullity," the court found that the "Secretary has ample authority to enforce subsection (30)(A)" by "disapproving a state plan and cutting off funds." *Id.* The court also compared § (30)(A) with the point favoring the result in *Gonzaga* cited by Justice Breyer – that "'much of the statute's key [substantive] language is broad and nonspecific,' suggesting that exclusive agency enforcement might fit the scheme better than a plethora of private actions threatening disparate outcomes." *Id.* at 58. "Subsection (30)(A) presents the same concern. The criteria (avoiding overuse, efficiency, quality of care, geographic equality) are highly general and potentially in tension. And read literally, the statute does not make these directly applicable to individual state decisions; rather state plans are to provide "methods and procedures" to achieve these general ends." *Id.* (citation omitted). This description of the provision applies to both providers and recipients, and leads to

only one conclusion: neither has a private right to enforce § (30)(A).

Plaintiffs citations to pre-*Gonzaga* cases are irrelevant as to whether under *Gonzaga* § (30)(A) the provision is privately enforceable by recipients. (In fact, only one case held that the provision was enforceable by recipients. See *Evergreen Presbyterian Ministries, Inc.*, 235 F. 3d at 928-29. The post-*Gonzaga* district court cases cited by Plaintiffs also do not establish congressional intent that Medicaid recipients have a private right of enforcement. The rights of recipients to enforce § (30)(A) were not even at issue in *American Soc'y of Consultant Pharmacists v. Concannon*, 214 F. Supp. 2d 23, 30 (D. Maine 2002). In that case, the court held that providers did have a private right of action, citing *Visiting Nuse Ass'n v. Bullen*, 93 F. 3d 997 (1st Cir. 1996) because "*Bullen* is the First Circuit's last, clear word on the subject and the Court is bound to follow it." *Id.* at 30. However, the court acknowledged that "Bullen's continued viability post-Gonzaga is in some doubt." *Id.* at 29.

Plaintiffs' reliance on *Association of Residential Resources of Minnesota (ARRM) v. Minnesota Comm'r of Human Services*, 2003 WL 22037719 (D. Minn. 2003) is also misplaced because "the *ARRM* court arrived at its holding without discussing the factors articulated by the Supreme Court in *Gonzaga*" as the district court here correctly found. *Sanchez*, 301 F. Supp. 2d at 1064. The only district court to hold that recipients can enforce § 1396a(a)(30)(A) under § 1983 is

Clayworth, which is on appeal. In *Clayworth*, the court primarily relied on 42 U.S.C. § 1320a-2 to find that § (30)(A) was enforceable by recipients, but not providers. If not for this faulty analysis, the court would likely not have concluded that the provision was enforceable by recipients. Therefore, Plaintiffs' reliance on *Clayworth* here should be rejected.

C. The "Efficiency, Economy, and Quality of Care" Provision of Section (30)(A) Is Too Vague and Amorphous to Be Judicially Enforced.

Under the second *Blessing* factor, it must be determined whether the statutory provision is "too vague and amorphous" to be judicially enforceable.[11] Plaintiffs cannot rely on *Orthopaedic Hosp. v. Belshe*, 103 F. 3d 1491 (9th Cir. 1997) because the issue of whether § 1396a(a)(30)(A) is enforceable under Sectio 1983 was *sub silento* in *Orthopaedic*, and should not be considered here. *Hagans v. Levine*, 415 U.S. 528, 535 (1974) (ruling "when questions of jurisdiction have been passed on in prior decisions *sub silento* this Court has never considered itself bound when a subsequent case finally brings the jurisdictional issue before us"). Thus, *Orthopaedic* has no precedential value here.

Plaintiffs' reliance on the language of the now repealed Boren Amendment is equally misplaced. The Boren Amendment required states to adopt rules that

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[11] Given its finding of no congressional intent to confer a right, the district court, like the *Gonzaga* Court, did not address this factor.

"the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate" to achieve identified objectives. (e.g., "meet the costs of efficiently and economically operated facilities.") See *Methodist Hosps. v. Sullivan*, 91 F. 3d 1026, 1030 (7th Cir. 1996). By contrast, the"economy, efficiency, and quality of care" provision of § (30)(A) does not even mention provider costs and contains no indication that Congress intended that states were to establish a rate that compensates a minimum portion of the efficient and economic cost of providing quality care for each of thousands of different outpatient medical services and items.

That the Secretary took action concerning the home and community-based waiver shows only that the Secretary, in his/her capacity as an executive branch administrator and monitor, is performing as authorized by the Act. It does not establish that § (30)(A) sets standards that are sufficiently objective to be enforced by the judicial branch.

The only two courts to considered the issue have found the "efficiency, economy, and quality of care" provision so vague and amorphous as not to be judicially enforceable. See *Florida Pharmacy Ass'n v. Cook*, 17 F. Supp. 2d 1293 (N.D. Fla. 1998) in which the court found that the "efficiency, economy, and quality of care" provision "provides no benchmark or guidance for determining whether any particular approach is 'efficient,' no standard for addressing

'economy,' no suggestion of how much 'quality' is enough. *These are goals for which the state must strive, but they are not standards a court can enforce.*" *Id.* at 1300 (emphasis added); see also *Fulkerson v. Commissioner*, 802 F. Supp. 529, 534-35 (D. Me. 1992) (finding that the "competing goals" of "keeping Medicaid costs as low as possible" and "providing quality of care to Medicaid recipients" "requires specified knowledge of the workings of the health care system and the exercise of significant administrative discretion in allocating scare fiscal resources" such that it is a "task for which the Secretary, not the courts, is uniquely qualified").

The decisions in *Florida Pharmacy* and *Fulkerson* are consistent with the position taken by the U.S. Department of Health and Human Services (DHHS) that the provision is not judicially enforceable. With regard to a petition for certiorari that California filed requesting review of the Ninth Circuit's decision in *Orthopaedic*, the Supreme Court had invited the U.S. Solicitor General to file on two questions, including whether hospital providers were entitled to bring suit under § 1983 to challenge rates as inconsistent with § (30)(A). In its brief, the Solicitor General supported DHHS's position that the "efficiency, economy, and quality of care" provision was too vague and amorphous for judicial

enforcement.[12]

In addition, none of the implementing regulations of § 1396a(a)(30)(A) establish that DHHS was concerned with attaining a certain level of quality for recipients. The regulations do not set cost-based requirements, standards, or otherwise provide guidance as to what constitutes efficiency, economy, or quality. The regulations concern upper limits on Medicaid spending and assuring against overutilization and fraud. See 42 C.F.R. §§ 447.300-477.361; 456.3. As DHHS has explained: "The upper limit based on Medicare payments is limited to implement the general requirement in § [1396a(a)(30)(A)] of the Act that Medicaid payment be consistent with efficiency, economy, and quality of care." 46 Fed. Reg. 47968 (Sept. 30, 1981.) Section 456.3 requires that states "must implement a statewide surveillance and utilization control program that – (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; [and] (b) Assesses the quality of those services . . . ." Thus, the implementing regulations of § 1396a(a)(30)(A) further demonstrate that the provision is too vague and amorphous to be enforced by the courts.

In arguing that § (30)(A) is not vague and amorphous, the Plaintiffs here rely solely on this Court's holding in *Orthopaedic* and the district court opinion in

[12] The Solicitor General's brief may be found at the following web site: http://www.usdoj.gov/osg/briefs/1996/w961742w.txt.

Clayworth. Plaintiffs read these decisions as construing § (30)(A) as meaning that rates for Medicaid covered services "must bear a reasonable relationship to efficient and economical [providers'] costs." *Clayworth*, 295 F. Supp. 2d at 1123 (citing *Orthopaedic* at 1496). Thus, plaintiffs implicitly argue that because *Orthopaedic* requires states to evaluate provider costs in order to comply with § (30)(A), the provision is not so vague and amorphous as to permit recipients to bring a private enforcement action.

However, *Orthopaedic* should not be read so broadly as to require states to evaluate provider costs for every service covered under Medicaid. Such a reading is not supported either by the terms of § (30)(A) or the legislative history of the Medicaid Act. In the Boren Amendment, congress had required states to conduct studies of the costs incurred by hospital and nursing facilities in setting rates for these services only. By contrast, § 1396a(a)(30)(A) contains no requirement for states to gather cost data for each of thousands of different outpatient services and items. When Congress repealed the Boren Amendment, its purpose was "to provide States with greater flexibility in setting provider reimbursement rates under the Medicaid Program." *Evergreen Presbyterian Ministries, Inc*, 235 F. 3d at 919. If the *Orthopaedic* decision is given the reading attributed to it by Plaintiffs, states would be required to conduct cost studies of every service provided to Medicaid recipients to conduct cost findings and establish cost based

rates was limited to relatively few daily rates for hospital inpatient and long term care facility services (e.g., there are six daily rates for freestanding nursing facility services according to Cal. Code of Regs., tit. 22, sec. 51511, subd. (a)(1).) In contrast, Plaintiffs would extend a similar burden on all types of Medicaid services which incorporate thousands of separate rates.[13] This result would circumvent Congress's intent. It would be nonsensical to infer from the language of § (30)(A) that, after eliminating the requirement to all Medicaid services. For this reason, the holding *Orthopaedic* should be limited to the unique facts of that case.

Dated: July 16, 2004

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[13] For example, there are thousands of physician procedures for which a rate has been established in the Schedule of Medi-Cal Physician Rates, incorporated by reference at 22 California Code of Regulations, § 51503. As another example, 22 California Code of Regulations, § 51515 lists rates for hundreds of prosthetic and orthotic appliances.

CERTIFICATE OF COMPLIANCE PURSUANT TO FED. R. APP. 32(A)(7)(C) AND CIRCUIT RULE 32-1 FOR CASE NUMBER 04-15228

I certify that:

XX 1. Pursuant to Fed. R. App. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached opening/answering/reply/cross-appeal brief is

☒ Proportionately spaced, has a typeface of 14 points or more and contains **13,426** words (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 14,000 words; reply briefs must not exceed 7,000 words),

or is

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__ 2. The attached brief in **not** subject to the type-volume limitations of Fed.R.App.P. 32(a)(7)(B) because

☐ This brief complies with Fed.R.App.P. 32(a)(1)-(7) and is a principal brief of no more than 30 pages or a reply brief of no more than 15 pages;

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__ 3. *Briefs in Capital Cases*

☐ This brief is being filed in a capital case pursuant to the type-volume limitations set forth at Circuit Rule 32-4 **and is**

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__ 4. *Amicus Briefs*

☐ Pursuant to Fed.R.App.P 29(d) and 9th Cir.R. 32-1, the attached amicus brief is proportionally spaced, has a typeface of 14 points or more and contains 7000 words or less.

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July 16, 2004
Date

Todd Boley
Attorney for State Defendant-Appellees

PROOF OF SERVICE

Sanchez, et al. v. Johnson, et al.
USCA for the Ninth Circuit Case No. 04-15228

THE UNDERSIGNED STATES:

I am a citizen of the United States of America and am employed in the County of Alameda, State of California; I am over the age of 18 years, and am not a party to the above-entitled action. My business address is Erickson, Beasley, Hewitt & Wilson LLP, 483 Ninth Street, Suite 200, Oakland, California 94607. On July 16, 2004, I served the following:

APPELLEES' OPENING BRIEF

APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD ON APPEAL, VOLS. 1 - 6

on the parties named below as follows:

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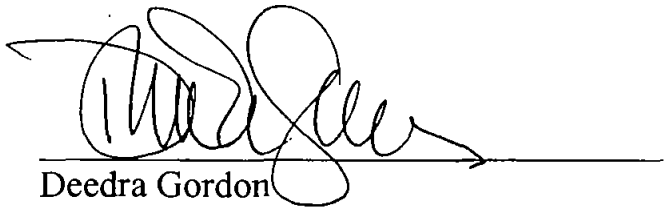
BY MAIL: I placed a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid for first-class mail, for collection and mailing at ERICKSON, BEASLEY, HEWITT & WILSON LLP, Oakland, California, following ordinary business practices. I am readily familiar with the practice of ERICKSON, BEASLEY, HEWITT & WILSON LLP for collection and processing

of correspondence for mailing with the United States Postal Service, said practice being that in the ordinary course of business, correspondence is deposited in the United States Postal Service the same day as it is collected.

I declare under penalty of perjury that the foregoing is true and correct. Executed in Oakland, California on July 16, 2004.



Deedra Gordon

ADDENDUM

LANTERMAN DEVELOPMENTAL DISABILITIES SERVICES ACT AND RELATED LAWS

January 2004

State of California
Department of Developmental Services

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GOVERNMENT CODE

retardation. Such clinics may be maintained only for persons not requiring institutional care, who voluntarily seek the aid of such clinics. Such clinics may be maintained at the locations in the communities of the state designated by the director, or at any institution under the jurisdiction of the department designated by the director.

The department may establish such rules and regulations as are necessary to carry out the provisions of this section. This section does not authorize any form of compulsory medical or physical examination, treatment, or control of any person.

(Added by Stats. 1977, Ch. 1252.)

4418. The State Department of Developmental Services may obtain psychiatric, medical and other necessary aftercare services for judicially committed patients on leave of absence from state hospitals by contracting with any city, county, local health district, or other public officer or agency, or with any private person or agency to furnish such services to patients in or near the home community of the patient. Any city, county, local health district, or other public officer or agency authorized by law to provide mental health and aftercare services is authorized to enter such contracts.

(Added by Stats. 1977, Ch. 1252.)

4418.1. (a) The Legislature recognizes that it has a special obligation to ensure the well-being of persons with developmental disabilities who are moved from state hospitals to the community.

(b) To ensure that persons with developmental disabilities who are moved from state hospitals to the community are receiving necessary services and supports, the department shall contract with an independent agency or organization for the tracking and monitoring of those persons, including all persons moved as a result of the Coffelt v. State Department of Developmental Services settlement agreement and any persons moved after the terms of that agreement have been met.

(c) The contractor shall be experienced in all of the following:

(1) Designing valid tracking instruments.

(2) Tracking the quality of community programs, including outcome-based measures such as health and safety, quality of life, integration, choice, and consumer satisfaction.

(3) Tracking the quality and appropriateness of community placements for persons moving from large institutions into community settings.

(4) Developing data systems.

(5) Data analysis and report preparation.

(d) The contractor shall measure consumer and family satisfaction with services provided, including case management and quality of life, including, but not limited to, health and safety, independence, productivity, integration, opportunities for choice, and delivery of needed services.

(e) The information maintained for each person shall include the person's name, address, nature of disability, medical condition, scope of community-based services and supports, and the annual data collected by the contractor.

(f) The contractor shall meet with each person, and the person's family, legal guardian, or conservator, when appropriate, no less than once a year to discuss quality of life and observe the person's services and supports. In cases where the

consumer is not capable of communicating his or her responses and where there is no family member, guardian, or conservator involved, the contractor shall meet with no less than two persons familiar with the consumer. Additionally, the contractor shall interview staff and friends who know the consumer best and review records, as appropriate.

(g) If the contractor identifies any suspected violation of the legal, civil, or service rights of an individual, or if the contractor determines that the health and welfare of the individual is at risk, that information shall be provided immediately to the regional center providing case management services, the client rights advocate, and to the department.

(h) The department shall monitor the corrective actions taken by the regional center and maintain a report in the person's file. The consumer and, when appropriate, his or her parents, legal guardian, or conservator, shall be provided with access to the person's file and be provided with copies of all reports filed with the regional center or department relative to them.

(i) The department shall establish a task force, including representatives from stakeholder organizations, to annually review the findings of the contractor and make recommendations regarding additional or differing criteria for information to be gathered by the contractor in future interviews.

(j) As of July 1, 1998, and annually thereafter, the contractor shall provide a report to the Governor, the Legislature, and the department outlining the activities and findings of this process. The reports shall be public and shall contain no personally identifying information about the persons being monitored.

(Added by Stats. 1997, Ch. 294, Sec. 32. Effective August 18, 1997.)

4418.2. The department shall support, utilizing regional resource development projects, the activities specified in Sections 4418.25, 4418.3, and 4418.7.

(Added by Stats. 2002, Ch. 1161, Sec. 27. Effective September 30, 2002.)

4418.25. (a) The department shall establish policies and procedures for the development of an annual community placement plan by regional centers. The community placement plan shall be based upon an individual program plan process as referred to in subdivision (a) of Section 4418.3 and shall be linked to the development of the annual state budget. The department's policies shall address statewide priorities, plan requirements, and the statutory roles of regional centers, developmental centers, and regional resource development projects in the process of assessing consumers for community living and in the development of community resources.

(b) The community placement plan shall provide for dedicated funding for comprehensive assessments of selected developmental center residents, for identified costs of moving selected individuals from developmental centers to the community, and for deflection of selected individuals from developmental center admission. The plans shall, where appropriate, include budget requests for regional center operations, assessments, resource development, and ongoing placement costs. These budget requests are intended to provide supplemental funding to regional centers. The plan is not intended to limit the department's or regional centers' responsibility to otherwise conduct assessments and individualized program planning, and to provide needed services and supports in

the least restrictive, most integrated setting in accord with the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(c) The department shall review, negotiate, and approve regional center community placement plans for feasibility and reasonableness, including recognition of each regional centers' current developmental center population and their corresponding placement level, as well as each regional centers' need to develop new and innovative service models. The department shall hold regional centers accountable for the development and implementation of their approved plans. The regional centers shall report, as required by the department, on the outcomes of their plans. The department shall make aggregate performance data for each regional center available, upon request, as well as data on admissions to, and placements from, each developmental center.

(d) Funds allocated by the department to a regional center for a community placement plan developed under this section shall be controlled through the regional center contract to ensure that the funds are expended for the purposes allocated. Funds allocated for community placement plans that are not used for that purpose may be transferred to Item 4300-003-0001 for expenditure in the state developmental centers if their population exceeds the budgeted level. Any unspent funds shall revert to the General Fund.

(Added by Stats. 2002, Ch. 1161, Sec. 28. Effective September 30, 2002.)

4418.3. (a) It is the intent of the Legislature to ensure that the transition process from a developmental center to a community living arrangement is based upon the individual's needs, developed through the individual program plan process, and ensures that needed services and supports will be in place at the time the individual moves. It is further the intent of the Legislature that regional centers, developmental centers, and regional resource development projects coordinate with each other for the benefit of their activities in assessment, in the development of individual program plans, and in planning, transition, and deflection, and for the benefit of consumers.

(b) As individuals are identified for possible movement to the community, an individual planning meeting shall be initiated by the developmental center, which shall notify the planning team, pursuant to subdivision (j) of Section 4512, and the regional resource development project of the meeting. The regional resource development project shall make services available to the developmental center and the regional center, including, but not limited to, consultations with the planning teams and the identification of services and supports necessary for the consumer to succeed in community living.

(c) The development of the individual program plan shall be consistent with Sections 4646 and 4646.5. For the purpose of this section, the planning team shall include developmental center staff knowledgeable about the service and support needs of the consumer.

(d) Regional resource development project services may include providing information in an understandable form to consumers and, where appropriate, their families, conservators, legal guardians, or authorized representatives, that will assist them in making decisions about community living and services and supports. This information may include affording the consumer the opportunity

to visit a variety of community living arrangements that could meet his or her needs. If the visits are not feasible, as determined by the planning team, a family member or other representative of the consumer may conduct the visits. Regional resource development projects may be requested to facilitate these visits. The availability of this service shall be made known by the planning team to consumers and, where appropriate, their families, conservators, legal guardians, or authorized representative.

(e) Once the individual program plan is completed and providers of services and supports are identified and agreed to, pursuant to subdivision (b) of Section 4646.5, and no less than 15 days prior to the move, unless otherwise ordered by a court, a transition conference, which may be facilitated by a regional resource development project, shall be held. Participants in the transition conference shall include, but not be limited to, the consumer, where appropriate the consumer's parents, legal guardian, conservator, or authorized representative, a regional center representative, a developmental center representative, and a representative of each provider of primary services and supports identified in the individual program plan. This meeting may take place in the catchment area to which the consumer is moving. If necessary, conferees may participate by telephone or video conference. The purpose of this conference shall be to ensure a smooth transition from the developmental center to the community.

(f) The department, through the appropriate regional resource development project, shall provide, in cooperation with regional centers and developmental centers, followup services to help ensure a smooth transition to the community. Followup services shall include, but shall not limited to, all of the following:

(1) Regularly scheduled as well as on an as-needed basis, contacts and visits with consumers and service providers during the 12 months following the consumers movement date.

(2) Participation in the development of an individual program plan in accordance with Sections 4646 and 4646.5.

(3) Identification of issues that need resolution.

(4) Arrangement for the provision of developmental center services, including, but not limited to, medication review, crisis services, and behavioral consultation.

(g) To ascertain that the individual program plan is being implemented, that planned services are being provided, and that the consumer and, where appropriate the consumer's parents, legal guardian, or conservator, are satisfied with the community living arrangement, the regional center shall schedule face-to-face reviews no less than once every 30 days for the first 90 days. Following the first 90 days, and following notification to the department, the regional center may conduct these reviews less often as specified in the individual program plan.

(h) The regional center and the regional resource development project shall coordinate their followup reviews required pursuant to subdivisions (f) and (g) and shall share with each other information obtained during the course of the followup visits.

(Amended by Stats. 2002, Ch. 1161, Sec. 29. Effective September 30, 2002.)

4418.5. The department may provide protective social services for the care of developmentally disabled patients released from state hospitals of the department or to prevent the unnecessary admission of developmentally disabled

persons to hospitals at public expense or to facilitate the release of developmentally disabled patients for whom such hospital care is no longer the appropriate treatment; provided that such services may be rendered only if provision for such services is made in the California Developmental Disabilities State Plan.

The department, to the extent funds are appropriated and available, shall pay for the cost of providing for care in a private home for developmentally disabled persons described in, and subject to the request and plan conditions of, the immediately preceding paragraph. The monthly rate for such private home care shall be set by the department at an amount which will provide the best possible care at minimum cost and also insure:

(1) That the person will receive proper treatment and may be expected to show progress in achieving the maximum adjustment toward returning to community life; and

(2) That sufficient homes can be recruited to achieve the stated objectives of this section.

It is the legislative intent that the department may make the fullest possible use of available resources in serving developmentally disabled persons.

The department may provide services pursuant to this section directly or through contract with public or private entities.

Notwithstanding any other provision of law, any contract or grant entered into with a public or private nonprofit corporation for the provision of services to developmentally disabled persons may provide for periodic advance payments for services to be performed under such contract. No advanced payment made pursuant to this section shall exceed 25 percent of the total annual contract amount.

The department may provide protective social services, including the cost of care in a private home pursuant to this section or in a suitable facility as specified in Section 7354, for judicially committed developmentally disabled patients released from a state hospital on leave of absence or parole, and payments therefor shall be made from funds available to the department for that purpose or for the support of patients in state hospitals.

(Amended by Stats. 1979, Ch. 1142.)

4418.6. The department may establish within its family care program respite care services for the developmentally disabled. Such respite care services may be available to both family home caretakers and to persons referred by the regional centers for the developmentally disabled. For purposes of this section, respite care means temporary and intermittent care provided for short periods of time.

The rate of reimbursement for such respite care service shall be established by the department after it conducts a study to determine if there are increased costs inherent in the provision of an intermittent and irregular service.

(Added by renumbering Section 10053.9 by Stats. 1978, Ch. 429.)

4418.7. (a) If the regional center determines, or is informed by the consumer's parents, legal guardian, conservator, or authorized representative that the community placement of a consumer is at risk of failing, and that admittance to a state developmental center is a likelihood, the regional center

shall immediately notify the appropriate regional resource development project, the consumer, and the consumer's parents, legal guardian, or conservator.

(b) In these cases, the regional resource development project shall immediately arrange for an assessment of the situation, including, visiting the consumer, if appropriate, determining barriers to successful integration, and recommending the most appropriate means necessary to assist the consumer to remain in the community. If, based on the assessment, the regional resource development project determines that additional or different services and supports are necessary, the department shall ensure that the regional center provides those services and supports on an emergency basis. An individual program plan meeting, including the regional resource development project's representative, shall be convened as soon as possible to review the emergency services and supports and determine the consumer's ongoing needs for services and supports. The regional resource development project shall follow up with the regional center as to the success of the recommended interventions until the consumer's living arrangement is stable.

(c) If the regional resource development project, in consultation with the regional center, the consumer, and the consumer's parents, legal guardian, or conservator, when appropriate, determines that admittance to a state developmental center is necessary to prevent a substantial risk to the individual's health and safety, the regional resource development project shall immediately facilitate that admission.

(d) The department shall collect data on the outcomes of efforts to assist at-risk consumers to remain in the community. The department shall make aggregate data on the implementation of the requirements of this section available, upon request.

(Amended by Stats. 2002, Ch. 1161, Sec. 30. Effective September 30, 2002.)

4419. Within the limits of available funds it is the intent of the Legislature that the department shall require all personnel working directly with patients to complete, within a reasonable time after the effective date of this section or after their appointments, whichever is later, or have completed, training with regard to the care and treatment of such patients.

(Added by Stats. 1977, Ch. 1252.)

4420. In order to assure an adequate number of qualified psychiatric technicians, psychiatrists, physicians and surgeons, psychologists, nurses, social workers, laboratory and other technicians, and ancillary workers, the department shall negotiate with any or all of the following: the University of California, the state colleges, the community colleges, private universities and colleges, and public and private hospitals, and arrange such affiliations or make such contracts for educational or training programs and awards training grants or stipends as may be necessary. Arrangements may be made in the hospitals and clinics operated by the department for the clinical experience essential to such educational and training programs, and positions in the department as interns and residents may be established.

(Amended by Stats. 1979, Ch. 373.)

the department shall include in its reports a description of the change and the fiscal impact. The department shall make this information available to the Legislature during the budget process, but no later than January 10 of each year and no later than the release of the May revision of the Governor's proposed budget each year.

(b) The department shall provide the information required by subdivision (a) on the same dates as specified in subdivision (a) to the State Council on Developmental Disabilities created by Section 4520. The State Council on Developmental Disabilities shall provide the Legislature with review and comment on the information in a report.

(Amended by Stats. 1992, Ch. 713, Sec. 34. Effective September 15, 1992.)

4433. (a) The Legislature finds and declares all of the following:

(1) The State of California accepts its responsibility to ensure and uphold the rights of persons with developmental disabilities and an obligation to ensure that laws, regulations, and policies on the rights of persons with developmental disabilities are observed and protected.

(2) Persons with developmental disabilities are vulnerable to abuse, neglect, and deprivations of their rights.

(3) Clients' rights advocacy services provided by the regional centers, the advocacy services currently provided by the department at the state hospitals, and the services provided by the department's Office of Human Rights may have conflicts of interest, or the appearance of a conflict of interest.

(4) The services provided to individuals with developmental disabilities and their families are of such a special and unique nature that they cannot satisfactorily be provided by state agencies or regional centers and must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code.

(b) (1) To avoid the potential for a conflict of interest or the appearance of a conflict of interest, beginning January 1, 1998, the department shall contract for clients' rights advocacy services. The department shall solicit a single statewide contract with a nonprofit agency that results in at least three responsive bids that meet all of the criteria specified in paragraph (2) to perform the services specified in subdivision (d). If three responsive bids are not received, the department may rebid the contract on a regional basis, not to exceed three regional contracts and one contract for developmental centers and headquarters.

(2) Any contractor selected shall meet the following requirements:

(A) The contractor can demonstrate the capability to provide statewide advocacy services to individuals with developmental disabilities living in developmental centers and in the community.

(B) The contractor does not directly or indirectly provide services to individuals with developmental disabilities, except advocacy services.

(C) The contractor has knowledge of the service system, entitlements, and service rights of persons receiving services from regional centers and in state hospitals.

(D) The contractor can demonstrate the capability of coordinating services with the protection and advocacy agency specified in Division 4.7 (commencing with Section 4900) and the area boards.

(E) The contractor has not provided any services, except advocacy services, to, or been employed by, any regional center or the Association of Regional Center Agencies during the two-year period prior to the effective date of the contract.

(c) For the purposes of this section, the Legislature further finds and declares that because of a potential conflict of interest or the appearance of a conflict of interest, the goals and purposes of the regional center clients' rights advocacy services, the state hospitals, and the services of the Office of Human Rights, cannot be accomplished through the utilization of persons selected pursuant to the regular civil service system, nor can the services be provided through the department's contracts with regional centers. Accordingly, contracts into which the department enters pursuant to this section are permitted and authorized by paragraphs (3) and (5) of subdivision (b) of Section 19130 of the Government Code.

(d) The contractor shall do all of the following:

(1) Provide clients' rights advocacy services to persons with developmental disabilities who are consumers of regional centers and to individuals who reside in the state developmental centers and hospitals, including ensuring the rights of persons with developmental disabilities, and assisting persons with developmental disabilities in pursuing administrative and legal remedies.

(2) Investigate and take action as appropriate and necessary to resolve complaints from, or concerning persons with, developmental disabilities residing in licensed health and community care facilities regarding abuse, and unreasonable denial, or punitive withholding, of rights guaranteed under this division.

(3) Provide consultation, technical assistance, supervision and training, and support services for clients' rights advocates that were previously the responsibility of the Office of Human Rights.

(4) Coordinate the provision of clients' rights advocacy services in consultation with the department, stakeholder organizations, and persons with developmental disabilities and their families representing California's multicultural diversity.

(5) Provide at least two self-advocacy trainings for consumers and family members.

(e) In order to ensure that individuals with developmental disabilities have access to high quality advocacy services, the contractor shall establish a grievance procedure and shall advise persons receiving services under the contract of the availability of other advocacy services, including the services provided by the protection and advocacy agency specified in Division 4.7 (commencing with Section 4900) and the area boards.

(f) The department shall contract on a multiyear basis for a contract term of up to five years, subject to the annual appropriation of funds by the Legislature.

(g) This section shall not prohibit the department and the regional centers from advocating for the rights, including the right to generic services, of persons with developmental disabilities.

(Amended by Stats. 2003, Ch. 230, Sec. 45. Effective August 11, 2003.)

4433.5. Notwithstanding Section 4433, the department may contract with the State Council on Developmental Disabilities for the purpose of utilizing area boards to provide clients' rights advocacy services to individuals with

developmental disabilities who reside in developmental centers and state hospitals. It is the intent of the Legislature that area boards maintain local discretion in the provision of these advocacy services. The state council shall not direct the advocacy services provided by area boards pursuant to this contract, except when necessary to ensure compliance with the contracts.

(Amended by Stats. 2002, Ch. 676, Sec. 2. Effective January 1, 2003.)

4434. (a) Notwithstanding preexisting rights to enforce the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)), it is the intent of the Legislature that the department ensure that the regional centers operate in compliance with federal and state law and regulation and provide services and supports to consumers in compliance with the principles and specifics of this division.

(b) The department shall take all necessary actions to support regional centers to successfully achieve compliance with this section and provide high quality services and supports to consumers and their families.

(c) The contract between the department and individual regional centers required by Chapter 5 (commencing with Section 4620) of Division 4.5 shall include a provision requiring each regional center to render services in accordance with applicable provisions of state laws and regulations. In the event that the department finds a regional center has violated this requirement, or whenever it appears that any regional center has engaged in or is about to engage in any act or practice constituting a violation of any provision of Division 4.5 (commencing with Section 4500) or any regulation adopted thereunder, the department shall promptly take the appropriate steps necessary to ensure compliance with the law, including actions authorized under Section 4632 or 4635. The department, as the director deems appropriate, may pursue other legal or equitable remedies for enforcement of the obligations of regional centers including, but not limited to, seeking specific performance of the contract between the department and the regional center or otherwise act to enforce compliance with Division 4.5 (commencing with Section 4500) or any regulation adopted thereunder.

(d) As part of its responsibility to monitor regional centers, the department shall collect and review printed materials issued by the regional centers, including, but not limited to, purchase of service policies and other policies and guidelines utilized by regional centers when determining the services needs of a consumer, instructions and training materials for regional center staff, board meeting agendas and minutes, and general policy and notifications provided to all providers and consumers and families. Within a reasonable period of time, the department shall review new or amended purchase-of-service policies prior to implementation by the regional center to ensure compliance with statute and regulation. The department shall take appropriate and necessary steps to prevent regional centers from utilizing a policy or guideline that violates any provision of Division 4.5 (commencing with Section 4500) or any regulation adopted thereunder.

(Amended by Stats. 1998, Ch. 310, Sec. 30. Effective August 19, 1998.)

DIVISION 4.5. SERVICES FOR THE DEVELOPMENTALLY DISABLED

(Division 4.5 added by Stats. 1977, Ch. 1252.)

CHAPTER 1. GENERAL PROVISIONS

(Chapter 1 added by Stats. 1977, Ch. 1252.)

4500. This division shall be known and may be cited as the Lanterman Developmental Disabilities Services Act.

(Added by Stats. 1977, Ch. 1252.)

4500.5. The Legislature makes the following findings regarding the State of California's responsibility to provide services to persons with developmental disabilities, and the right of those individuals to receive services, pursuant to this division:

(a) Since the enactment of this division in 1977, the number of consumers receiving services under this division has substantially increased and the nature, variety, and types of services necessary to meet the needs of the consumers and their families have also changed. Over the years the concept of service delivery has undergone numerous revisions. Services that were once deemed desirable by consumers and families may now no longer be appropriate, or the means of service delivery may be outdated.

(b) As a result of the increased demands for services and changes in the methods in which those services are provided to consumers and their families, the value statements and principles contained in this division should be updated.

(c) It is the intent of the Legislature, in enacting the act that added this section, to update existing law; clarify the role of consumers and their families in determining service needs; and to describe more fully service options available to consumers and their families, pursuant to the individual program plan. Nothing in these provisions shall be construed to expand the existing entitlement to services for persons with developmental disabilities set forth in this division.

(d) It is the intent of the Legislature that the department monitor regional centers so that an individual consumer eligible for services and supports under this division receive the services and supports identified in his or her individual program plan.

(Amended by Stats. 1997, Ch. 414, Sec. 4. Effective September 22, 1997.)

4501. The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors, and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance.

The complexities of providing services and supports to persons with developmental disabilities requires the coordination of services of many state departments and community agencies to ensure that no gaps occur in communication or provision of services and supports. A consumer of services and supports, and where appropriate, his or her parents, legal guardian, or conservator, shall have a leadership role in service design.

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Consumers of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. In providing these services, consumers and their families, when appropriate, should participate in decisions affecting their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way in which they spend their time, including education, employment, and leisure, the pursuit of their own personal future, and program planning and implementation. The contributions made by parents and family members in support of their children and relatives with developmental disabilities are important and those relationships should also be respected and fostered, to the maximum extent feasible, so that consumers and their families can build circles of support within the community.

The Legislature finds that the mere existence or the delivery of services and supports is, in itself, insufficient evidence of program effectiveness. It is the intent of the Legislature that agencies serving persons with developmental disabilities shall produce evidence that their services have resulted in consumer or family empowerment and in more independent, productive, and normal lives for the persons served. It is further the intent of the Legislature that the Department of Developmental Services, through appropriate and regular monitoring activities, ensure that regional centers meet their statutory, regulatory, and contractual obligations in providing services to persons with developmental disabilities. The Legislature declares its intent to monitor program results through continued legislative oversight and review of requests for appropriations to support developmental disabilities programs.

(Amended by Stats. 1997, Ch. 414, Sec. 5. Effective September 22, 1997.)

4501.5. In counties where State Department of Developmental Services hospitals are located, the state hospitals shall ensure that appropriate special education and related services, pursuant to Chapter 8 (commencing with Section 56850) of Part 30 of the Education Code, are provided eligible individuals with exceptional needs residing in state hospitals.

(Added by Stats. 1980, Ch. 1191, Sec. 8. Effective September 29, 1980.)

4502. Persons with developmental disabilities have the same legal rights and responsibilities guaranteed all other individuals by the United States Constitution and laws and the Constitution and laws of the State of California. No otherwise

qualified person by reason of having a developmental disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity, which receives public funds.

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. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. 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.

(b) A right to dignity, privacy, and humane care. To the maximum extent possible, treatment, services, and supports shall be provided in natural community settings.

(c) A right to participate in an appropriate program of publicly supported education, regardless of degree of disability.

(d) A right to prompt medical care and treatment.

(e) A right to religious freedom and practice.

(f) A right to social interaction and participation in community activities.

(g) A right to physical exercise and recreational opportunities.

(h) A right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse, or neglect.

(i) A right to be free from hazardous procedures.

(j) A right to make choices in their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way they spend their time, including education, employment, and leisure, the pursuit of their personal future, and program planning and implementation.

(Amended by Stats. 1992, Ch. 1011, Sec. 3. Effective January 1, 1993.)

4502.1. 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. Those public or private agencies shall provide consumers with opportunities to exercise decisionmaking skills in any aspect of day-to-day living and shall provide consumers with relevant information in an understandable form to aid the consumer in making his or her choice.

(Added by Stats. 1992, Ch. 1011, Sec. 3.5. Effective January 1, 1993.)

4503. Each person with developmental disabilities who has been admitted or committed to a state hospital, community care facility as defined in Section 1502 of the Health and Safety Code, or a health facility as defined in Section 1250 of the Health and Safety Code shall have the following rights, a list of which shall be prominently posted in English, Spanish, and other appropriate languages, in all facilities providing those services and otherwise brought to his or her attention by

any additional means as the Director of Developmental Services may designate by regulation:

(a) To wear his or her own clothes, to keep and use his or her own personal possessions including his or her toilet articles, and to keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases.

(b) To have access to individual storage space for his or her private use.

(c) To see visitors each day.

(d) To have reasonable access to telephones, both to make and receive confidential calls.

(e) To have ready access to letterwriting materials, including stamps, and to mail and receive unopened correspondence.

(f) To refuse electroconvulsive therapy.

(g) To refuse behavior modification techniques which cause pain or trauma.

(h) To refuse psychosurgery notwithstanding the provisions of Sections 5325, 5326, and 5326.3. Psychosurgery means those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for any of the following purposes:

(1) Modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain.

(2) Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, action, or behavior.

(3) Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behavior.

(i) To make choices in areas including, but not limited to, his or her daily living routines, choice of companions, leisure and social activities, and program planning and implementation.

(j) Other rights, as specified by regulation.

(Amended by Stats. 2003, Ch. 62, Sec. 324. Effective January 1, 2004.)

4504. The professional person in charge of the facility or his designee may, for good cause, deny a person any of the rights specified under subdivisions (a), (b), (c), (d), and (e) of Section 4503. To ensure that these rights are denied only for good cause, the Director of Developmental Services shall adopt regulations specifying the conditions under which they may be denied. Denial of a person's rights shall in all cases be entered into the person's treatment record and shall be reported to the Director of Developmental Services on a quarterly basis. The content of these records shall enable the Director of Developmental Services to identify individual treatment records, if necessary, for future analysis and investigation. These reports shall be available, upon request, to Members of the Legislature. Information pertaining to denial of rights contained in the person's treatment record shall be made available, on request, to the person, his attorney, his parents, his conservator or guardian, the State Department of Developmental Services, and Members of the Legislature.

(Added by Stats. 1977, Ch. 1252.)

4505. For the purposes of subdivisions (f) and (g) of Section 4503, if the patient is a minor age 15 years or over, the right to refuse may be exercised either by the minor or his parent, guardian, conservator, or other person entitled to his custody.

If the patient or his parent, guardian, conservator, or other person responsible for his custody do not refuse the forms of treatment or behavior modification described in subdivisions (f) and (g) of Section 4503, such treatment and behavior modification may be provided only after review and approval by a peer review committee. The Director of Developmental Services shall, by March 1, 1977, adopt regulations establishing peer review procedures for this purpose.

(Amended by Stats. 1979, Ch. 373.)

4506. It is the intent of the Legislature that the State Department of Developmental Services adopt staffing standards in state hospitals serving persons with developmental disabilities which will assure the maximum personal growth and development of those served. By March 1, 1977, the department shall submit a report to the Legislature on the results of a pilot study of the staffing standards known as Program Review Unit Number 72, and shall include recommendations regarding modifications to such standards or similar standards developed by the department.

The Legislature shall review and approve or disapprove staffing standards by May 1, 1977.

The department shall adopt, and to the extent funds are available, begin implementation of the approved standards in the 1977–78 fiscal year.

It is further the intent of the Legislature that the adopted standards be fully implemented by June 30, 1980.

(Added by Stats. 1977, Ch. 1252.)

4507. Developmental disabilities alone shall not constitute sufficient justification for judicial commitment. Instead, persons with developmental disabilities shall receive services pursuant to this division. Persons who constitute a danger to themselves or others may be judicially committed if evidence of such danger is proven in court.

(Added by Stats. 1977, Ch. 1252.)

4508. Persons with developmental disabilities may be released from developmental centers for provisional placement, with parental consent in the case of a minor or with the consent of an adult person with developmental disabilities or with the consent of the guardian or conservator of the person with developmental disabilities, not to exceed twelve months, and shall be referred to a regional center for services pursuant to this division. Any person placed pursuant to this section shall have an automatic right of return to the developmental center during the period of provisional placement.

(Amended by Stats. 1997, Ch. 414, Sec. 6. Effective September 22, 1997.)

4509. By January 1, 1977, the Director of Developmental Services shall compile a roster of all persons who are in the custody of a state hospital, or on leave therefrom, pursuant to an order of judicial commitment as a mentally retarded person made prior to January 1, 1976. The appropriate regional center shall be given a copy of the names and pertinent records of the judicially committed

retarded persons within its jurisdiction, and shall investigate the need and propriety of further judicial commitment of such persons under the provisions of Sections 6500 and 6500.1.

Each regional center shall complete all investigations required by this section within two years after the roster is submitted. In conducting its investigations, each regional center shall solicit information, advice, and recommendations of state hospital personnel familiar with the person whose needs are being evaluated.

For those persons found by a regional center to no longer require state hospital care, the regional center shall immediately prepare an individual program plan pursuant to Sections 4646 and 4648 for the provision of appropriate alternative services outside the state hospital.

If such alternative is not immediately available, the regional center shall give continuing high priority to the location and development of such services. As part of the program budget submission required in Section 4776, the regional director shall include a report specifying:

(a) The number of state hospital residents for whom a community alternative is deemed more suitable than a state hospital.

(b) The number of residents for whom no placement is made because of a lack of community services.

(c) The number, type, nature, and cost of community services that would be necessary in order for placement to occur.

For those persons found to be in continued need of state hospital care, the regional center shall either admit such person as a voluntary resident of the state hospital, or shall file a petition seeking the commitment of those persons for whom commitment is believed to be appropriate.

(Added by Stats. 1977, Ch. 1252.)

4510. The State Department of Developmental Services and the State Department of Mental Health shall jointly develop and implement a statewide program for encouraging the establishment of sufficient numbers and types of living arrangements, both in communities and state hospitals, as necessary to meet the needs of persons served by those departments. The departments shall consult with the following organizations in the development of procedures pursuant to this section:

(a) The League of California Cities, the County Supervisors Association of California, and representatives of other local agencies.

(b) Organizations or advocates for clients receiving services in residential care services.

(c) Providers of residential care services.

(Amended by Stats. 1992, Ch. 713, Sec. 36. Effective September 15, 1992.)

4511. (a) The Legislature finds and declares that meeting the needs and honoring the choices of persons with developmental disabilities and their families requires information, skills and coordination and collaboration between consumers, families, regional centers, advocates and service and support providers.

(b) The Legislature further finds and declares that innovative and ongoing training opportunities can enhance the information and skills necessary and foster improved coordination and cooperation between system participants.

(c) The department shall be responsible, subject to the availability of fiscal and personnel resources, for securing, providing, and coordinating training to assist consumers and their families, regional centers, and services and support providers in acquiring the skills, knowledge, and competencies to achieve the purposes of this division.

(d) This training may include health and safety issues; person-centered planning; consumer and family rights; building circles of support; training and review protocols for the use of psychotropic and other medications; crime prevention; life quality assessment and outcomes; maximizing inclusive opportunities in the community; how to communicate effectively with consumers; and developing opportunities for decisionmaking.

(e) Whenever possible, the department shall utilize existing training tools and expertise.

(f) Each training module shall include an evaluation component.

(g) The department shall establish an advisory group, consisting of consumers, family members, regional centers, service providers, advocates and legislative representatives. The advisory group shall make recommendations for training subjects, review the design of training modules, and assess training outcomes.

(Added by Stats. 1998, Ch. 310, Sec. 31. Effective August 19, 1998.)

4512. As used in this division:

(a) "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. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

(b) "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan 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 individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements,

physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills training, specialized medical and dental care, supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan.

(c) Notwithstanding subdivisions (a) and (b), for any organization or agency receiving federal financial participation under the federal Developmental Disabilities Assistance and Bill of Rights Act, as amended "developmental disability" and "services for persons with developmental disabilities" means the terms as defined in the federal act to the extent required by federal law.

(d) "Consumer" means a person who has a disability that meets the definition of developmental disability set forth in subdivision (a).

(e) "Natural supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships, friendships reflecting the diversity of the neighborhood and the community, associations with fellow students or employees in regular classrooms and workplaces, and associations developed through participation in clubs, organizations, and other civic activities.

(f) "Circle of support" means a committed group of community members, who may include family members, meeting regularly with an individual with developmental disabilities in order to share experiences, promote autonomy and community involvement, and assist the individual in establishing and maintaining natural supports. A circle of support generally includes a plurality of members who neither provide nor receive services or supports for persons with developmental disabilities and who do not receive payment for participation in the circle of support.

(g) "Facilitation" means the use of modified or adapted materials, special instructions, equipment, or personal assistance by an individual, such as assistance with communications, that will enable a consumer to understand and participate to the maximum extent possible in the decisions and choices that effect his or her life.

(h) "Family support services" means services and supports that are provided to a child with developmental disabilities or his or her family and that contribute to the ability of the family to reside together.

(i) "Voucher" means any authorized alternative form of service delivery in which the consumer or family member is provided with a payment, coupon, chit, or other form of authorization that enables the consumer or family member to choose his or her own service provider.

(j) "Planning team" means the individual with developmental disabilities, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, one or more regional center representatives, including the designated regional center service coordinator pursuant to subdivision (b) of Section 4640.7, any individual, including a service provider, invited by the consumer, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, or the authorized representative, including those appointed pursuant to Section 4590 and subdivision (e) of Section 4705.

(k) "Stakeholder organizations" means statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations.

(*l*) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

(Amended by Stats. 2003, Ch. 230, Sec. 46. Effective August 11, 2003.)

4513. (a) Whenever the department allocates funds to a regional center through a request for proposal process to implement special projects funded through the Budget Act, the department shall require that the regional center demonstrate community support for the proposal.

(b) In awarding funds to regional centers to implement such proposals, the department shall consider, among other indicators, the following:

(1) The demonstrated commitment of the regional center in establishing or expanding the service or support.

(2) The demonstrated ability of the regional center to implement the proposal.

(3) The success or failure of previous efforts to establish or expand the service or support.

(4) The need for the establishment or expansion of the service and support in the regional center catchment area as compared to other geographic areas.

(c) The department may require periodic progress reports from the regional center in implementing a proposal.

itself, by the officers or employees of the regional center, or by an independent contractor, consultant or attorney.

State funds shall not be used to litigate the issue of the application of the National Labor Relations Act to, nor the jurisdiction of the National Labor Relations Board over, non-profit corporations operating regional centers.

Nothing in this section shall be construed as limiting the employers rights under Section 8(c) of the National Labor Relations Act. Nothing in this section shall be construed as limiting the use of state funds by the regional center in the employment of, or for contracting for, assistance in good faith collective bargaining or in handling employee grievances, including arbitration, under an employee-employer contract.

(Added by Stats. 1982, Ch. 327, Sec. 200. Effective June 30, 1982.)

4639. The governing board of a regional center shall annually contract with an independent accounting firm for an audited financial statement. The audit report and accompanying management letter shall be reviewed and approved by the regional center board and submitted to the department within 60 days of completion and before April 1 of each year. Upon submission to the department, the audit report and accompanying management letter shall be made available to the public by the regional center. It is the intent of the Legislature that no additional funds be appropriated for this purpose.

(Added by Stats. 1997, Ch 294, Sec. 36. Effective August 18, 1997.)

4639.5. (a) By December 1 of each year, each regional center shall provide a listing to the State Department of Developmental Services a complete current salary schedule for all personnel classifications used by the regional center. The information shall be provided in a format prescribed by the department. The department shall provide this information to the public upon request.

(b) By December 1 of each year, each regional center shall report information to the State Department of Developmental Services on all prior fiscal year expenditures from the regional center operations budget for all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services, whether procured under a written contract or otherwise. Expenditures for the maintenance, repair or purchase of equipment or property shall not be required to be reported for purposes of this subdivision. The report shall be prepared in a format prescribed by the department and shall include, at a minimum, for each recipient the amount of funds expended, the type of service, and purpose of the expenditure. The department shall provide this information to the public upon request.

(Added by Stats. 2000, Ch. 93, Sec. 47. Effective July 7, 2000.)

Article 2. Regional Center Responsibilities

(Article 2 added by Stats. 1977, Ch. 1252.)

4640. (a) Contracts between the department and regional centers shall specify the service area and the categories of persons that regional centers shall be expected to serve and the services and supports to be provided.

(b) In order to ensure uniformity in the application of the definition of developmental disability contained in this division, the Director of

Developmental Services shall, by March 1, 1977, issue regulations that delineate, by diagnostic category and degree of disability, those persons who are eligible for services and supports by regional centers. In issuing the regulations, the director shall invite and consider the views of regional center contracting agencies, the state council, and persons with a demonstrated and direct interest in developmental disabilities.

(Amended by Stats. 1998, Ch. 1043, Sec. 4. Effective January 1, 1999.)

4640.6. (a) In approving regional center contracts, the department shall ensure that regional center staffing patterns demonstrate that direct service coordination are the highest priority.

(b) Contracts between the department and regional centers shall require that regional centers implement an emergency response system that ensures that a regional center staff person will respond to a consumer, or individual acting on behalf of a consumer, within two hours of the time an emergency call is placed. This emergency response system shall be operational 24 hours per day, 365 days per year.

(c) Contracts between the department and regional centers shall require regional centers to have service coordinator-to-consumer ratios, as follows:

(1) An average service coordinator-to-consumer ratio of 1 to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.

(2) An average service coordinator-to-consumer ratio of 1 to 45 for all consumers who have moved from a developmental center to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 59 consumers for more than 60 days.

(3) Commencing January 1, 2004, to June 30, 2007, inclusive, the following coordinator-to-consumer ratios shall apply:

(A) All consumers three years of age and younger and for consumers enrolled on the Home and Community-based Services Waiver for persons with developmental disabilities, an average service coordinator-to-consumer ratio of 1 to 62.

(B) All consumers who have moved from a developmental center to the community since April 14, 1993, and have lived continuously in the community for at least 12 months, an average service coordinator-to-consumer ratio of 1 to 62.

(C) All consumers who have not moved from the developmental centers to the community since April 14, 1993, and who are not described in subparagraph (A), an average service coordinator-to-consumer ratio of 1 to 66.

(4) For purposes of paragraph (3), service coordinators may have a mixed caseload of consumers three years of age and younger, consumers enrolled on the Home and Community-based Services Waiver program for persons with developmental disabilities, and other consumers if the overall average caseload is weighted proportionately to ensure that overall regional center average service coordinator-to-consumer ratios as specified in paragraph (3) are met. For purposes of paragraph (3), in no case shall a service coordinator have an assigned caseload in excess of 84 for more than 60 days.

(d) For purposes of this section, "service coordinator" means a regional center employee whose primary responsibility includes preparing, implementing, and monitoring consumers' individual program plans, securing and coordinating consumer services and supports, and providing placement and monitoring activities.

(e) In order to ensure that caseload ratios are maintained pursuant to this section, each regional center shall provide service coordinator caseload data to the department, annually for each fiscal year. The data shall be submitted in the format, including the content, prescribed by the department. Within 30 days of receipt of data submitted pursuant to this subdivision, the department shall make a summary of the data available to the public upon request. The department shall verify the accuracy of the data when conducting regional center fiscal audits. Data submitted by regional centers pursuant to this subdivision shall:

(1) Only include data on service coordinator positions as defined in subdivision (d). Regional centers shall identify the number of positions that perform service coordinator duties on less than a full-time basis. Staffing ratios reported pursuant to this subdivision shall reflect the appropriate proportionality of these staff to consumers served.

(2) Be reported separately for service coordinators whose caseload includes any of the following:

(A) Consumers who are three years of age and older and who have not moved from the developmental center to the community since April 14, 1993.

(B) Consumers who have moved from a developmental center to the community since April 14, 1993.

(C) Consumers who are younger than three years of age.

(D) Consumers enrolled in the Home and Community-based Services Waiver program.

(3) Not include positions that are vacant for more than 60 days or new positions established within 60 days of the reporting month that are still vacant.

(f) The department shall provide technical assistance and require a plan of correction for any regional center that, for two consecutive reporting periods, fails to maintain service coordinator caseload ratios required by this section or otherwise demonstrates an inability to maintain appropriate staffing patterns pursuant to this section. Plans of correction shall be developed following input from the local area board, local organizations representing consumers, family members, regional center employees, including recognized labor organizations, and service providers, and other interested parties.

(g) Contracts between the department and regional center shall require the regional center to have, or contract for, all of the following areas:

(1) Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.

(2) Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.

(3) Family support expertise to assist the regional center in maximizing the effectiveness of support and services provided to families.

(4) Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supportive living arrangements.

(5) Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.

(6) Quality assurance expertise, to assist the regional center to provide the necessary coordination and cooperation with the area board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

(7) Each regional center shall employ at least one consumer advocate who is a person with developmental disabilities.

(8) Other staffing arrangements related to the delivery of services that the department determines are necessary to ensure maximum cost-effectiveness and to ensure that the service needs of consumers and families are met.

(h) Any regional center proposing a staffing arrangement that substantially deviates from the requirements of this section shall request a waiver from the department. Prior to granting a waiver, the department shall require a detailed staffing proposal, including, but not limited to, how the proposed staffing arrangement will benefit consumers and families served, and shall demonstrate clear and convincing support for the proposed staffing arrangement from constituencies served and impacted, that include, but are not limited to, consumers, families, providers, advocates, and recognized labor organizations. In addition, the regional center shall submit to the department any written opposition to the proposal from organizations or individuals, including, but not limited to, consumers, families, providers, and advocates, including recognized labor organizations. The department may grant waivers to regional centers that sufficiently demonstrate that the proposed staffing arrangement is in the best interest of consumers and families served, complies with the requirements of this chapter, and does not violate any contractual requirements. A waiver shall be approved by the department for up to 12 months, at which time a regional center may submit a new request pursuant to this subdivision.

(i) The requirements of subdivisions (c), (f), and (h) shall not apply when a regional center is required to develop an expenditure plan pursuant to Section 4791, and when the expenditure plan addresses the specific impact of the budget reduction on staffing requirements and the expenditure plan is approved by the department.

(j) (1) Any contract between the department and a regional center entered into on and after January 1, 2003, shall require that all employment contracts entered into with regional center staff or contractors be available to the public for review, upon request. For purposes of this subdivision, an employment contract or portion thereof may not be deemed confidential nor unavailable for public review.

(2) Notwithstanding paragraph (1), the social security number of the contracting party may not be disclosed.

(3) The term of the employment contract between the regional center and an employee or contractor shall not exceed the term of the state's contract with the regional center.

(Amended by Stats. 2003, Ch. 230, Sec. 49. Effective August 11, 2003.)

4640.7. (a) It is the intent of the Legislature that regional centers assist persons with developmental disabilities and their families in securing those services and supports which maximize opportunities and choices for living, working, learning, and recreating in the community.

(b) Each regional center design shall reflect the maximum cost-effectiveness possible and shall be based on a service coordination model, in which each consumer shall have a designated service coordinator who is responsible for providing or ensuring that needed services and supports are available to the consumer. Regional centers shall examine the differing levels of coordination services needed by consumers and families in order to establish varying caseload ratios within the regional center which will best meet those needs of their consumers.

(Added by Stats. 1992, Ch. 1011, Sec. 9. Effective January 1, 1993.)

4640.8. When convening any task force or advisory group, a regional center shall make its best effort to ensure representation by consumers and family members representing the community's multicultural diversity.

(Added by Stats. 1997, Ch. 414, Sec. 16. Effective September 22, 1997.)

4641. All regional centers shall conduct casefinding activities, including notification of availability of service in English and such other languages as may be appropriate to the service area, outreach services in areas with a high incidence of developmental disabilities, and identification of persons who may need service.

(Added by Stats. 1977, Ch. 1252.)

4642. Any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant shall be eligible for initial intake and assessment services in the regional centers. In addition, any infant having a high risk of becoming developmentally disabled may be eligible for initial intake and assessment services in the regional centers. For purposes of this section, "high-risk infant" means a child less than 36 months of age whose genetic, medical, or environmental history is predictive of a substantially greater risk for developmental disability than that for the general population. The department, in consultation with the State Department of Health Services, shall develop specific risk and service criteria for the high-risk infant program on or before July 1, 1983. These criteria may be modified in subsequent years based on analysis of actual clinical experience.

Initial intake shall be performed within 15 working days following request for assistance. Initial intake shall include, but need not be limited to, information and advice about the nature and availability of services provided by the regional center and by other agencies in the community, including guardianship, conservatorship, income maintenance, mental health, housing, education, work activity and vocational training, medical, dental, recreational, and other services or programs that may be useful to persons with developmental disabilities or their families. Intake shall also include a decision to provide assessment.

(Amended by Stats. 1982, Ch. 1242, Sec. 1.)

4643. (a) If assessment is needed, prior to July 1, 2004, the assessment shall be performed within 120 days following initial intake. Assessment shall be

performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b). On and after July 1, 2004, the assessment shall be performed within 60 days following intake and if unusual circumstances prevent the completion of assessment within 60 days following intake, this assessment period may be extended by one 30-day period with the advance written approval of the department.

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

(Amended by Stats. 2003, Ch. 230, Sec. 50. Effective August 11, 2003.)

4643.3. (a) (1) On or before April 1, 2002, the department shall develop evaluation and diagnostic procedures for the diagnosis of autism disorder and other autistic spectrum disorders.

(2) The department shall publish or arrange for the publication of the evaluation and diagnostic procedures required by paragraph (1). The published evaluation and diagnostic procedures shall be available to the public.

(b) The department shall develop a training program for regional center clinical staff in the utilization of diagnostic procedures for the diagnosis of autism disorder. The training program shall be implemented on or before July 1, 2002.

(Added by Stats. 2001, Ch. 171, Sec. 26. Effective August 10, 2001.)

4643.5. (a) If a consumer is or has been determined to be eligible for services by a regional center, he or she shall also be considered eligible by any other regional center if he or she has moved to another location within the state.

(b) An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

(c) Whenever a consumer transfers from one regional center catchment area to another, the level and types of services and supports specified in the consumer's individual program plan shall be authorized and secured, if available, pending the development of a new individual program plan for the consumer. If these services and supports do not exist, the regional center shall convene a meeting to develop a new individual program plan within 30 days. Prior to approval of the new individual program plan, the regional center shall provide alternative services and supports that best meet the individual program plan objectives in the least restrictive setting. The department shall develop guidelines that describe the

responsibilities of regional centers in ensuring a smooth transition of services and supports from one regional center to another, including, but not limited to, pretransferring planning and a dispute resolution process to resolve disagreements between regional centers regarding their responsibilities related to the transfer of case management services.

(Amended by Stats. 1997, Ch. 294, Sec. 37. Effective August 18, 1997.)

4644. (a) In addition to any person eligible for initial intake or assessment services, regional centers may cause to be provided preventive services to any potential parent requesting these services and who is determined to be at high risk of parenting a developmentally disabled infant, or, at the request of the parent or guardian, to any infant at high risk of becoming developmentally disabled. It is the intent of the Legislature that preventive services shall be given equal priority with all other basic regional center services. These services shall, inasmuch as feasible, be provided by appropriate generic agencies, including, but not limited to, county departments of health, perinatal centers, and genetic centers. The department shall implement operating procedures to ensure that prevention activities are funded from regional center purchase of service funds only when funding for these services is unavailable from local generic agencies. In no case, shall regional center funds be used to supplant funds budgeted by any agency which has a responsibility to provide prevention services to the general public.

(b) For purposes of this section, "generic agency" means any agency which has a legal responsibility to serve all members of the general public and which is receiving public funds for providing such services.

(Amended by Stats. 1982, Ch. 1242, Sec. 2.)

4646. (a) It is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments. It is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.

(b) The individual program plan is developed through a process of individualized needs determination. The individual with developmental disabilities and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, shall have the opportunity to actively participate in the development of the plan.

(c) An individual program plan shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment. At the time of intake, the regional center shall inform the consumer and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, of the services available through the local area board and the protection and advocacy agency designated by the Governor pursuant to

federal law, and shall provide the address and telephone numbers of those agencies.

(d) Individual program plans shall be prepared jointly by the planning team. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the consumer's individual program plan and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative at the program plan meeting.

(e) Regional centers shall comply with the request of a consumer, or where appropriate, the request of his or her parents, legal guardian, or conservator, that a designated representative receive written notice of all meetings to develop or revise his or her individual program plan and of all notices sent to the consumer pursuant to Section 4710. The designated representative may be a parent or family member.

(f) If a final agreement regarding the services and supports to be provided to the consumer cannot be reached at a program plan meeting, then a subsequent program plan meeting shall be convened within 15 days, or later at the request of the consumer or, when appropriate, the parents, legal guardian, conservator, or authorized representative or when agreed to by the planning team. Additional program plan meetings may be held with the agreement of the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative.

(g) An authorized representative of the regional center and the consumer or, where appropriate, his or her parents, legal guardian, or conservator, shall sign the individual program plan prior to its implementation. If the consumer or, where appropriate, his or her parents, legal guardian, or conservator, does not agree with all components of the plan, they may indicate that disagreement on the plan. Disagreement with specific plan components shall not prohibit the implementation of services and supports agreed to by the consumer or, where appropriate, his or her parents, legal guardian, or conservator. If the consumer or, where appropriate, his or her parents, legal guardian, or conservator, does not agree with the plan in whole or in part, he or she shall be sent written notice of the fair hearing rights, as required by Section 4701.

(Amended by Stats. 1998, Ch. 1043, Sec. 5. Effective January 1, 1999.)

4646.5. (a) The planning process for the individual program plan described in Section 4646 shall include all of the following:

(1) Gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the person with developmental disabilities. For children with developmental disabilities, this process should include a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments shall be conducted by qualified individuals and performed in natural environments whenever possible. Information shall be taken from the consumer, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The assessment process shall reflect awareness of,

and sensitivity to. the lifestyle and cultural background of the consumer and the family.

(2) A statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities, and a statement of specific, time-limited objectives for implementing the person's goals and addressing his or her needs. These objectives shall be stated in terms that allow measurement of progress or monitoring of service delivery. These goals and objectives should maximize opportunities for the consumer to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over his or her life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals.

(3) When developing individual program plans for children, regional centers shall be guided by the principles, process, and services and support parameters set forth in Section 4685.

(4) A schedule of the type and amount of services and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the individual program plan goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. The plan shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services.

(5) When agreed to by the consumer, the parents or legally appointed guardian of a minor consumer, or the legally appointed conservator of an adult consumer or the authorized representative, including those appointed pursuant to Section 4590 and subdivision (e) of Section 4705, a review of the general health status of the adult or child including a medical, dental, and mental health needs shall be conducted. This review shall include a discussion of current medications, any observed side effects, and the date of last review of the medication. Service providers shall cooperate with the planning team to provide any information necessary to complete the health status review. If any concerns are noted during the review, referrals shall be made to regional center clinicians or to the consumer's physician, as appropriate. Documentation of health status and referrals shall be made in the consumer's record by the service coordinator.

(6) A schedule of regular periodic review and reevaluation to ascertain that planned services have been provided, that objectives have been fulfilled within the times specified, and that consumers and families are satisfied with the individual program plan and its implementation.

(b) For all active cases, individual program plans shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years. If the consumer or, where appropriate, the consumer's parents, legal guardian, or conservator requests an individual program plan review, the individual program shall be reviewed within 30 days after the request is submitted.

(c) (1) The department, with the participation of representatives of a statewide consumer organization, the Association of Regional Center Agencies, an organized labor organization representing service coordination staff, and the

Organization of Area Boards shall prepare training material and a standard format and instructions for the preparation of individual program plans, which embodies an approach centered on the person and family.

(2) Each regional center shall use the training materials and format prepared by the department pursuant to paragraph (1).

(3) The department shall biennially review a random sample of individual program plans at each regional center to assure that these plans are being developed and modified in compliance with Section 4646 and this section.

(Amended by Stats. 2002, Ch. 1161, Sec. 33. Effective September 30, 2002.)

4647. (a) Pursuant to Section 4640.7, service coordination shall include those activities necessary to implement an individual program plan, including, but not limited to, participation in the individual program plan process; assurance that the planning team considers all appropriate options for meeting each individual program plan objective; securing, through purchasing or by obtaining from generic agencies or other resources, services and supports specified in the person's individual program plan; coordination of service and support programs; collection and dissemination of information; and monitoring implementation of the plan to ascertain that objectives have been fulfilled and to assist in revising the plan as necessary.

(b) The regional center shall assign a service coordinator who shall be responsible for implementing, overseeing, and monitoring each individual program plan. The service coordinator may be an employee of the regional center or may be a qualified individual or employee of an agency with whom the regional center has contracted to provide service coordination services, or persons described in Section 4647.2. The regional center shall provide the consumer or, where appropriate, his or her parents, legal guardian, or conservator or authorized representative, with written notification of any permanent change in the assigned service coordinator within 10 business days. No person shall continue to serve as a service coordinator for any individual program plan unless there is agreement by all parties that the person should continue to serve as service coordinator.

(c) Where appropriate, a consumer or the consumer's parents or other family members, legal guardian, or conservator, may perform all or part of the duties of the service coordinator described in this section if the regional center director agrees and it is feasible.

(d) If any person described in subdivision (c) is designated as the service coordinator, that person shall not deviate from the agreed-upon program plan and shall provide any reasonable information and reports required by the regional center director.

(e) If any person described in subdivision (c) is designated as the service coordinator, the regional center shall provide ongoing information and support as necessary, to assist the person to perform all or part of the duties of service coordinator.

(Amended by Stats. 1999, Ch. 146, Sec. 26. Effective July 22, 1999.)

4648. In order to achieve the stated objectives of a consumer's individual program plan, the regional center shall conduct activities including, but not limited to, all of the following:

(a) Securing needed services and supports.

(1) It is the intent of the Legislature that services and supports assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible and in exercising personal choices. The regional center shall secure services and supports that meet the needs of the consumer, as determined in the consumer's individual program plan, and within the context of the individual program plan, 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.

(2) 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.

(3) A regional center may, pursuant to vendorization or a contract, purchase services or supports for a consumer from any individual or agency which the regional center and consumer or, where appropriate, his or her parents, legal guardian, or conservator, or authorized representatives, determines will best accomplish all or any part of that consumer's program plan.

(A) Vendorization or contracting is the process for identification, selection, and utilization of service vendors or contractors, based on the qualifications and other requirements necessary in order to provide the service.

(B) A regional center may reimburse an individual or agency for services or supports provided to a regional center consumer if the individual or agency has a rate of payment for vendored or contracted services established by the department, pursuant to this division, and is providing services pursuant to an emergency vendorization or has completed the vendorization procedures or has entered into a contract with the regional center and continues to comply with the vendorization or contracting requirements. The director shall adopt regulations governing the vendorization process to be utilized by the department, regional centers, vendors and the individual or agency requesting vendorization.

(C) Regulations shall include, but not be limited to: the vendor application process, and the basis for accepting or denying an application; the qualification and requirements for each category of services that may be provided to a regional center consumer through a vendor; requirements for emergency vendorization; procedures for termination of vendorization; the procedure for an individual or an agency to appeal any vendorization decision made by the department or regional center.

(D) A regional center may vendorize a licensed facility for exclusive services to persons with developmental disabilities at a capacity equal to or less than the facility's licensed capacity. A facility already licensed on January 1, 1999, shall continue to be vendorized at their full licensed capacity until the facility agrees to vendorization at a reduced capacity.

(4) Notwithstanding subparagraph (B), a regional center may contract or issue a voucher for services and supports provided to a consumer or family at a cost not to exceed the maximum rate of payment for that service or support established by the department. If a rate has not been established by the department, the regional center may, for an interim period, contract for a specified service or support with, and establish a rate of payment for, any provider of the service or support necessary to implement a consumer's individual program plan. Contracts may be negotiated for a period of up to three years, with annual review and subject to the availability of funds.

(5) In order to ensure the maximum flexibility and availability of appropriate services and supports for persons with developmental disabilities, the department shall establish and maintain an equitable system of payment to providers of services and supports identified as necessary to the implementation of a consumers' individual program plan. The system of payment shall include provision for a rate to ensure that the provider can meet the special needs of consumers and provide quality services and supports in the least restrictive setting as required by law.

(6) The regional center and the consumer, or where appropriate, his or her parents, legal guardian, conservator, or authorized representative, including those appointed pursuant to Section 4590 or subdivision (e) of Section 4705, shall, pursuant to the individual program plan, 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 individual program plan.

(B) A provider's success in achieving the objectives set forth in the individual program plan.

(C) Where appropriate, the existence of licensing, accreditation, or professional certification.

(D) The cost of providing services or supports of comparable quality by different providers, if available.

(E) The consumer's or, where appropriate, the parents, legal guardian, or conservator of a consumer's choice of providers.

(7) 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, including those appointed pursuant to Section 4590 or subdivision (e) of Section 4705, is satisfied and the regional center and the consumer or, when appropriate, the person's parents or legal guardian or conservator agree that planned services and supports have been provided, and reasonable progress toward objectives have been made.

(8) Regional center funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services.

(9) (A) A regional center may, directly or through an agency acting on behalf of the center, provide placement in, purchase of, or follow-along services to persons with developmental disabilities in, appropriate community living arrangements, including, but not limited to, support service for consumers in homes they own or lease, foster family placements, health care facilities, and licensed community care facilities. In considering appropriate placement

alternatives for children with developmental disabilities, approval by the child's parent or guardian shall be obtained before placement is made.

(B) Each person with developmental disabilities placed by the regional center in a community living arrangement shall have the rights specified in this division. These rights shall be brought to the person's attention by any means necessary to reasonably communicate these rights to each resident, provided that, at a minimum, the Director of Developmental Services prepare, provide, and require to be clearly posted in all residential facilities and day programs a poster using simplified language and pictures that is designed to be more understandable by persons with cognitive disabilities and that the rights information shall also be available through the regional center to each residential facility and day program in alternative formats, including, but not limited to, other languages, braille, and audio tapes, when necessary to meet the communication needs of consumers.

(C) Consumers are eligible to receive supplemental services including, but not limited to, additional staffing, pursuant to the process described in subdivision (d) of Section 4646. Necessary additional staffing that is not specifically included in the rates paid to the service provider may be purchased by the regional center if the additional staff are in excess of the amount required by regulation and the individual's planning team determines the additional services are consistent with the provisions of the individual program plan. Additional staff should be periodically reviewed by the planning team for consistency with the individual program plan objectives in order to determine if continued use of the additional staff is necessary and appropriate and if the service is producing outcomes consistent with the individual program plan. Regional centers shall monitor programs to ensure that the additional staff is being provided and utilized appropriately.

(10) Emergency and crisis intervention services including, but not limited to, mental health services and behavior modification services, may be provided, as needed, to maintain persons with developmental disabilities in the living arrangement of their own choice. Crisis services shall first be provided without disrupting a person's living arrangement. If crisis intervention services are unsuccessful, emergency housing shall be available in the person's home community. If dislocation cannot be avoided, every effort shall be made to return the person to his or her living arrangement of choice, with all necessary supports, as soon as possible.

(11) Among other service and support options, planning teams shall consider the use of paid roommates or neighbors, personal assistance, technical and financial assistance, and all other service and support options which would result in greater self-sufficiency for the consumer and cost-effectiveness to the state.

(12) When facilitation as specified in an individual program plan requires the services of an individual, the facilitator shall be of the consumer's choosing.

(13) The community support may be provided to assist individuals with developmental disabilities to fully participate in community and civic life, including, but not limited to, programs, services, work opportunities, business, and activities available to persons without disabilities. This facilitation shall include, but not be limited to, any of the following:

(A) Outreach and education to programs and services within the community.

(B) Direct support to individuals which would enable them to more fully participate in their community.

(C) Developing unpaid natural supports when possible.

(14) Other services and supports may be provided as set forth in Sections 4685, 4686, 4687, 4688, and 4689, when necessary.

(b) (1) Advocacy for, and protection of, the civil, legal, and service rights of persons with developmental disabilities as established in this division.

(2) Whenever the advocacy efforts of a regional center to secure or protect the civil, legal, or service rights of any of its consumers prove ineffective, the regional center or the person with developmental disabilities or his or her parents, legal guardian, or other representative may request the area board to initiate action under the provisions defining area board advocacy functions established in this division.

(c) The regional center may assist consumers and families directly, or through a provider, in identifying and building circles of support within the community.

(d) In order to increase the quality of community services and protect consumers, the regional center shall, when appropriate, take either of the following actions:

(1) Identify services and supports that are ineffective or of poor quality and provide or secure consultation, training, or technical assistance services for any agency or individual provider to assist that agency or individual provider in upgrading the quality of services or supports.

(2) Identify providers of services or supports that may not be in compliance with local, state, and federal statutes and regulations and notify the appropriate licensing or regulatory authority, or request the area board to investigate the possible noncompliance.

(e) When necessary to expand the availability of needed services of good quality, a regional center may take actions that include, but are not limited to, the following:

(1) Soliciting an individual or agency by requests for proposals or other means, to provide needed services or supports not presently available.

(2) Requesting funds from the Program Development Fund, pursuant to Section 4677, or community placement plan funds designated from that fund, to reimburse the startup costs needed to initiate a new program of services and supports.

(3) Using creative and innovative service delivery models, including, but not limited to, natural supports.

(f) Except in emergency situations, a regional center shall not provide direct treatment and therapeutic services, but shall utilize appropriate public and private community agencies and service providers to obtain those services for its consumers.

(g) Where there are identified gaps in the system of services and supports or where there are identified consumers for whom no provider will provide services and supports contained in his or her individual program plan, the department may provide the services and supports directly.

(Amended by Stats. 1998, Ch. 1043, Sec. 7. Effective January 1, 1999.)

4648.1. (a) The State Department of Developmental Services and regional centers may monitor services and supports purchased for regional center consumers with or without prior notice. Not less than two monitoring visits to a licensed long-term health care or community care facility or family home agency home each year shall be unannounced. The department may conduct fiscal reviews and audits of the service providers' records.

(b) Department and regional center staff involved in monitoring or auditing services provided to the regional centers' consumers by a service provider shall have access to the provider's grounds, buildings, and service program, and to all related records, including books, papers, computerized data, accounting records, and related documentation. All persons connected with the service provider's program, including, but not limited to, program administrators, staff, consultants, and accountants, shall provide information and access to facilities as required by the department or regional center.

(c) The department, in cooperation with regional centers, shall ensure that all providers of services and supports purchased by regional centers for their consumers are informed of all of the following:

(1) The provisions of this section.

(2) The responsibility of providers to comply with laws and regulations governing both their service program and the provision of services and supports to people with developmental disabilities.

(3) The responsibility of providers to comply with conditions of any contract or agreement between the regional center and the provider, and between the provider and the department.

(4) The rights of providers established in regulations adopted pursuant to Sections 4648.2, 4748, and 4780.5, to appeal actions taken by regional centers or the department as a result of their monitoring and auditing findings.

(d) A regional center may terminate payments for services, and may terminate its contract or authorization for the purchase of consumer services if it determines that the provider has not complied with provisions of its contract or authorization with the regional center or with applicable state laws and regulations. When terminating payments for services or its contract or authorization for the purchase of consumer services, a regional center shall make reasonable efforts to avoid unnecessary disruptions of consumer services.

(e) A regional center or the department may recover from the provider funds paid for services when the department or the regional center determines that either of the following has occurred:

(1) The services were not provided in accordance with the regional center's contract or authorization with the provider, or with applicable state laws or regulations.

(2) The rate paid is based on inaccurate data submitted by the provider on a provider cost statement.

Any funds so recovered shall be remitted to the department.

(f) Any evidence of suspected licensing violations found by department or regional center personnel shall be reported immediately to the appropriate state licensing agency.

(g) Regional centers may establish volunteer teams, made up of consumers, parents, other family members, and advocates to conduct the monitoring activities described in this section.

(h) In meeting its responsibility to provide technical assistance to providers of community living arrangements for persons with developmental disabilities, including, but not limited to, licensed residential facilities, family home agencies, and supported or independent living arrangements, a regional center shall utilize the "Looking at Service Quality-Provider's Handbook" developed by the department or subsequent revisions developed by the department.

(Amended by Stats. 1998, Ch. 1043, Sec. 8. Effective January 1, 1999.)

4648.2. By September 1, 1986, the State Department of Developmental Services shall promulgate regulations which establish a process for service providers to appeal actions the department takes as a result of its auditing and monitoring activities. To the extent possible, this process shall include procedures contained in fiscal audit appeals regulations established pursuant to Section 4780.5.

(Added by Stats. 1985, Ch. 873, Sec. 2.)

4648.3. A provider of transportation services to regional center clients for the regional center shall maintain protection against liability for damages for bodily injuries or death and for damage to or destruction of property, which may be incurred by the provider in the course of providing those services. The protection shall be maintained at the level established by the regional center to which the transportation services are provided.

(Added by Stats. 1987, Ch. 492, Sec. 3. Effective September 10, 1987.)

4648.4. (a) The Legislature finds and declares that the state faces a fiscal crisis requiring that unprecedented measures be taken to reduce General Fund expenditures.

(b) Notwithstanding any other provision of law or regulation, during the 2003–04 fiscal year, no regional center may pay any provider of the following services or supports a rate that is greater than the rate that is in effect on or after June 30, 2003, unless the increase is required by a contract between the regional center and the vendor that is in effect on June 30, 2003, or the regional center demonstrates that the approval is necessary to protect the consumer's health or safety and the department has granted prior written authorization:

(1) Supported living services.
(2) Transportation, including travel reimbursement.
(3) Socialization training programs.
(4) Behavior intervention training.
(5) Community integration training programs.
(6) Community activities support services.
(7) Mobile day programs.
(8) Creative art programs.
(9) Supplemental day services program supports.
(10) Adaptive skills trainers.
(11) Independent living specialists.

(Added by Stats. 2003, Ch. 230, Sec. 51. Effective August 11, 2003.)

4649. Regional centers shall cooperate with area boards in joint efforts to inform the public of services available to persons with developmental disabilities and of their unmet needs, provide materials and education programs to community groups and agencies with interest in, or responsibility for, persons with developmental disabilities, and develop resource materials, if necessary, containing information about local agencies, facilities, and service providers offering services to persons with developmental disabilities.

(Added by Stats. 1977, Ch. 1252.)

4650. Regional centers shall be responsible for developing an annual plan and program budget to be submitted to the director no later than September 1 of each fiscal year. An information copy shall be submitted to the area board and state council by the same date.

(Added by Stats. 1977, Ch. 1252.)

4651. (a) It is the intent of the Legislature that regional centers shall find innovative and economical methods of achieving the objectives contained in individual program plans of persons with developmental disabilities.

(b) The department shall encourage and assist regional centers to use innovative programs, techniques, and staffing arrangements to carry out their responsibilities.

(Amended by Stats. 1992, Ch. 1011, Sec. 18. Effective January 1, 1993.)

4652. A regional center shall investigate every appropriate and economically feasible alternative for care of a developmentally disabled person available within the region. If suitable care cannot be found within the region, services may be obtained outside of the region.

(Added by Stats. 1977, Ch. 1252.)

4653. Except for those developmentally disabled persons judicially committed to state hospitals, no developmentally disabled person shall be admitted to a state hospital except upon the referral of a regional center. Upon discharge from a state hospital, a developmentally disabled person shall be referred to an appropriate regional center.

(Added by Stats. 1977, Ch. 1252.)

4654. Before any person is examined by a regional center pursuant to Section 1370.1 of the Penal Code, the court ordering such medical examination shall transmit to the regional center a copy of the orders made pursuant to proceedings conducted under Sections 1368 and 1369 of the Penal Code. The purpose of the mental examination shall be to determine if developmental disability is the primary diagnosis.

(Added by Stats. 1977, Ch. 1252.)

4655. The director of a regional center or his designee may give consent to medical, dental, and surgical treatment of a regional center client and provide for such treatment to be given to the person under the following conditions:

(a) If the developmentally disabled person's parent, guardian, or conservator legally authorized to consent to such treatment does not respond within a reasonable time to the request of the director or his designee for the granting or

(5) "Property costs" include mortgages, leases, rent, taxes, capital or leasehold improvements, depreciation, and other expenses related to the physical structure. The amount identified for property costs shall be based on the fair rental value of a model facility which is adequately designed, constructed, and maintained to meet the needs of persons with developmental disabilities. The amount identified for property costs shall be calculated as the average projected fair rental value of an economically and efficiently operated community care facility.

(b) The cost model shall take into account factors which include, but are not limited to, all of the following:

(1) Facility size, as defined by the department on the basis of the number of facility beds licensed by the State Department of Social Services and vendorized by the regional center.

(2) Specific geographic areas, as defined by the department on the basis of cost of living and other pertinent economic indicators.

(3) Common levels of direct care, as defined by the department on the basis of services specific to an identifiable group of persons as determined through the individual program plan.

(4) Positive outcomes, as defined by the department on the basis of increased integration, independence, and productivity at the aggregate facility and individual consumer level.

(5) Owner-operated and staff-operated reimbursement which shall, not differ for facilities that are required to comply with the same program requirements.

(c) The rates established for individual community care facilities serving persons with developmental disabilities shall reflect all of the model cost elements and rate development factors described in this section. The cost model design shall include a process for updating the cost model elements that address variables, including, but not limited to, all of the following:

(1) Economic trends in California.

(2) New state or federal program requirements.

(3) Changes in the state or federal minimum wage.

(4) Increases in fees, taxes, or other business costs.

(5) Increases in federal supplemental security income/state supplementary program for the aged, blind, and disabled payments.

(d) Rates established for developmentally disabled persons who are also dually diagnosed with a mental disorder may be fixed at a higher rate. The department shall work with the State Department of Mental Health to establish criteria upon which higher rates may be fixed pursuant to this subdivision. The higher rate for developmentally disabled persons who are also dually diagnosed with a mental disorder may be paid when requested by the director of the regional center and approved by the Director of Developmental Services.

(e) By January 1, 2001, the department shall prepare proposed regulations to implement the changes outlined in this section. The department may use a private firm to assist in the development of these changes and shall confer with consumers, providers, and other interested parties concerning the proposed regulations. By May 15, 2001, and each year thereafter, the department shall provide the Legislature with annual community care facility rates, including any draft amendments to the regulations as required. By July 1, 2001, and each year thereafter, contingent upon an appropriation in the annual Budget Act for this

purpose, the department shall adopt emergency regulations which establish the annual rates for community care facilities serving persons with developmental disabilities for each fiscal year.

(f) During the first year of operation under the revised rate model, individual facilities shall be held harmless for any reduction in aggregate facility payments caused solely by the change in reimbursement methodology.

(Amended by Stats. 1998, Ch. 1043, Sec. 10. Effective January 1, 1999.)

4681.2. The Legislative Analyst shall conduct a study of the feasibility of establishing an independent rate-setting commission responsible for the establishment of rates and fees for community care facilities as defined in Section 1502 of the Health and Safety Code, and health facilities, as defined in Section 1250 of the Health and Safety Code, for developmentally disabled persons and report thereon to the Legislature no later than March 1, 1978. The study shall evaluate the feasibility of adopting a system similar to the rate-setting system for public utilities in California.

(Added by Stats. 1978, Ch. 429.)

4681.3. (a) Notwithstanding any other provision of this article, for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based upon the amount appropriated in the Budget Act of 1996 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1997–98 fiscal year, the rate schedule authorized by the department in operation on June 30, 1997, shall be increased based upon the amount appropriated in the Budget Act of 1997 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(c) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on June 30, 1998, shall be increased commencing July 1, 1998, based upon the amount appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(d) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on December 31, 1998, shall be increased January 1, 1999, based upon the cost-of-living adjustments in the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage and the percentage shall be the same for all providers.

(e) Notwithstanding any other provision of this article, for the 1999–2000 fiscal year, the rate schedule authorized by the department in operation on June 30, 1999, shall be increased July 1, 1999, based upon the amount appropriated in the Budget Act of 1999 for that purpose. The increase shall be applied as a percentage and the percentage shall be the same for all providers.

(f) In addition, commencing January 1, 2000, any funds available from cost-of-living adjustments in the Supplemental Security Income/State Supplementary Payment (SSI/SSP) for the 1999–2000 fiscal year shall be used to

further increase the community care facility rate. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(Amended by Stats. 1999, Ch. 146, Sec. 27. Effective July 22, 1999.)

4681.4. (a) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule increased pursuant to subdivision (d) of Section 4681.3 shall be increased by an additional amount on January 1, 1999, based upon the amount appropriated in the Budget Act of 1998 for that purpose. The rate increase permitted by this section shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1999–2000 fiscal year, the rate schedule authorized by the department in operation on December 31, 1999, shall be increased on January 1, 2000, based upon the amount appropriated in the Budget Act of 1999 for that purpose. The rate increase permitted by this section shall be applied as a percentage and the percentage shall be the same for all providers.

(c) In order to help reduce direct care staff turnover and improve overall quality of care in Alternative Residential Model (ARM) facilities, funds appropriated by the Budget Act of 1998 and the Budget Act of 1999 to increase facility rates effective January 1, 1999, excluding any additional funds appropriated due to increases in benefits under Article 5 (commencing with Section 12200) of Chapter 3 of Part 3 of Division 9, and January 1, 2000, respectively, shall be used only for any of the following:

(1) Increasing direct care staff salaries, wages, and benefits.

(2) Providing coverage while direct care staff are in training classes or taking a training or competency test pursuant to Section 4681.5.

(3) Other purposes approved by the director.

(d) ARM providers shall report to regional centers, in a format and frequency determined by the department, information necessary for the department to determine, through the regional center, compliance with subdivision (c), including, but not limited to, direct care staff salaries, wages, benefits, and staff turnover.

(e) The department shall adopt emergency regulations in order to implement this section, which shall include, but are not limited to, the following:

(1) A process for enforcing the requirements of subdivisions (c) and (d).

(2) Consequences to an ARM provider for failing to comply with the requirements of subdivisions (c) and (d), including a process for obtaining approval from the director for the expenditure of funds for other purposes, as permitted by paragraph (3) of subdivision (c).

(3) A process for adjudicating provider appeals.

(Added by Stats. 1998, Ch. 310, Sec. 39. Effective August 19, 1998.)

4681.5. (a) The Legislature finds and declares that the state faces a fiscal crisis requiring that unprecedented measures be taken to reduce General Fund expenditures.

(b) Notwithstanding any other provision of law or regulation, during the 2003–04 fiscal year, 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 the

rate to be paid to the provider that is greater than the rate that is in effect on or after June 30, 2003, unless the regional center demonstrates to the department that the approval is necessary to protect the consumer's health or safety and the department has granted prior written authorization.

(Added by Stats. 2003, Ch. 230, Sec. 52. Effective August 11, 2003.)

4682. Under no circumstances shall the rate of state payment to any provider of out-of-home care exceed the average amount charged to private clients residing in the same facility, nor shall the monthly rate of state payment to any such facility, with the exception of a licensed acute care or emergency hospital, exceed the average monthly cost of services for all persons with developmental disabilities who reside in state hospitals.

(Added by Stats. 1977, Ch. 1252.)

4682. Under no circumstances shall the rate of state payment to any provider of out-of-home care exceed the average amount charged to private clients residing in the same facility, nor shall the monthly rate of state payment to any such facility, with the exception of a licensed acute care or emergency hospital, exceed the average monthly cost of services for all persons with developmental disabilities who reside in state hospitals.

(Added by Stats. 1977, Ch. 1252.)

4683. It is the intent of the Legislature that rates of payment for out-of-home care shall be established in such ways as to assure the maximum utilization of all federal and other sources of funding, to which persons with developmental disabilities are legally entitled, prior to the commitment of state funds for such purposes.

(Added by Stats. 1977, Ch. 1252.)

4684. Notwithstanding any other provision of law, the cost of providing 24-hour out-of-home nonmedical care and supervision in licensed community care facilities shall be funded by the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program pursuant to Section 11464, for children who are both AFDC-FC recipients and regional center clients.

Regional centers shall pay the cost of services which they authorize for AFDC-FC recipients but which are not allowable under state or federal AFDC-FC program requirements. Regional centers shall accept referrals for evaluations of AFDC-FC eligible children and assist county welfare and probation departments in identifying appropriate placement resources for children who are eligible for regional center services.

(Added by Stats. 1986, Ch. 355, Sec. 1. Operative July 1, 1987, by Sec. 5 of Ch. 355.)

Article 4. Services and Supports for Persons Living in the Community

(Heading of Article 4 amended by Stats. 1992, Ch. 1011, Sec. 20. Effective January 1, 1993.)

4685. (a) Consistent with state and federal law, the Legislature finds and declares that children with developmental disabilities most often have greater opportunities for educational and social growth when they live with their families. The Legislature further finds and declares that the cost of providing necessary services and supports which enable a child with developmental disabilities to live

at home is typically equal to or lower than the cost of providing out-of-home placement. The Legislature places a high priority on providing opportunities for children with developmental disabilities to live with their families, when living at home is the preferred objective in the child's individual program plan.

(b) It is the intent of the Legislature that regional centers provide or secure family support services that do all of the following:

(1) Respect and support the decisionmaking authority of the family.

(2) Be flexible and creative in meeting the unique and individual needs of families as they evolve over time.

(3) Recognize and build on family strengths, natural supports, and existing community resources.

(4) Be designed to meet the cultural preferences, values, and lifestyles of families.

(5) Focus on the entire family and promote the inclusion of children with disabilities in all aspects of school and community.

(c) In order to provide opportunities for children to live with their families, the following procedures shall be adopted:

(1) The department and regional centers shall give a very high priority to the development and expansion of services and supports designed to assist families that are caring for their children at home, when that is the preferred objective in the individual program plan. This assistance may include, but is not limited to specialized medical and dental care, special training for parents, infant stimulation programs, respite for parents, homemaker services, camping, day care, short-term out-of-home care, child care, counseling, mental health services, behavior modification programs, special adaptive equipment such as wheelchairs, hospital beds, communication devices, and other necessary appliances and supplies, and advocacy to assist persons in securing income maintenance, educational services, and other benefits to which they are entitled.

(2) When children with developmental disabilities live with their families, the individual program plan shall include a family plan component which describes those services and supports necessary to successfully maintain the child at home. Regional centers shall consider every possible way to assist families in maintaining their children at home, when living at home will be in the best interest of the child, before considering out-of-home placement alternatives. When the regional center first becomes aware that a family may consider an out-of-home placement, or is in need of additional specialized services to assist in caring for the child in the home, the regional center shall meet with the family to discuss the situation and the family's current needs, solicit from the family what supports would be necessary to maintain the child in the home, and utilize creative and innovative ways of meeting the family's needs and providing adequate supports to keep the family together, if possible.

(3) To ensure that these services and supports are provided in the most cost-effective and beneficial manner, regional centers may utilize innovative service-delivery mechanisms, including, but not limited to, vouchers; alternative respite options such as foster families, vacant community facility beds, crisis child care facilities; and alternative child care options such as supplemental support to generic child care facilities and parent child care cooperatives.

(4) If the parent of any child receiving services and supports from a regional center believes that the regional center is not offering adequate assistance to enable the family to keep the child at home, the parent may initiate a request for fair hearing as established in this division. A family shall not be required to start a placement process or to commit to placing a child in order to receive requested services.

(5) Nothing in this section shall be construed to encourage the continued residency of adult children in the home of their parents when that residency is not in the best interests of the person.

(6) When purchasing or providing a voucher for day care services for parents who are caring for children at home, the regional center may pay only the cost of the day care service that exceeds the cost of providing day care services to a child without disabilities. The regional center may pay in excess of this amount when a family can demonstrate a financial need and when doing so will enable the child to remain in the family home.

(7) A regional center may purchase or provide a voucher for diapers for children three years of age or older. A regional center may purchase or provide vouchers for diapers under three years of age when a family can demonstrate a financial need and when doing so will enable the child to remain in the family home.

(Amended by Stats. 1998, Ch. 1043, Sec. 11. Effective January 1, 1999.)

4685.1. (a) When a minor child requires a living arrangement outside of the family home, as determined in the individual program plan developed pursuant to Section 4646 and Section 4648, the regional center shall make every effort to secure a living arrangement, consistent with the individual program plan, in reasonably close proximity to the family home.

(b) When the parents or guardian of a minor child requests that an out-of-home living arrangement for a minor child be in close proximity to the family home, and when such a living arrangement cannot be secured by the regional center, the regional center shall include with the individual program plan a written statement of its efforts to locate, develop, or adapt appropriate services and supports in a living arrangement within close proximity to the family home and what steps will be taken by the regional center to develop the services and supports necessary to return the child to the family home or within close proximity of the family home. This statement shall be updated every six months, or as agreed to by the parents or guardians, and a copy shall be forwarded to the parents or guardians of the minor and to the director of the department.

(c) This section shall not be construed to impede the movement of consumers to other geographic areas or the preference of the parent or guardian for the placement of their minor child.

(Added by Stats. 1998, Ch. 1043, Sec. 12. Effective January 1, 1999.)

4685.5. (a) Notwithstanding any other provision of law, commencing January 1, 1999, the department shall conduct a pilot project under which funds shall be allocated for local self-determination pilot programs that will enhance the ability of a consumer and his or her family to control the decisions and resources required to meet all or some of the objectives in his or her individual program plan.

(b) Local self-determination pilot programs funded pursuant to this section may include, but not be limited to, all of the following:

(1) Programs that provide for consumer and family control over which services best meet their needs and the objectives in the individual program plan.

(2) Programs that provide allowances or subsidies to consumers and their families.

(3) Programs providing for the use of debit cards.

(4) Programs that provide for the utilization of parent vendors, direct pay options, individual budgets for the procurement of services and supports, alternative case management, and vouchers.

(5) Wraparound programs.

(c) The department shall allow the continuation of the existing pilot project in five regional center catchment areas and shall expand the pilot project to other regional center catchment areas only when consistent with federal approval of a self-determination waiver. The department may approve additional regional center proposals to offer self-determination or self-directed services to consumers that meet criteria established by the department and that demonstrate purchase-of-services savings are achieved in the aggregate and have no impact on the General Fund.

(d) Funds allocated to implement this section may be used for administrative and evaluation costs. Purchase-of-services costs shall be based on the estimated annual service costs associated with each participating consumer and family. Each proposal shall include a budget outlining administrative, service, and evaluation components.

(e) Pilot projects shall be conducted in the following regional center catchment areas:

(1) Tri-Counties Regional Center.

(2) Eastern Los Angeles Regional Center.

(3) Redwood Coast Regional Center.

(4) Kern Regional Center.

(5) San Diego Regional Center.

(f) Each pilot operating area receiving funding under this section shall demonstrate joint regional center and area board support for the local self-determination pilot program, and shall establish a local advisory committee, appointed jointly by the regional center and area board, made up of consumers, family members, advocates, and community leaders and that shall reflect the multicultural diversity and geographic profile of the catchment area. The local advisory committee shall review the development and ongoing progress of the local self-determination pilot program and may make ongoing recommendations for improvement to the regional center.

(Amended by Stats. 2003, Ch. 230, Sec. 53. Effective August 11, 2003.)

4686. (a) Notwithstanding any other provision of law, an in-home respite worker may perform gastrostomy care and feeding of clients of regional centers, after successful completion of training as provided in this section.

(b) In order to be eligible to receive training for purposes of this section, an in-home respite worker shall submit to the trainer proof of successful completion

of a first aid course and successful completion of a cardiopulmonary resuscitation course within the preceding year.

(c) The training in gastrostomy care and feeding required under this section shall be provided by physicians or registered nurses through a gastroenterology or surgical center in an acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, which meets California Children Services' Program standards for centers for children with congenital gastrointestinal disorders, or comparable standards for adults, or by a physician or registered nurse who has been certified to provide training by the center.

(d) The gastroenterology or surgical center providing the training shall develop a training protocol which shall be submitted for approval to the State Department of Developmental Services. The department shall approve those protocols which specifically address all of the following:

(1) Care of the gastrostomy site.

(2) Performance of gastrostomy tube feeding.

(3) Identification of, and appropriate response to, problems and complications associated with gastrostomy care and feeding.

(4) Continuing education requirements.

(e) Training by the gastroenterology or surgical center, or the certified physician or registered nurse, shall be done in accordance with the approved training protocol. Training of in-home respite workers shall be specific to the individual needs of the developmentally disabled regional center client receiving the gastrostomy feeding and shall be in accordance with orders from the client's treating physician or surgeon.

(f) The primary care physician shall give assurances to the regional center that the patient's condition is stable prior to the regional center's purchasing in-home gastrostomy care for the client through an appropriately trained respite worker.

(g) Prior to the purchase of in-home gastrostomy care through a trained respite worker, the regional center shall do all of the following:

(1) Ensure that a nursing assessment of the client, performed by a registered nurse, is conducted to determine whether an in-home respite worker, licensed vocational nurse, or registered nurse may perform the services.

(2) Ensure that a nursing assessment of the home has been conducted to determine whether gastrostomy care and feeding can appropriately be provided in that setting.

(h) The agency providing in-home respite services shall do all of the following:

(1) Ensure adequate training of the in-home respite worker.

(2) Ensure that telephone backup and emergency consultation by a registered nurse or physician is available.

(3) Develop a plan for care of the gastrostomy site and for gastrostomy tube feeding to be carried out by the respite worker.

(4) Ensure that the in-home respite worker and the gastrostomy services provided by the respite worker are adequately supervised by a registered nurse.

(i) For purposes of this section, "in-home respite worker" means an individual employed by an agency which is vendored by a regional center to provide in-home respite services. These agencies include, but are not limited to, in-home respite

services agencies, home health agencies, or other agencies providing these services.

(Amended by Stats. 1993, Ch. 829, Sec. 1. Effective January 1, 1994.)

4687. Consistent with state and federal law, the Legislature recognizes the rights of persons with disabilities to have relationships, marry, be a part of a family, and to parent if they so choose. The Legislature further recognizes that individuals with developmental disabilities may need support and counseling in order to make informed decisions in these areas. In order to achieve these goals, the following services may be made available to persons with developmental disabilities:

(a) Sexuality training.

(b) Parenting skills training.

(c) Supported living arrangements for parents with developmental disabilities and their children.

(d) Advocacy assistance to deal with agencies, including, but not limited to, child protective services, and assistance in reunification planning.

(e) Family counseling services.

(f) Other services and supports listed in Section 4685 when needed to maintain and strengthen the family unit, where one or both of the parents is an individual with developmental disabilities.

(Added by Stats. 1992, Ch. 1011, Sec. 22. Effective January 1, 1993.)

4688. (a) Consistent with state and federal law, the Legislature places a high priority on providing opportunities for individuals with developmental disabilities to be integrated into the mainstream life of their natural communities. In order to ensure that opportunities for integration are maximized, the procedure described in subdivision (b) shall be adopted.

(b) Regional centers shall be responsible for expanding opportunities for the full and equal participation of persons with developmental disabilities in their local communities through, activities, that may include, but shall not be limited to, the following:

(1) Outreach to, and training and education of, representatives of community service agencies and programs, businesses, and community activity providers regarding the provision and expansion of opportunities for participation by regional center consumers.

(2) Developing a community resources list.

(3) Providing assistance to case managers and family members on expanding community integration options for consumers in the areas of work, recreation, social, community service, education, and public services.

(4) Developing and facilitating the use of innovative methods of contracting with community members to provide support in natural environments to regional center consumers.

(5) Development and facilitating the use of natural supports to enhance community participation.

(6) Providing technical assistance to, and coordinating with, community support facilitators who will be used to provide supports to individual consumers for community participation, as needed.

(Added by Stats. 1992, Ch. 1011, Sec. 23. Effective January 1, 1993.)

4689. Consistent with state and federal law, the Legislature places a high priority on providing opportunities for adults with developmental disabilities, regardless of the degree of disability, to live in homes that they own or lease with support available as often and for as long as it is needed, when that is the preferred objective in the individual program plan. In order to provide opportunities for adults to live in their own homes, the following procedures shall be adopted:

(a) The department and regional centers shall ensure that supported living arrangements adhere to the following principles:

(1) Consumers shall be supported in living arrangements which are typical of those in which persons without disabilities reside.

(2) The services or supports that a consumer receives shall change as his or her needs change without the consumer having to move elsewhere.

(3) The consumer's preference shall guide decisions concerning where and with whom he or she lives.

(4) Consumers shall have control over the environment within their own home.

(5) The purpose of furnishing services and supports to a consumer shall be to assist that individual to exercise choice in his or her life while building critical and durable relationships with other individuals.

(6) The services or supports shall be flexible and tailored to a consumer's needs and preferences.

(7) Services and supports are most effective when furnished where a person lives and within the context of his or her day-to-day activities.

(8) Consumers shall not be excluded from supported living arrangements based solely on the nature and severity of their disabilities.

(b) Regional centers may contract with agencies or individuals to assist consumers in securing their own homes and to provide consumers with the supports needed to live in their own homes.

(c) The range of supported living services and supports available include, but are not limited to, assessment of consumer needs; assistance in finding, modifying and maintaining a home; facilitating circles of support to encourage the development of unpaid and natural supports in the community; advocacy and self-advocacy facilitation; development of employment goals; social, behavioral, and daily living skills training and support; development and provision of 24-hour emergency response systems; securing and maintaining adaptive equipment and supplies; recruiting, training, and hiring individuals to provide personal care and other assistance, including in-home supportive services workers, paid neighbors, and paid roommates; providing respite and emergency relief for personal care attendants; and facilitating community participation. Assessment of consumer needs may begin before 18 years of age to enable the consumer to move to his or her own home when he or she reaches 18 years of age.

(d) Regional centers shall provide information and education to consumers and their families about supported living principles and services.

(e) Regional centers shall monitor and ensure the quality of services and supports provided to individuals living in homes that they own or lease. Monitoring shall take into account all of the following:

(1) Adherence to the principles set forth in this section.

(2) Whether the services and supports outlined in the consumer's individual program plan are congruent with the choices and needs of the individual.

home and community-based waiver. The hearing request form shall also indicate whether the claimant or his or her authorized representative is requesting mediation. A copy of the appointment of the authorized representative, by the claimant or the area board if any, shall also be included.

(Amended by Stats. 1998, Ch. 310, Sec. 46. Effective August 19, 1998.)

4702.7. For purposes of this section, "medicaid home and community-based waiver participant" means an individual deemed eligible and receiving services through the Medicaid Home and Community-based waiver program.

(Added by Stats. 2000, Ch. 416, Sec. 2. Effective January 1, 2001.)

4703. "Persons who have the right to request a fair hearing" means applicant, recipient, applicant or recipient's legal guardian or conservator, applicant or recipient's parent, if a minor, and applicant or recipient's authorized representative.

(Added by Stats. 1982, Ch. 506, Sec. 2.)

4703.5. "Recipient" means a person with a developmental disability who is eligible for and receives services from a service agency.

(Added by Stats. 1982, Ch. 506, Sec. 2.)

4703.6. "Responsible state agency" means the state agency with which a state appeal is required to be filed.

(Added by Stats. 1982, Ch. 506, Sec. 2.)

4703.7. "Services" means the type and amount of services and service components set forth in the recipient's individual program plan pursuant to Section 4646.

(Added by Stats. 1982, Ch. 506, Sec. 2.)

4704. "Service agency" means any developmental center or regional center that receives state funds to provide services to persons with developmental disabilities.

(Amended by Stats. 1998, Ch. 310, Sec 47. Effective August 19, 1998.)

4704.5. For purposes of Sections 4710.9, 4711, 4711.5, 4711.7, 4712, and 4712.5, the director of the responsible state agency includes a designee thereof, which may, but need not, be a public or private agency that contracts with the State Department of Developmental Services for the provision of hearing officers or mediators.

(Amended by Stats. 1998, Ch. 310, Sec. 48. Effective August 19, 1998.)

Article 2. General Provisions

(Article 2 added by Stats. 1982, Ch. 506, Sec. 2.)

4705. (a) Every service agency shall, as a condition of continued receipt of state funds, have an agency fair hearing procedure for resolving conflicts between the service agency and recipients of, or applicants for, service. The State Department of Developmental Services shall promulgate regulations to implement this chapter by July 1, 1999, which shall be binding on every service agency.

Any public or private agency receiving state funds for the purpose of serving persons with developmental disabilities not otherwise subject to the provisions of this chapter shall, as a condition of continued receipt of state funds, adopt and periodically review a written internal grievance procedure.

(b) An agency that employs a fair hearing procedure mandated by any other statute shall be considered to have an approved procedure for purposes of this chapter.

(c) The service agency's mediation and fair hearing procedure shall be stated in writing, in English and any other language that may be appropriate to the needs of the consumers of the agency's service. A copy of the procedure and a copy of the provisions of this chapter shall be prominently displayed on the premises of the service agency.

(d) All recipients and applicants, and persons having legal responsibility for recipients or applicants, shall be informed verbally of, and shall be notified in writing in a language which they comprehend of, the service agency's mediation and fair hearing procedure when they apply for service, when they are denied service, and when notice of service modification is given pursuant to Section 4710.

(e) If, in the opinion of any person, the rights or interests of a claimant who has not personally authorized a representative will not be properly protected or advocated, the local area board and the clients' right advocate assigned to the regional center or developmental center shall be notified, and the area board may appoint a person or agency as representative, pursuant to Section 4590, to assist the claimant in the mediation and fair hearing procedure. The appointment shall be in writing to the authorized representative and a copy of the appointment shall be immediately mailed to the service agency director.

(Amended by Stats. 2000, Ch. 416, Sec. 3. Effective January 1, 2001.)

4706. (a) Except as provided in subdivision (b) to the extent permitted by federal law, all issues concerning the rights of persons with developmental disabilities to receive services under this division shall be decided under this chapter, including those issues related to fair hearings, provided under the medicaid home- and community-services waiver granted to the State Department of Health Services.

(b) Whenever a fair hearing under this chapter involves services provided under the medicaid home- and community-based services waiver, the State Department of Health Services shall retain the right, as provided in Section 4712.5, to review and modify any decision reached under this chapter.

(Added by Stats. 1998, Ch. 310, Sec. 50. Effective August 19, 1998.)

4707. By July 1, 1999, the State Department of Developmental Services shall implement a mediation process for resolving conflicts between regional centers and recipients of services specified in this chapter. Regulations implementing the mediation process shall be adopted by July 1, 2000.

(Added by Stats. 1998, Ch. 310, Sec. 51. Effective August 19, 1998.)

differing costs associated with the differing types and levels of care and services provided.

(Added by Stats. 1980, Ch. 1285, Sec. 17.)

4787. (a) The department shall, in developing the annual budget for regional center-funded services and supports for residents of developmental centers who are projected to move into the community in the budget year, estimate the costs of these services and supports. Budgeted funding shall be allocated to each regional center based on each regional center's share of the projected placements to be made within the budget year.

(b) When a resident of a developmental center moves into a community placement outside of their regional catchment area, the department shall transfer from the regional center an appropriate amount of the funding allocated for that consumer to the regional center that will provide services.

(c) A regional center able to exceed its projected placements within the fiscal year shall be allocated additional funding for that purpose in that fiscal year, if sufficient funding is available, and to the extent that additional funding is necessary to make those placements.

(d) If the department determines that a regional center will not make all of the projected placements during the fiscal year for which it has received funding, those funds shall be made available to regional centers who have exceeded their projected placements, to the extent that additional funding is necessary to make those placements.

(e) With the approval of the Department of Finance, savings that result from population reductions in the developmental centers may be transferred to regional centers for the purpose of providing services and supports to residents of developmental centers who have moved into a community placement pursuant to their individual program plan.

(f) This section shall not expand or limit the entitlement to services for a person with developmental disabilities set forth in this division.

(Added by Stats. 1995, Ch. 513, Sec. 4. Effective January 1, 1996.)

4790. (a) It is the intent of the Legislature to provide an incentive for regional centers to select out-of-home placements that are most appropriate for each person with a developmental disability requiring out-of-home care and to provide a disincentive for inappropriate placement in or delayed discharge from state hospitals.

(b) By March 1, 1982, the Health and Welfare Agency shall submit to the Legislature a detailed implementation plan for a pilot project involving four regional centers. These regional centers shall receive allocations of funds equivalent to the cost of state hospital care for the clients of the individual regional center from which they shall purchase services from state hospitals or other providers.

(c) Funds so allocated shall cover costs of care of all clients of the pilot project regional centers in state hospitals and, in addition, shall be used to pay costs of (1) community care, including but not limited to, out-of-home care for clients currently residing in state hospitals who have been deemed more appropriately

served in the community, and (2) out-of-home costs for persons placed after receipt of the allocation.

(d) Regional centers shall be selected on the basis of their willingness to participate in the project, their demonstrated ability to provide necessary community care resources, and their relative standing in the provision of high quality programmatic and administrative services in accordance with the systems evaluation package review of regional centers by the State Department of Developmental Services. In order to ensure the most efficient use of these provisions, one of the four selected regional centers shall have the highest ratio of nonstate hospital out-of-home residential placements in its total active caseload.

(Added by Stats. 1981, Ch. 821, Sec. 1.)

CHAPTER 10. JUDICIAL REVIEW

(Chapter 10 added by Stats. 1977, Ch. 1252.)

4800. (a) Every adult who is or has been admitted or committed to a state hospital, developmental center, community care facility, as defined in Section 1502 of the Health and Safety Code, health facility, as defined in Section 1250 of the Health and Safety Code, or any other appropriate placement permitted by law, as a developmentally disabled patient shall have a right to a hearing by writ of habeas corpus for his or her release from the hospital, developmental center, community care facility, or health facility after he or she or any person acting on his or her behalf makes a request for release to any member of the staff of the state hospital, developmental center, community care facility, or health facility or to any employee of a regional center.

(b) The member of the staff or regional center employee to whom a request for release is made shall promptly provide the person making the request for his or her signature or mark a copy of the form set forth below. The member of the staff, or regional center employee, as the case may be, shall fill in his or her own name and the date, and, if the person signs by mark, shall fill in the person's name, and shall then deliver the completed copy to the medical director of the state hospital or developmental center, the administrator or director of the community care facility, or the administrator or director of the health facility, as the case may be, or his or her designee, notifying him or her of the request. As soon as possible, the person notified shall inform the superior court for the appropriate county, as indicated in Section 4801, of the request for release and shall transmit a copy of the request for release to the person's parent or conservator together with a statement that notice of judicial proceedings taken pursuant to that request will be forwarded by the court. The copy of the request for release and the notice shall be sent by the person notified by registered or certified mail with proper postage prepaid, addressed to the addressee's last known address, and with a return receipt requested. The person notified shall also transmit a copy of the request for release and the name and address of the person's parent or conservator to the court.

(c) Any person who intentionally violates this section is guilty of a misdemeanor.

(d) The form for a request for release shall be substantially as follows:

(Name of the state hospital, developmental center, community care facility, or health facility or regional center) _____ day of _____ 19____

I, _____ (member of the staff of the state hospital, developmental center, community care facility, or health facility or employee of the regional center), have today received a request for the release from _____ (name of state hospital, developmental center, or community care facility) State Hospital, developmental center, community care facility, or health facility of _____ (name of patient) from the undersigned patient on his or her own behalf or from the undersigned person on behalf of the patient.

_____

Signature or mark of patient making request for release

_____

Signature or mark of person making request on behalf of patient

(Amended by Stats. 1996, Ch. 1076, Sec. 3. Effective January 1, 1997.)

4801. (a) Judicial review shall be in the superior court for the county in which the state hospital, developmental center, community care facility, or health facility is located, except that, if the adult has been found incompetent to stand trial and has been committed pursuant to Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 of the Penal Code, judicial review shall be in the superior court of the county that determined the question of the mental competence of the defendant. The adult requesting to be released shall be informed of his or her right to counsel by a member of the staff of the state hospital, developmental center, community care facility, or health facility and by the court; and if he or she does not have an attorney for the proceedings, the court shall immediately appoint the public defender or other attorney to assist him or her in the preparation of a petition for the writ of habeas corpus and to represent him or her in the proceedings. The person shall pay the costs of those legal services if he or she is able.

(b) At the time the petition for the writ of habeas corpus is filed with the court, the clerk of the court shall transmit a copy of the petition, together with notification as to the time and place of any evidentiary hearing in the matter, to the parent or conservator of the person seeking release or for whom release is sought and to the director of the appropriate regional center. Notice shall also be provided to the director of the appropriate developmental center if the person seeking release or for whom release is sought resides in a developmental center. The notice shall be sent by registered or certified mail with proper postage prepaid, addressed to the addressee's last known address, and with a return receipt requested.

(c) The court shall either release the adult or order an evidentiary hearing to be held not sooner than five judicial days nor more than 10 judicial days after the petition and notice to the adult's parent or conservator and to the director of the

appropriate regional center and developmental center are deposited in the United States mail pursuant to this section.

(1) Except as provided in paragraph (2), if the court finds (A) that the adult requesting release or for whom release is requested is not developmentally disabled, or (B) that he or she is developmentally disabled and that he or she is able to provide safely for his or her basic personal needs for food, shelter, and clothing, he or she shall be released within 72 hours. If the court finds that he or she is developmentally disabled and that he or she is unable to provide safely for his or her basic personal needs for food, shelter, or clothing, but that a responsible person or a regional center or other public or private agency is willing and able to provide therefor, the court shall release the developmentally disabled adult to the responsible person or regional center or other public or private agency, as the case may be, subject to any conditions that the court deems proper for the welfare of the developmentally disabled adult and that are consistent with the purposes of this division.

(2) If the person is charged with a violent felony and has been committed to his or her current placement pursuant to Section 1370.1 of the Penal Code or Section 6500, and the court finds (A) that the adult requesting release or for whom release is requested is not developmentally disabled or mentally retarded, or (B) that he or she is able to provide safely for his or her basic personal needs for food, shelter, and clothing, the court shall, before releasing the person, determine that the release will not pose a danger to the health or safety of others due to the person's known behavior. If the court finds there is no danger pursuant to the finding required by subparagraph (D) of paragraph (1) of subdivision (a) of Section 1370.1 of the Penal Code, the person shall be released within 72 hours. If the person's release poses a danger to the health or safety of others, the court may grant or deny the request, taking into account the danger to the health or safety of others posed by the person. If the court finds that release of the person can be made subject to conditions that the court deems proper for the preservation of public health and safety and the welfare of the person, the person shall be released subject to those conditions.

(d) If in any proceeding under this section, the court finds that the adult is developmentally disabled and has no parent or conservator, and is in need of a conservator, the court shall order the appropriate regional center or the state department to initiate, or cause to be initiated, proceedings for the appointment of a conservator for the developmentally disabled adult.

(e) This section shall become operative January 1, 1988.

(Amended by Stats. 1996, Ch. 1076, Sec. 4. Effective January 1, 1997.)

4802. This chapter shall not be construed to impair the right of a conservator of an adult developmentally disabled patient to remove the patient from the state hospital at any time pursuant to Section 4825.

(Amended by Stats. 1979, Ch. 730.)

4803. If a regional center recommends that a person be admitted to a community care facility or health facility as a developmentally disabled resident, the employee or designee of the regional center responsible for making such recommendations shall certify in writing that neither the person recommended for admission to a community care facility or health facility, nor the parent of a

minor or conservator of an adult, if appropriate, nor the person or agency appointed pursuant to Section 4590 or subdivision (e) of Section 4705 has made an objection to the admission to the person making the recommendation. The regional center shall transmit the certificate, or a copy thereof, to the community care facility or health facility.

A community care facility or health facility shall not admit any adult as a developmentally disabled patient on recommendation of a regional center unless a copy of the certificate has been transmitted pursuant to this section.

Any person who, knowing that objection to a community care facility or health facility admission has been made, certifies that no objection has been made, shall be guilty of a misdemeanor.

Objections to proposed placements shall be resolved by a fair hearing procedure pursuant to Section 4700.

(Amended by Stats. 1997, Ch. 414, Sec. 31. Effective September 22, 1997.)

4804. Whenever a proceeding is held in a superior court under the provisions of this chapter, involving a person who has been placed in a state hospital located outside the county of residence of the person, the provisions of this section shall apply. The appropriate financial officer or other designated official of the county in which the proceeding is held may make out a statement of all of the costs incurred by the county for the investigation, preparation, and conduct of the proceedings, and the costs of appeal, if any. The statement may be certified by a judge of the superior court of the county. The statement may then be sent to the county of residence of the person, which shall reimburse the county providing the services. If it is not possible to determine the actual county of residence of the person, the statement may be sent to the county in which the person was originally detained, which shall reimburse the county providing the services.

(Amended by Stats. 2002, Ch. 221, Sec. 207. Effective January 1, 2003.)

4805. Objections to proposed transfers between state hospitals shall be resolved pursuant to Chapter 7 (commencing with Section 4700).

(Added by Stats. 1981, Ch. 990, Sec. 4.)

CHAPTER 11. GUARDIANSHIP AND CONSERVATORSHIP

(Chapter 11 added by Stats. 1977, Ch. 1252.)

4825. The provisions of this division shall not be construed to terminate any appointment of the State Department of Mental Health as guardian of the estate of a developmentally disabled person prior to July 1, 1971.

It is the intent of this section that the Director of Developmental Services be appointed as guardian or conservator of a developmentally disabled person as provided pursuant to the provisions of Article 7.5 (commencing with Section 416) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code.

Notwithstanding the provisions of Section 6000, the admission of an adult developmentally disabled person to a state hospital or private institution shall be upon the application of the person's parent or conservator in accordance with the provisions of Sections 4653 and 4803. Any person so admitted to a state hospital may leave the state hospital at any time, if such parent or conservator gives notice of his or her desire for the departure of the developmentally disabled person to

any member of the hospital staff and completes normal hospitalization departure procedures.

Notwithstanding the provisions of Section 4655, any adult developmentally disabled person who is competent to do so may apply for and receive any services provided by a regional center.

(Amended by Stats. 1980, Ch. 246, Sec. 8.)

CHAPTER 12. COMMUNITY LIVING CONTINUUMS

(Chapter 12 added by Stats. 1978, Ch. 1232.)

4830. As used in this chapter:

(a) "Continuum" means a coordinated multicomponent services system within the geographic borders of each of the 13 area boards on developmental disabilities whose design shall support the sequential developmental needs of persons such that the pattern of these services provides an unbroken chain of experience, maximum personal growth and liberty.

(b) "Normalization" means making available programs, methods, and titles which are culturally normative, and patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society.

(c) "Designated agency" means the legal entity selected by the Department of Developmental Services to be responsible for organizing or providing services within each continuum or both.

(Added by Stats. 1978, Ch. 1232.)

4831. The State Department of Developmental Services may develop the design and phase-in plan for continuums and may designate one or more designated agencies to implement community living continuums throughout the state, after consideration of a recommendation from the respective area board on developmental disabilities in conjunction with recommendations from the appropriate regional center.

(Added by Stats. 1978, Ch. 1232.)

4832. An area board may review and evaluate existing and proposed community living arrangement programs within their jurisdiction and may make a recommendation to the Director of the Department of Developmental Services concerning programs which should be considered as the most appropriate agency to be designated as responsible for the implementation of the community living continuum within their area. These programs shall include, but not be limited to, those which have been funded through the issuance of Mental Retardation Private Institutions' Fund grants, Developmental Disability Community Development grants, and model state hospital programs. Consideration shall be given to all of the following:

(a) Private nonprofit corporations.

(b) Public agencies.

(c) A joint powers agreement agency.

At least one-third of the board of directors, public or private or an advisory committee in the event a public agency is selected, shall be composed of consumer representatives, including members of the immediate family of the consumer.

advance payment made pursuant to this section shall exceed 25 percent of the total annual contract amount.

(Added by Stats. 1978, Ch. 1232.)

4838. The Department of Developmental Services shall study and report to the Legislature, no later than January 1, 1980, on the feasibility for integration of state services, staff, and programs into the continuum of local services. The report should include, but not be limited to, the issues of:

(a) Continuity of state services, staff relocations, and retraining.

(b) The transfer of program and administration funds to the designated agency without service loss.

(c) Employment rights of staff in programs within the continuum.

(d) Analysis of problems which may be encountered with the transfer of state employees to the designated agency and recommendations for solutions to such problems.

(e) The establishment of information and data exchange on a regular basis, not less than quarterly, between the designated agency and the most proximate state hospital in association with the appropriate regional center or centers to assure integration of effort, program continuity, nonduplication of effort, high-quality services, and interagency confidence.

(f) Provisions for the establishment of internal and external monitoring criteria based on agreements with local developmental disability consumer organizations, the local area board, the State Council on Developmental Disabilities.

(Added by Stats. 1978, Ch. 1232.)

4839. The Department of Developmental Services may study and prepare a plan in cooperation with the State Council on Developmental Disabilities. Such a plan should consider the following: necessary technical assistance, training, and evaluation to assure standards of quality and program success.

(b) Maximize existing state and federal resources available to assist persons with developmental special needs to live in the least restrictive environment possible, including:

(1) Federal housing subsidy and assistance.

(2) Supplemental security income.

(3) Local social services.

(4) Local and state health services and related resources.

(c) Procedural standards for designated agencies, including:

(1) Program development process.

(2) Training for workers in the developmental services field.

(3) Management information system.

(4) Fiscal accountability and cost benefit control.

(5) Establishment of contractual relationships.

(6) Evaluation.

(Added by Stats. 1978, Ch. 1232.)

4840. The Director of Developmental Services shall study and report to the Legislature, no later than June 15, 1979, on the:

(a) Development of methods for the continuation of funding to complement client purchase of service funds and other resources for better utilization.

(b) Feasibility of integration and use of Title XIX funds for individualized developmental programs for in-home and community care facilities and staff.

(Added by Stats. 1978, Ch. 1232.)

4841. Notwithstanding the provisions of Sections 4675, 4676 and 4677, the Director of Developmental Services, when reviewing, approving, and allocating money from the Program Development Fund for community living arrangements, shall give high priority to programs which may be included in a continuum.

(Added by Stats. 1978, Ch. 1232.)

4842. The Director of Developmental Services shall report to the Legislature, no later than June 1, 1979, on the status of coordination activities with Department of Social Services licensing and Department of Health Services licensing for all ongoing and new community living arrangement activities for individuals who need developmental services with the following goals:

(a) To implement a statewide network of community living arrangements and support services, based on the least restrictive alternative with priority placed upon supporting the individual in the family home wherever possible.

(b) To implement the principles of normalization in community living arrangements in the state.

(c) To be responsible for coordinating and reviewing all state activities related to community living arrangements and support services for people who need developmental services.

(Added by Stats. 1978, Ch. 1232.)

4843. To accomplish the goals enumerated in Section 4833, the director may:

(a) Develop a continuum training model and provide technical assistance to providers of community living arrangements through state and county agencies and regional center professional collaboration.

(b) Establish competency-based training programs.

(c) Centralize and increase the availability and dissemination of information regarding community living arrangements.

(d) Assist the agencies in community living continuums and regional centers in the recruitment of qualified care providers and staff in order to fulfill the increasing need for quality living arrangements and support services.

(Added by Stats. 1978, Ch. 1232.)

4844. The Director of Developmental Services shall initiate and monitor interagency performance agreements between the Department of Rehabilitation, the Department of Mental Health, the Department of Health Services, the Department of Social Services, and the Department of Housing and Community Development to assure planning, coordination and resource sharing.

(Added by Stats. 1978, Ch. 1232.)

4845. If authorized by regulations adopted by the department and if not available through other state or local programs, the continuum services may with respect to the designated agency, include, but shall not be limited to:

(a) Family subsidy programs.

(b) In-home support services.

(c) Subsidized adoptive and quasi-adoptive foster care services.

(d) Alternative respite services.
(e) Crisis assistance.
(f) Independent and semi-independent living.
(g) Group living for six or fewer persons.
(h) Programs to meet the special needs of individuals who are medically fragile.
(i) Services to persons requiring maximum supervision due to intensive behavioral and severe developmental special needs.

It is not the intent of this section to release any other state or local agency of its program responsibilities.

(Added by Stats. 1978, Ch. 1232.)

4846. Interagency agreements shall be established between the regional centers and the community living continuums to assure clear roles and responsibilities for delivery of services; and may include the Department of Rehabilitation Independent Living Programs where applicable.

(Added by Stats. 1978, Ch. 1232.)

CHAPTER 13. HABILITATION SERVICES FOR THE DEVELOPMENTALLY DISABLED

(Chapter 13 added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch 226, Secs. 1 and 3. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226, Sec. 2. Note: Prior to July 1, 2004, the operative provisions for this subject matter are in Sections 19350 to 19361.)

4850. Commencing July 1, 2004, the State Department of Developmental Services shall succeed to all functions and responsibilities of the Department of Rehabilitation with respect to the administration of the Habilitation Services Program established pursuant to former Chapter 4.5 (commencing with Section 19350) of Part 2 of Division 10.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4850.1. (a) Except as otherwise specifically provided, this chapter shall only apply to those services purchased by the Habilitation Services Program.

(b) Nothing in this section shall be construed to abridge the rights stated in Section 4502.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4851. As used in this chapter, the following definitions apply:

(a) "Habilitation services" means those community-based services purchased or provided for adults with developmental disabilities including work activity and supported employment, to prepare and maintain them at their highest level of vocational functioning, or to prepare them for referral to vocational rehabilitation services.

(b) "Individual program plan" means the overall plan developed by a regional center pursuant to Section 4646.

(c) "Individual habilitation component" means that portion of the individual program plan developed for each eligible individual for whom services are purchased under this chapter.

(d) "Department" means the State Department of Developmental Services.

(e) "Work-activity program" includes, but is not limited to, sheltered workshops or work-activity centers, or community-based work activity programs accredited under departmental regulations.

(f) "Work-activity program day" means the period of time during which a work-activity program provides services to consumers.

(g) "Full day of service" means, for purposes of billing, a day in which the consumer attends a minimum of the declared and approved work-activity program day, less 30 minutes, excluding the lunch period.

(h) "Half day of service" means, for purposes of billing, (1) all days of attendance in which the consumer's attendance does not meet the criteria for billing for a full day of service as defined in subdivision (g), and (2) the consumer attends the work activity program not less than two hours, excluding the lunch period.

(i) "Supported employment program" means a program that meets the requirements of Sections 4861 and 4862.

(j) "Consumer" means any adult who receives services purchased under this chapter.

(k) "Accreditation" means a determination of compliance with the set of standards appropriate to the delivery of services by a work-activity program or supported employment program, developed by the Commission on Accreditation of Rehabilitation Facilities, and applied by the commission or the department.

(*l*) "Direct service professional" means a staff member within a work activity program who deals directly with the consumer, including activities such as supervision, training, counseling, and teaching.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4852. An individual shall be eligible for habilitation services under this chapter when all of the following exist:

(a) The individual is an adult who has been diagnosed as having a developmental disability.

(b) The disability is so severe that the individual does not presently have potential for competitive employment.

(c) The individual's disability is too severe for the individual to benefit from vocational rehabilitation services and it is determined that the individual may be mutually served by the vocational rehabilitation program and it is also determined that the individual needs extended supported employment services following successful rehabilitation by the department's vocational rehabilitation program.

(d) The individual is determined to be in need of habilitation services in an individual program plan developed by a regional center pursuant to Section 4646.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4853. The work-activity program or supported employment program in which the consumer is placed shall evaluate the performance of the consumer in all of the following areas:

(a) Appropriate behavior to safely conduct himself or herself in a work setting.

(b) Adequate attention span to reach a productivity level in paid work.

(c) Ability to understand simple instructions within a reasonable length of time.

(d) Ability to communicate basic needs and understand basic receptive language.

(e) Attendance level.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4854. In developing the individual habilitation component, the individual program plan team shall develop specific and measurable objectives in order to determine whether the consumer demonstrates ability to reach or maintain individual habilitation component goals in at least all of the following areas:

(a) Participation in paid work for a specified period of time.

(b) Obtaining or sustaining a productivity rate.

(c) Obtaining or sustaining a specified attendance level.

(d) Demonstration of appropriate behavior for a work setting.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4855. The regional center shall monitor, evaluate, and audit habilitation services providers for program effectiveness, taking into consideration criteria, including, but not limited to, all of the following:

(a) Service quality.

(b) Protections for individuals receiving services.

(c) Compliance with applicable standards of the Commission on Accreditation of Rehabilitation Facilities.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4856. Regional centers may purchase habilitation services only from providers who are accredited community nonprofit agencies that provide work-activity services or supported employment services, or both, and that have been vendored as described in Section 4648 and regulations adopted pursuant thereto, except that each habilitation services provider who, on July 1, 2004, is providing services to consumers and is not being sanctioned, shall be deemed to be an approved vendor, as described in Section 4648 and regulations promulgated pursuant thereto.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

of Rehabilitation Facilities within three years of the onset of purchase of services by the regional center.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4861. (a) The definitions contained in this subdivision shall govern the construction of this section, with respect to services provided through the regional center, and unless the context requires otherwise, the following terms shall have the following meanings:

(1) "Supported employment" means paid work that is integrated in the community for individuals with developmental disabilities whose vocational disability is so severe that they would be unable to achieve this employment without specialized services and would not be able to retain this employment without an appropriate level of ongoing postemployment support services.

(2) "Integrated work" means the engagement of an employee with a disability in work in a setting typically found in the community in which individuals interact with nondisabled individuals other than those who are providing services to those individuals, to the same extent that nondisabled individuals in comparable positions interact with other persons.

(3) "Supported employment placement" means the employment of an individual with a developmental disability by an employer in the community, directly or through contract with a supported employment program, and the provision of supported employment services including the provision of ongoing postemployment services necessary for the individual to retain employment. Services for those individuals receiving individualized services from a supported employment program shall decrease as the individual adjusts to his or her employment and the employer assumes many of those functions.

(4) "Allowable supported employment services" means the services approved in the individual program plan and provided, to the extent allowed by the regional center for the purpose of achieving supported employment as an outcome for individuals with developmental disabilities, which may include any of the following:

(A) Program staff time spent conducting job analysis of supported employment opportunities for a specific consumer.

(B) Program staff time spent in the direct supervision or training of a consumer or consumers while they engage in integrated work unless other arrangements for consumer supervision, such as employer supervision reimbursed by the supported employment program, are approved by the regional center.

(C) Training occurring in the community, in adaptive functional and social skills necessary to ensure job adjustment and retention such as social skills, money management, and independent travel.

(D) Counseling with a consumer's significant others to ensure support of a consumer in job adjustment.

(E) Advocacy or intervention on behalf of a consumer to resolve problems affecting the consumer's work adjustment or retention.

(F) Job development to the extent authorized by the regional center.

(G) Ongoing postemployment support services needed to ensure the consumer's retention of the job.

(5) "Group services" means job coach-supported employment services in a group supported employment placement at a job coach-to-consumer ratio of not less than one-to-four nor more than one-to-eight where a minimum of four consumers are department-funded.

(6) "Individualized services" means job coach and other supported employment services for department-funded consumers in a supported employment placement at a job coach-to-consumer ratio of one-to-one.

(b) (1) The department shall set rates for supported employment services provided in accordance with this section. The department shall apply rates in accordance with this section to those work-activity programs or program components of work-activity programs approved by the regional center to provide supported employment and to new programs or components approved by the regional center to provide supported employment services.

(2) (A) The hourly rate for supported employment services provided to consumers receiving individualized services shall be twenty-eight dollars and thirty-three cents ($28.33).

(B) The hourly rate for group services shall be twenty-eight dollars and thirty-three cents ($28.33), regardless of the number of consumers served in the group. Consumers in a group shall be scheduled to start and end work at the same time, unless an exception is approved in advance by the regional center. The department shall adopt regulations to define the appropriate grounds for granting these exceptions. Except as provided in paragraph (5) of subdivision (a), where the number of consumers in a group supported employment placement drops to fewer than four supported employment consumers, department funding for the group services in that group shall be terminated unless the program provider, within 90 days from the date of this occurrence does one of the following:

(i) Add one or more supported employment consumers to the group.

(ii) Move the remaining consumers to another existing group.

(iii) Move the remaining consumers, if appropriate, to individualized placement.

(iv) Terminate services.

(C) For consumers receiving group services the department may set a higher hourly rate for supported employment services, based upon the additional cost to provide ancillary services, when there is a documented and demonstrated need for a higher rate because of the nature and severity of the disabilities of the consumer, as determined by the department.

(D) In addition, fees shall be authorized for the following:

(i) A two hundred dollar ($200) fee shall be paid upon intake of a consumer into an agency's supported employment program, unless that individual has completed a supported employment intake process with that same agency within the past 12 months, in which case no fee shall be paid.

(ii) A four hundred dollar ($400) fee shall be paid upon placement of a consumer in an integrated job, unless that consumer is placed with another consumer or consumers assigned to the same job coach during the same hours of employment, in which case no fee shall be paid.

(iii) A four hundred dollar ($400) fee shall be paid after a 90-day retention of a consumer in a job, unless that consumer has been placed with another consumer or consumers, assigned to the same job coach during the same hours of employment, in which case no fee shall be paid.

(3) For consumers receiving individualized services, services may be provided on or off the jobsite.

(4) For consumers receiving group services, ancillary services may be provided, except that all postemployment and ancillary services shall be provided at the worksite.

(c) If, on July 1, 2004, a consumer is on a Department of Rehabilitation waiting list for vocational rehabilitation as a result of the Department of Rehabilitation's order of selection regulations, the regional center may pay for those supported employment services leading to job development set forth in subparagraph (D) of paragraph (2) of subdivision (b).

(d) The regional center shall approve, in advance, any change in the number of consumers served in a group.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats 2003, Ch. 226.)

4861.1. (a) Proposals for funding of new, and modifications to existing, supported employment programs and components by the Habilitation Services Program shall be submitted to the Habilitation Services Program and shall contain sufficient information to enable the Habilitation Services Program to act on the proposal under this section.

(b) If sufficient funding is available to finance services by supported employment programs and components, the Habilitation Services Program may approve or disapprove proposals based on all of the following criteria:

(1) The need for a supported employment program or component.

(2) The capacity of the program to deliver supported employment services effectively.

(3) The ability of the program to comply with accreditation requirements of the Habilitation Services Program. The accreditation standards adopted by the department shall be the standards developed by the Commission on Rehabilitation Facilities and published in the most current edition of the Standards Manual for Organizations Serving People with Disabilities, as well as any subsequent amendments to the manual.

(4) A profile of an average consumer in the program or component, showing the planned progress toward self-reliance as an employee, measured, as appropriate, in terms of decreasing support services.

(5) The ability of the program to achieve integrated paid work on the average for consumers served.

(c) For purposes of evaluating the effectiveness of the entire program, and individual supported employment programs or components, the Habilitation Services Program may monitor supported employment programs or components to determine whether the performance agreed upon in the approved proposal is being achieved. When the performance of a supported employment program or component does not comply with the criteria according to which it was approved

for funding pursuant to subdivision (b), the Habilitation Services Program may establish prospective performance criteria for the program or component, with which the program or component shall comply as a condition of continued funding.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4862. The regional centers may purchase supported employment services at the rates authorized in Section 4861 from supported employment programs or components approved prior to July 1, 2004.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4863. (a) The length of a work-activity program day shall not be less than five hours, in addition to the lunch period.

(b) (1) Except as provided in paragraph (1), the length of a work-activity program day shall not be reduced from the length of the work-activity program day in the historical period that was the basis for the approved habilitation services rate.

(2) (A) A work-activity program may, by prior written approval of the department upon the recommendation of the regional center, change the length of a work-activity program day.

(B) If the department approves a reduction in the work-activity program day pursuant to subparagraph (A), the department may change the habilitation services rate.

(c) (1) A work-activity program may change the length of a work-activity program day on an individual basis in order to meet the needs of the consumer, if the department, upon the recommendation of the regional center, approves the reason or reasons for the change.

(2) The work-activity program shall document the reasons for any change in a work-activity program day on an individual basis.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4864. (a) In accordance with regulations adopted by the department, hourly billing shall be permitted, provided that it is cost-neutral and does not increase the department's costs when used in lieu of full-day or half-day billing, if agreed upon by the work-activity program and the department. A work-activity program shall be required to submit a request for the hourly billing option to the department not less than 60 days prior to the program's implementation of this billing option.

(b) If a work-activity program and the department elect to utilize hourly billing, the hourly billing process shall be required to be used for a minimum of one year.

(c) When the hourly billing process is being used, the definitions contained in subdivisions (f) and (g) of Section 4851 shall not apply.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003. Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4865. (a) The department may allow for payment to work-activity programs based on their average daily consumer attendance during days in which there has been a state of emergency declared in the program's local city or county.

(b) The department may implement this section through the adoption of emergency regulations.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003 Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

4866. At the request of the department, or the regional center, the work-activity programs shall release accreditation and state licensing reports and consumer incident reports required by law or regulations in instances of suspected abuse.

(Added by Stats. 2003, 1st Ex. Sess., Ch. 7, Sec. 12. Effective May 5, 2003 Operative July 1, 2004, by Sec. 17 of Ch. 7. Repealed as of July 1, 2004, by Stats. 2003, Ch. 226. Thereafter, see similar subject matter in Chapter 13 (Sections 4850 to 4867) as added by Stats. 2003, Ch. 226.)

CHAPTER 13. HABILITATION SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

(Chapter 13 repealed (by Sec. 1) and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4850. (a) The Legislature reaffirms its intent that habilitation services for adults with developmental disabilities should be planned and provided as a part of a continuum and that habilitation services should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to nondisabled people of the same age.

(b) The Legislature further intends that habilitation services shall be provided to adults with developmental disabilities as specified in this chapter in order to guarantee the rights stated in Section 4502.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4850.1. Notwithstanding Section 19050.9 of the Government Code, beginning July 1, 2004, the State Department of Developmental Services shall succeed to all functions and responsibilities of the Department of Rehabilitation with respect to the administration of the Habilitation Services Program established pursuant to former Chapter 4.5 (commencing with Section 19350) of Part 2 of Division 10.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4850.2. (a) Except as otherwise specifically provided, this chapter shall only apply to those habilitation services purchased by the regional centers.

(b) Nothing in this section shall be construed to abridge the rights stated in Section 4502.

(Added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4851. The definitions contained in this chapter shall govern the construction of this chapter, with respect to habilitation services provided through the regional

center, and unless the context requires otherwise, the following terms shall have the following meanings:

(a) "Habilitation services" means community-based services purchased or provided for adults with developmental disabilities, including services provided under the Work Activity Program and the Supported Employment Program, to prepare and maintain them at their highest level of vocational functioning, or to prepare them for referral to vocational rehabilitation services.

(b) "Individual program plan" means the overall plan developed by a regional center pursuant to Section 4646.

(c) "Individual habilitation service plan" means the service plan developed by the habilitation service vendor to meet employment goals in the individual program plan.

(d) "Department" means the State Department of Developmental Services.

(e) "Work activity program" includes, but is not limited to, sheltered workshops or work activity centers, or community-based work activity programs certified pursuant to subdivision (f) or accredited by CARF, the Rehabilitation Accreditation Commission.

(f) "Certification" means certification procedures developed by the Department of Rehabilitation.

(g) "Work activity program day" means the period of time during which a Work Activity Program provides services to consumers.

(h) "Full day of service" means, for purposes of billing, a day in which the consumer attends a minimum of the declared and approved work activity program day, less 30 minutes, excluding the lunch period.

(i) "Half day of service" means, for purposes of billing, any day in which the consumer's attendance does not meet the criteria for billing for a full day of service as defined in subdivision (g), and the consumer attends the work activity program not less than two hours, excluding the lunch period.

(j) "Supported employment program" means a program that meets the requirements of subdivisions (n) to (s), inclusive.

(k) "Consumer" means any adult who receives services purchased under this chapter.

(*l*) "Accreditation" means a determination of compliance with the set of standards appropriate to the delivery of services by a work activity program or supported employment program, developed by CARF, the Rehabilitation Accreditation Commission, and applied by the commission or the department.

(m) "CARF" means CARF the Rehabilitation Accreditation Commission.

(n) "Supported employment" means paid work that is integrated in the community for individuals with developmental disabilities.

(o) "Integrated work" means the engagement of an employee with a disability in work in a setting typically found in the community in which individuals interact with individuals without disabilities other than those who are providing services to those individuals, to the same extent that individuals without disabilities in comparable positions interact with other persons.

(p) "Supported employment placement" means the employment of an individual with a developmental disability by an employer in the community, directly or through contract with a supported employment program. This includes

provision of ongoing support services necessary for the individual to retain employment.

(q) "Allowable supported employment services" means the services approved in the individual program plan and specified in the individual habilitation service plan for the purpose of achieving supported employment as an outcome, and may include any of the following:

(1) Job development, to the extent authorized by the regional center.

(2) Program staff time for conducting job analysis of supported employment opportunities for a specific consumer.

(3) Program staff time for the direct supervision or training of a consumer or consumers while they engage in integrated work unless other arrangements for consumer supervision, including, but not limited to, employer supervision reimbursed by the supported employment program, are approved by the regional center.

(4) Community-based training in adaptive functional and social skills necessary to ensure job adjustment and retention.

(5) Counseling with a consumer's significant other to ensure support of a consumer in job adjustment.

(6) Advocacy or intervention on behalf of a consumer to resolve problems affecting the consumer's work adjustment or retention.

(7) Ongoing support services needed to ensure the consumer's retention of the job.

(r) "Group services" means job coaching in a group supported employment placement at a job coach-to-consumer ratio of not less than one-to-four nor more than one-to-eight where services to a minimum of four consumers are funded by the regional center or the Department of Rehabilitation. For consumers receiving group services, ongoing support services shall be limited to job coaching and shall be provided at the worksite.

(s) "Individualized services" means job coaching and other supported employment services for regional center-funded consumers in a supported employment placement at a job coach-to-consumer ratio of one-to-one, and that decrease over time until stabilization is achieved. Individualized services may be provided on or off the jobsite.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4852. A consumer shall be referred to a provider of habilitation services under this chapter when all of the following apply:

(a) The individual is an adult who has been diagnosed as having a developmental disability.

(b) The individual is determined to be in need of and has chosen habilitation services through the individual program planning process pursuant to Section 4646.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4853. (a) When a referral for habilitation services pursuant to Section 4852 has been made and if the individual is placed in a work activity program, he or she shall be deemed presumptively eligible for a period not to exceed 90 days.

(b) During the period of presumptive eligibility, the work activity program shall submit a work skills evaluation report to the regional center. The work skills evaluation report shall reflect the performance of the consumer in all of the following areas:

(1) Appropriate behavior to safely conduct himself or herself in a work setting.

(2) Adequate attention span to reach a productivity level in paid work.

(3) Ability to understand and act on simple instructions within a reasonable length of time.

(4) Ability to communicate basic needs and understand basic receptive language.

(5) Attendance level.

(c) During the period of presumptive eligibility, the individual program plan planning team shall, pursuant to Section 4646, utilize the work skills evaluation report to determine the appropriateness of the referral.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4854. In developing the individual habilitation service plan pursuant to Section 4853, the habilitation service provider shall develop specific and measurable objectives to determine whether the consumer demonstrates ability to reach or maintain individual employment goals in all of the following areas:

(a) Participation in paid work for a specified period of time.

(b) Obtaining or sustaining a specified productivity rate.

(c) Obtaining or sustaining a specified attendance level.

(d) Demonstration of appropriate behavior for a work setting.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4854.1. The individual program plan planning team, shall, pursuant to Section 4646, meet, when it is necessary to review any of the following:

(a) The appropriateness of job placement.

(b) The appropriateness of the services available at the Work Activity Program or Supported Employment Program.

(c) The individual habilitation service plan.

(Added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4855. When an individual who is eligible for habilitation services under this chapter is referred to the Department of Rehabilitation for vocational rehabilitation services, including supported employment services, and is placed on a Department of Rehabilitation waiting list for vocational rehabilitation as a result of the Department of Rehabilitation's order of selection regulations, the regional center shall authorize appropriate services for the individual pursuant to this chapter as needed until services can be provided by the vocational rehabilitation program.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4856. (a) The regional center shall monitor, evaluate, and audit habilitation services providers for program effectiveness, using performance criteria that include, but are not limited to, all of the following:

(1) Service quality.

(2) Protections for individuals receiving services.

(3) Compliance with applicable CARF standards.

(b) (1) The regional center may impose immediate sanctions on providers of work activity programs and supported employment programs for noncompliance with accreditation or services standards contained in regulations adopted by the department, and for safety violations which pose a threat to consumers of habilitation services.

(2) Sanctions include, but are not limited to, the following:

(A) A moratorium on new referrals.

(B) Imposition of a corrective plan as specified in regulations.

(C) Removal of consumers from a service area where dangerous conditions or abusive conditions exist.

(D) Termination of vendorization.

(c) A moratorium on new referrals may be the first formal sanction to be taken except in instances where consumers are at imminent risk of abuse or other harm. When the regional center determines a moratorium on new referrals to be the first formal sanction, a corrective action plan shall be developed. The moratorium shall be lifted only when the conditions cited are corrected per a corrective action plan.

(d) A corrective action plan is a formal sanction, that may be imposed either simultaneously with a moratorium on new referrals, or as a single sanction in circumstances that do not require a moratorium, as determined by the regional center. Noncompliance with the conditions and timelines of the corrective action plan shall result in termination of vendorization.

(e) Removal of consumers from a program shall only take place where dangerous or abusive conditions are present, or upon termination of vendorization. In instances of removal for health and safety reasons, when the corrections are made by the program, as determined by the regional center, consumers may return, at their option.

(f) Any provider sanctioned under subparagraph (B) or (C) of paragraph (2) of subdivision (b) may request an administrative review as specified in Section 4648.1.

(g) Any provider sanctioned under subparagraph (D) of paragraph (2) of subdivision (b) shall have a right to a formal review by the Office of Administrative Hearings under Chapter 4 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Effective July 1, 2004, if a habilitation services provider is under sanction under former Section 19354.5, the provider shall complete the requirements of the corrective action plan or any other terms or conditions imposed upon it as part of the sanctions. At the end of the term of the corrective action plan or other compliance requirements, the services provider shall be evaluated by the regional center based upon the requirements in this section.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4857. The regional center shall purchase habilitation services pursuant to the individual program plan. Habilitation services shall continue as long as satisfactory progress is being made toward achieving the objectives of the individual habilitation service plan or as long as these services are determined by the regional center to be necessary to maintain the individual at their highest level of vocational functioning, or to prepare the individual for referral to vocational rehabilitation services.

(Repealed and added by Stats. 2003, Ch 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4857.1. Regional centers may purchase habilitation services only from providers who are accredited community nonprofit agencies that provide work activity services or supported employment services, or both, and that have been vendored as described in Section 4861 and regulations promulgated pursuant thereto. Habilitation services providers who, on July 1, 2004, are providing services to consumers shall be deemed to be an approved vendor.

(Added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4858. (a) Each work activity program vendor shall, at a minimum, annually review the status of consumers participating in their program to determine whether these individuals would benefit from vocational rehabilitation services, including supported employment.

(b) If it is determined that the consumer would benefit from vocational rehabilitation services, the work activity program vendor shall, in conjunction with the regional center and in accordance with the individual program plan process, refer the consumer to the Department of Rehabilitation.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4859. (a) The department shall adopt regulations to establish rates for work activity program services subject to the approval of the Department of Finance. The regulations shall provide for an equitable and cost-effective ratesetting procedure in which each specific allowable service, activity, and provider administrative cost comprising an overall habilitation service, as determined by the department, reflects the reasonable cost of service. Reasonable costs shall be determined biennially by the department, subject to audit at the discretion of the department.

(b) The department shall adopt the existing work activity program rates as of July 1, 2004, that shall remain in effect until the next ratesetting year.

(c) Notwithstanding paragraph (4) of subdivision (a) of Section 4648, the regional center shall pay the work activity program rates established by the department.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4860. (a) (1) The hourly rate for supported employment services provided to consumers receiving individualized services shall be twenty-seven dollars and sixty-two cents ($27.62).

(2) Job coach hours spent in travel to consumer worksites may be reimbursable for individualized services only when the job coach travels from the vendor's headquarters to the consumer's worksite or from one consumer's worksite to another, and only when the travel is one way.

(b) The hourly rate for group services shall be twenty-seven dollars and sixty-two cents ($27.62), regardless of the number of consumers served in the group. Consumers in a group shall be scheduled to start and end work at the same time, unless an exception that takes into consideration the consumer's compensated work schedule is approved in advance by the regional center. The department, in consultation with stakeholders, shall adopt regulations to define the appropriate grounds for granting these exceptions. When the number of consumers in a supported employment placement group drops to fewer than the minimum required in subdivision (r) of Section 4851 the regional center may terminate funding for the group services in that group, unless, within 90 days, the program provider adds one or more regional center, or Department of Rehabilitation funded supported employment consumers to the group.

(c) Job coaching hours for group services shall be allocated on a prorated basis between a regional center and the Department of Rehabilitation when regional center and Department of Rehabilitation consumers are served in the same group.

(d) When Section 4855 applies, fees shall be authorized for the following:

(1) A two hundred dollar ($200) fee shall be paid to the program provider upon intake of a consumer into a supported employment program. No fee shall be paid if that consumer completed a supported employment intake process with that same supported employment program within the previous 12 months.

(2) A four hundred dollar ($400) fee shall be paid upon placement of a consumer in an integrated job, except that no fee shall be paid if that consumer is placed with another consumer or consumers assigned to the same job coach during the same hours of employment.

(3) A four hundred dollar ($400) fee shall be paid after a 90-day retention of a consumer in a job, except that no fee shall be paid if that consumer has been placed with another consumer or consumers, assigned to the same job coach during the same hours of employment.

(e) Notwithstanding paragraph (4) of subdivision (a) of Section 4648 the regional center shall pay the supported employment program rates established by this section.

(Repealed and added by Stats. 2003, Ch 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4861. The regional center may vendor new work activity or supported employment programs, after determining the capacity of the program to deliver effective services, and assessing the ability of the program to comply with CARF requirements.

(a) Programs that receive the regional center's approval to provide supported employment services shall receive rates in accordance with Section 4860.

(b) A new work activity program shall receive the statewide average rate, as determined by the department. As soon as the new work activity program has a historical period of not less than three months that is representative of the cost per

consumer, as determined by the department, the department shall set the rate in accordance with Section 4859.

(c) The regional center may purchase services from new work activity programs and supported employment programs, even though the program in not yet accredited by CARF, if all of the following apply:

(1) The vendor can demonstrate that the program is in compliance with certification standards established by the Department of Rehabilitation, to allow a period for becoming CARF accredited.

(2) (A) The program commits, in writing, to apply for accreditation by CARF within three years of the approval to purchase services by the regional center.

(B) CARF shall accredit a program within four years after the program has been vendored.

(d) The regional center may approve or disapprove proposals submitted by new or existing vendors based on all of the following criteria to the extent that it is federally permissible:

(1) The need for a work activity or supported employment program.

(2) The capacity of the vendor to deliver work activity or supported employment services effectively.

(3) The ability of the vendor to comply with the requirements of this section.

(4) The ability of the vendor to achieve integrated paid work for consumers served in supported employment.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4862. (a) The length of a work activity program day shall not be less than five hours, excluding the lunch period.

(b) (1) Except as provided in paragraph (2), the length of a work activity program day shall not be reduced from the length of the work activity program day in the historical period that was the basis for the approved habilitation services rate.

(2) (A) A work activity program may, upon consultation with, and prior written approval from, the regional center, change the length of a work activity program day.

(B) If the regional center approves a reduction in the work activity program day pursuant to subparagraph (A), the department may change the work activity program.

(c) (1) A work activity program may change the length of a work activity program day for a specific consumer in order to meet the needs of that consumer, if the regional center, upon the recommendation of the individual program planning team, approves the change.

(2) The work activity program shall specify in writing to the regional center the reasons for any proposed change in a work activity program day on an individual basis.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226. This version will be superseded by amendment on July 1, 2004, by Stats. 2003, Ch. 886.)

4862. (a) The length of a work activity program day shall not be less than five hours, excluding the lunch period.

(b) (1) Except as provided in paragraph (2), the length of a work activity program day shall not be reduced from the length of the work activity program day in the historical period that was the basis for the approved habilitation services rate.

(2) (A) A work activity program may, upon consultation with, and prior written approval from, the regional center, change the length of a work activity program day.

(B) If the regional center approves a reduction in the work activity program day pursuant to subparagraph (A), the department may change the work activity program rate.

(c) (1) A work activity program may change the length of a work activity program day for a specific consumer in order to meet the needs of that consumer, if the regional center, upon the recommendation of the individual program planning team, approves the change.

(2) The work activity program shall specify in writing to the regional center the reasons for any proposed change in a work activity program day on an individual basis.

(Amended (as added by Stats. 2003, Ch. 226) by Stats. 2003, Ch. 886, Sec. 3. Effective January 1, 2004. Operative July 1, 2004, by Sec. 4 of Ch. 886.)

4863. (a) In accordance with regulations adopted by the department, and if agreed upon by the work activity program and the regional center, hourly billing shall be permitted, provided that it does not increase the regional center's costs when used in lieu of full-day or half-day billing. A work activity program shall be required to submit a request for the hourly billing option to the regional center not less than 60 days prior to the program's proposed implementation of this billing option.

(b) If a work activity program and the regional center elect to utilize hourly billing, the hourly billing process shall be required to be used for a minimum of one year.

(c) When the hourly billing process is being used, the definitions contained in subdivisions (h) and (i) of Section 4851 shall not apply.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4864. The department shall authorize payment for absences in work activity programs and supported employment programs that are directly consequent to a declaration of a State of Emergency by the Governor. If the department authorizes payment for absences due to a state of emergency, the vendor shall bill only for absences in excess of the average number of absences experienced by the vendor during the 12-month period prior to the month in which the disaster occurred.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4865. At the request of the Department of Rehabilitation, a work activity or supported employment program or both shall release accreditation and state

licensing reports and consumer special incident reports as required by law or regulations in instances of suspected abuse.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4866. The department may promulgate emergency regulations to carry out the provisions of this chapter. If the Department of Developmental Services promulgates emergency regulations, the adoption of the regulations shall be deemed necessary for the immediate preservation of the public peace, health and safety, or general welfare for purposes of subdivision (h) of Section 11346.1 of the Government Code.

(Repealed and added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

4867. Nothing in this chapter shall be interpreted to mean that work activity programs or supported employment programs cannot serve consumers who are funded by agencies other than regional centers, including, but not limited to, the Department of Rehabilitation.

(Added by Stats. 2003, Ch. 226, Sec. 2. Effective January 1, 2004. Operative July 1, 2004, by Sec. 3 of Ch. 226.)

DIVISION 4.7. PROTECTION AND ADVOCACY AGENCY

(Division 4.7 added by Stats. 1991, Ch. 534, Sec. 7.)

CHAPTER 1. DEFINITIONS

(Chapter 1 added by Stats. 1991, Ch. 534, Sec. 7.)

4900. (a) The definitions contained in this section shall govern the construction of this division, unless the context requires otherwise. These definitions shall not be construed to alter or impact the definitions or other provisions of the Elder and Dependent Adult Civil Protection Act (Chapter 11 (commencing with Section 15600), or Chapter 13 (commencing with Section 15750), of Part 3 of Division 9.

(b) "Abuse" means an act, or failure to act, that would constitute abuse as that term is defined in federal regulations pertaining to the authority of protection and advocacy agencies, including Section 51.2 of Title 42 of the Code of Federal Regulations or Section 1386.19 of Title 45 of the Code of Federal Regulations. "Abuse" also means an act, or failure to act, that would constitute abuse as that term is defined in Section 15610.07 of the Welfare and Institutions Code or Section 11165.6 of the Penal Code.

(c) "Complaint" has the same meaning as "complaint" as defined in federal statutes and regulations pertaining to the authority of protection and advocacy agencies, including Section 10802(1) of Title 42 of the United States Code, Section 51.2 of Title 42 of the Code of Federal Regulations, or Section 1386.19 of Title 45 of the Code of Federal Regulations.

(d) "Disability" means a developmental disability, as defined in Section 15002(8) of Title 42 of the United States Code, a mental illness, as defined in Section 10802(4) of Title 42 of the United States Code, a disability within the meaning of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.), as defined in Section 12102(2) of Title 42 of the United States Code, or a disability within the meaning of the California Fair Employment and Housing Act (Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code), as defined in subdivision (i) or (k) of Section 12926 of the Government Code.

(e) "Facility" or "program" means a public or private facility or program providing services, support, care, or treatment to persons with disabilities, even if only on an as-needed basis or under contractual arrangement. "Facility" or "program" includes, but is not limited to, a hospital, a long-term health care facility, a community living arrangement for people with disabilities, including a group home, a board and care home, an individual residence or apartment of a person with a disability where services are provided, a day program, a juvenile detention facility, a homeless shelter, a jail, or a prison, including all general areas, as well as special, mental health, or forensic units. The term includes any facility licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code and any facility that is unlicensed but is not exempt from licensure as provided in subdivision (a) of Section 1503.5 of the Health and Safety Code. The term also includes a public or private school or other institution or program providing education, training, habilitation, therapeutic, or residential services to persons with disabilities.

(f) "Legal guardian," "conservator," or "legal representative," means a person appointed by a state court or agency empowered under state law to appoint and review the legal guardian, conservator, or legal representative, as appropriate. With respect to an individual described under paragraph (2) of subdivision (i), this person is one who has the legal authority to consent to health or mental health care or treatment on behalf of the individual. With respect to an individual described under paragraphs (1) or (3) of subdivision (i), this person is one who has the legal authority to make all decisions on behalf of the individual. These terms include the parent of a minor who has legal custody of the minor. These terms do not include a person acting solely as a representative payee, a person acting solely to handle financial matters, an attorney or other person acting on behalf of an individual with a disability solely in individual legal matters, or an official or his or her designee who is responsible for the provision of treatment or services to an individual with a disability.

(g) "Neglect" means a negligent act, or omission to act, that would constitute neglect as that term is defined in federal statutes and regulations pertaining to the authority of protection and advocacy agencies, including Section 10802(5) of Title 42 of the United States Code, Section 51.2 of Title 42 of the Code of Federal Regulations, or Section 1386.19 of Title 45 of the Code of Federal Regulations. "Neglect" also means a negligent act, or omission to act, that would constitute neglect as that term is defined in subdivision (b) of Section 15610.07 of the Welfare and Institutions Code or Section 11165.2 of the Penal Code.

(h) "Probable cause" to believe that an individual has been subject to abuse or neglect, or is at significant risk of being subjected to abuse or neglect, exists when the protection and advocacy agency determines that it is objectively reasonable for a person to entertain that belief. The individual making a probable cause determination may base the decision on reasonable inferences drawn from his or her experience or training regarding similar incidents, conditions, or problems that are usually associated with abuse or neglect. Information supporting a probable cause determination may result from monitoring or other activities, including, but not limited to, media reports and newspaper articles.

(i) "Protection and advocacy agency" means the private nonprofit corporation designated by the Governor in this state pursuant to federal law for the protection and advocacy of the rights of persons with disabilities, including the following:

(1) People with developmental disabilities, as authorized under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code.

(2) People with mental illness, as authorized under the federal Protection and Advocacy for Mentally Ill Individuals Amendments Act of 1991, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code.

(3) People with disabilities within the meaning of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.) as defined in Section 12102(2) of Title 42 of the United States Code, who do not have a developmental disability as defined in Section 15002(8) of Title 42 of the United States Code, people with a mental illness as defined in Section 10802(4) of Title 42 of the United States Code, and who are receiving services under the federal Protection

and Advocacy of Individual Rights Act as defined in Section 794e of Title 29 of the United States Code, or people with a disability within the meaning of the California Fair Employment and Housing Act (Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code), as defined in subdivision (i) or (k) of Section 12926 of the Government Code.

(j) "Reasonable unaccompanied access" means access that permits the protection and advocacy agency, without undue interference, to monitor, inspect, and observe conditions in facilities and programs, to meet and communicate with residents and service recipients privately and confidentially on a regular basis, formally or informally, by telephone, mail, electronic mail, and in person, and to review records privately and confidentially, in a manner that minimizes interference with the activities of the program or service, that respects residents' privacy interests and honors a resident's request to terminate an interview, and that does not jeopardize the physical health or safety of facility or program staff, residents, service recipients, or protection and advocacy agency staff.

(Amended by Stats. 2003, Ch. 878, Sec. 4. Effective January 1, 2004.)

4901. (a) The protection and advocacy agency, for purposes of this division, shall be a private nonprofit corporation and shall meet all of the requirements of federal law applicable to protection and advocacy systems, including, but not limited to, the requirement that it establish a grievance procedure for clients or prospective clients of the system to ensure that people with disabilities have full access to services of the system.

(b) State officers and employees, in taking any action relating to the protection and advocacy agency, shall meet the requirements of federal law applicable to protection and advocacy systems.

(c) The authority of the protection and advocacy agency set forth in this division shall not diminish the authority of the protection and advocacy agency under federal statutes pertaining to the authority of protection and advocacy systems, or under federal rules and regulations adopted in implementation of those statutes.

(d) Nothing in this division shall be construed to supplant the jurisdiction or the responsibilities of adult protective services programs pursuant to Chapter 11 (commencing with Section 15600), or Chapter 13 (commencing with Section 15750), of Part 3 of Division 9.

(e) (1) Nothing in this division shall be construed to supplant the duties or authority of the State Long-Term Care Ombudsman Program pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(2) The protection and advocacy agency shall cooperate with the Office of the State Long-Term Care Ombudsman when appropriate, as provided in Section 9717.

(f) (1) Nothing in this division shall be construed to alter or impact the Elder and Dependent Adult Civil Protection Act (Chapter 11 (commencing with Section 15600), or Chapter 13 (commencing with Section 15750), of Part 3 of Division 9, including the confidentiality requirements of Section 15633 and the legal responsibility of the protection and advocacy agency to report elder or dependent adult abuse or neglect as required by paragraph (1) of subdivision (b) of Section 15630.

(2) The adult protective services agency shall retain the responsibility to investigate any report of abuse or neglect in accordance with Chapter 13 (commencing with Section 15750) of Part 3 of Division 9 when the reported abuse or neglect is within the jurisdiction of the adult protective services agency.

(Amended by Stats. 2003, Ch. 878, Sec. 5. Effective January 1, 2004.)

4902. (a) The protection and advocacy agency, in protecting and advocating for the rights of people with disabilities, pursuant to the federal mandate, may do all of the following:

(1) Investigate any incident of abuse or neglect of any person with a disability if the incident is reported to the protection and advocacy agency or if the protection and advocacy agency determines there is probable cause to believe the abuse or neglect occurred. This authority shall include reasonable access to a facility or program and authority to examine all relevant records and interview any facility or program service recipient, employee, or other person who might have knowledge of the alleged abuse or neglect.

(2) Pursue administrative, legal, and other appropriate remedies or approaches to ensure the protection of the rights of people with disabilities.

(3) Provide information and training on, and referral to, programs and services addressing the needs of people with disabilities, including information and training regarding individual rights and the services available from the protection and advocacy agency.

(b) The protection and advocacy agency shall, in addition, have reasonable access to facilities or programs in the state that provide care and treatment to people with disabilities, and access to those persons.

(1) The protection and advocacy agency shall have reasonable unaccompanied access to public or private facilities, programs, and services, and to recipients of services therein, at all times as are necessary to investigate incidents of abuse and neglect in accord with paragraph (1) of subdivision (a). Access shall be afforded, upon request, to the agency when any of the following has occurred:

(A) An incident is reported or a complaint is made to the agency.

(B) The agency determines there is probable cause to believe that an incident has or may have occurred.

(C) The agency determines that there is or may be imminent danger of serious abuse or neglect of an individual with a disability.

(2) The protection and advocacy agency shall have reasonable unaccompanied access to public and private facilities, programs, and services, and recipients of services therein during normal working hours and visiting hours for other advocacy services. In the case of information and training services, access shall be at times mutually agreeable to the protection and advocacy agency and facility management. This access shall be for the purpose of any of the following:

(A) Providing information and training on, and referral to programs addressing the needs of, individuals with disabilities, and information and training on individual rights and the protection and advocacy services available from the agency, including, but not limited to, the name, address, and telephone number of the protection and advocacy agency.

(B) Monitoring compliance with respect to the rights and safety of residents or service recipients.

(C) Inspecting, viewing, and photographing all areas of the facility or program that are used by residents or service recipients, or that are accessible to them.

(c) If the protection and advocacy agency's access to facilities, programs, service recipients, residents, or records covered by this division is delayed or denied by a facility, program, or service, the facility, program, or service shall promptly provide the agency with a written statement of reasons. In the case of denial of access for alleged lack of authorization, the facility, program, or service shall promptly provide to the agency the name, address, and telephone number of the legal guardian, conservator, or other legal representative of the individual with a disability for whom authorization is required. Access to a facility, program, service recipient, resident, or to records, shall not be delayed or denied without the prompt provision of a written statement of the reasons for the denial.

(d) The protection and advocacy agency may not enter an individual residence or apartment of a client or his or her family without the consent of an adult occupant. In the absence of this consent, the protection and advocacy agency may enter only if it has obtained the legal authority to enforce its access authority pursuant to legal remedies available under this division or applicable federal law.

(e) A care provider, including, but not limited to, any individual, state entity, or other organization that is required to respond to these requests, may charge a reasonable fee to cover the cost of copying records pursuant to this division that may take into account the costs incurred by the care provider in locating, identifying, and making the records available as required pursuant to this division. Charges for copying records that would otherwise be available to the protection and advocacy agency or the person with a disability whose records are requested, under other statutes providing for access to records, may not exceed any rates for obtaining copies of the records specified in the applicable provisions.

(Amended by Stats. 2003, Ch. 878, Sec. 6. Effective January 1, 2004.)

4903. (a) The protection and advocacy agency shall have access to the records of any of the following people with disabilities:

(1) Any person who is a client of the agency, or any person who has requested assistance from the agency, if that person or the agent designated by that person, or the legal guardian, conservator, or other legal representative of that person, has authorized the protection and advocacy agency to have access to the records and information. If a person with a disability who is able to authorize the protection and advocacy agency to access his or her records expressly denies this access after being informed by the protection and advocacy agency of his or her right to authorize or deny access, the protection and advocacy agency may not have access to that person's records.

(2) Any person, including any individual who cannot be located, to whom all of the following conditions apply:

(A) The individual, due to his or her mental or physical condition, is unable to authorize the protection and advocacy agency to have access to his or her records.

(B) The individual does not have a legal guardian, conservator, or other legal representative, or the individual's representative is a public entity, including the state or one of its political subdivisions.

(C) The protection and advocacy agency has received a complaint that the individual has been subject to abuse or neglect, or has determined that probable cause exists to believe that the individual has been subject to abuse or neglect.

(3) Any person who is deceased, and for whom the protection and advocacy agency has received a complaint that the individual had been subjected to abuse or neglect, or for whom the agency has determined that probable cause exists to believe that the individual had been subjected to abuse or neglect.

(4) Any person who has a legal guardian, conservator, or other legal representative with respect to whom a complaint has been received by the protection and advocacy agency, or with respect to whom the protection and advocacy agency has determined that probable cause exists to believe that the person has been subjected to abuse or neglect, whenever all of the following conditions exist:

(A) The representative has been contacted by the protection and advocacy agency upon receipt of the representative's name and address.

(B) The protection and advocacy agency has offered assistance to the representatives to resolve the situation.

(C) The representative has failed or refused to act on behalf of the person.

(b) Individual records that shall be available to the protection and advocacy agency under this section shall include, but not be limited to, all of the following information and records related to the investigation, whether written or in another medium, draft or final, including, but not limited to, handwritten notes, electronic files, photographs, videotapes, or audiotapes:

(1) Information and records prepared or received in the course of providing intake, assessment, evaluation, education, training, or other supportive services, including, but not limited to, medical records, financial records, monitoring reports, or other reports, prepared or received by a member of the staff of a facility, program, or service that is providing care, treatment, or services.

(2) Reports prepared by an agency charged with investigating reports of incidents of abuse, neglect, injury, or death occurring at the program, facility, or service while the individual with a disability is under the care of a member of the staff of a program, facility, or service, or by or for a program, facility, or service, that describe any or all of the following:

(A) Abuse, neglect, injury, or death.

(B) The steps taken to investigate the incidents.

(C) Reports and records, including, but not limited to, personnel records prepared or maintained by the facility, program, or service in connection with reports of incidents, subject to the following:

(i) If a state statute specifies procedures with respect to personnel records, the protection and advocacy agency shall follow those procedures.

(ii) Personnel records shall be protected from disclosure in compliance with the fundamental right of privacy established pursuant to Section 1 of Article I of the California Constitution. The custodian of personnel records shall have a right and a duty to resist attempts to allow the unauthorized disclosure of personnel records, and may not waive the privacy rights that are guaranteed pursuant to Section 1 of Article I of the California Constitution.

(D) Supporting information that was relied upon in creating a report, including, but not limited to, all information and records that document

interviews with persons who were interviewed, physical and documentary evidence that was reviewed, or related investigative findings.

(3) Discharge planning records.

(c) Information in the possession of a program, facility, or service that must be available to the agency investigating instances of abuse or neglect pursuant to paragraph (1) of subdivision (a) of Section 4902, whether written or in another medium, draft or final, including, but not limited to, handwritten notes, electronic files, photographs, videotapes, audiotapes, or records, shall include, but not be limited to, all of the following:

(1) Information in reports prepared by individuals and entities performing certification or licensure reviews, or by professional accreditation organizations, as well as related assessments prepared for a program, facility, or service by its staff, contractors, or related entities, subject to any other provision of state law protecting records produced by medical care evaluation or peer review committees.

(2) Information in professional, performance, building, or other safety standards, or demographic and statistical information, relating to the facility.

(d) The authority of the protection and advocacy agency to have access to records does not supersede any prohibition on discovery specified in Sections 1157 and 1157.6 of the Evidence Code, nor does it supersede any prohibition on disclosure subject to the physician-patient privilege or the psychotherapist-patient privilege.

(e) (1) The protection and advocacy agency shall have access to records of individuals described in paragraph (1) of subdivision (a) of Section 4902 and in subdivision (a), and other records that are relevant to conducting an investigation, under the circumstances described in those subdivisions, not later than three business days after the agency makes a written request for the records involved.

(2) The protection and advocacy agency shall have immediate access to the records, not later than 24 hours after the agency makes a request, without consent from another party, in a situation in which treatment, services, supports, or other assistance is provided to an individual with a disability, if the agency determines there is probable cause to believe that the health or safety of the individual is in serious and immediate jeopardy, or in a case of death of an individual with a disability.

(f) Confidential information kept or obtained by the protection and advocacy agency shall remain confidential and may not be subject to disclosure. This subdivision shall not, however, prevent the protection and advocacy agency from doing any of the following:

(1) Sharing the information with the individual client who is the subject of the record or report or other document, or with his or her legally authorized representative, subject to any limitation on disclosure to recipients of mental health services as provided in subsection (b) of Section 10806 of Title 42 of the United States Code.

(2) Issuing a public report of the results of an investigation that maintains the confidentiality of individual service recipients.

(3) Reporting the results of an investigation to responsible investigative or enforcement agencies should an investigation reveal information concerning the facility, its staff, or employees warranting possible sanctions or corrective action.

This information may be reported to agencies that are responsible for facility licensing or accreditation, employee discipline, employee licensing or certification suspension or revocation, or criminal prosecution.

(4) Pursuing alternative remedies, including the initiation of legal action.

(5) Reporting suspected elder or dependent adult abuse pursuant to the Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 (commencing with Section 15600) of Part 3 of Division 9).

(g) The protection and advocacy agency shall inform and train employees as appropriate regarding the confidentiality of client records.

(Amended by Stats. 2003, Ch. 878, Sec. 7. Effective January 1, 2004.)

4904. (a) The protection and advocacy agency, its employees, and designated agents, shall not be liable for an injury resulting from an employee's or agent's act or omission where the act or omission was the result of the exercise, in good faith, of the discretion vested in him or her.

(b) The protection and advocacy agency, its employees, and designated agents, shall not be liable for damages awarded under Section 3294 of the Civil Code or other damages imposed primarily for the sake of example and by way of punishing the defendant.

(c) The protection and advocacy agency, its employees, and designated agents, when participating in filing a complaint or providing information pursuant to this division or participating in a judicial proceeding resulting therefrom shall be presumed to be acting in good faith and unless the presumption is rebutted, shall be immune from any liability, civil or criminal, and shall be immune from any penalty, sanction, or restriction that might be incurred or imposed.

(Added by Stats. 1991, Ch. 534, Sec. 7.)

4905. (a) No employee or agent of a facility, program, or service shall subject a person with a disability to reprisal or harassment or directly or indirectly take or threaten to take any action that would prevent the person, his or her legally authorized representative, or family member from reporting or otherwise bringing to the attention of the protection and advocacy agency any facts or information relative to suspected abuse, neglect, or other violations of the person's rights.

(b) Any attempt to involuntarily remove from a facility, program, or service, or to deny privileges or rights without good cause to a person with a disability by whom or for whom a complaint has been made to the protection and advocacy agency, within 60 days after the date the complaint is made or within 60 days after the conclusion of any proceeding resulting from the complaint, shall raise a presumption that the action was taken in retaliation for the filing of the complaint.

(Amended by Stats. 2003, Ch. 878, Sec. 8. Effective January 1, 2004.)

4906. (a) The protection and advocacy agency may not obtain access through the use of physical force to facilities, programs, service recipients, residents, or records required by the division if this access is delayed or denied.

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42 U.S.C.A. § 1396a

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UNITED STATES CODE ANNOTATED
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7--SOCIAL SECURITY
SUBCHAPTER XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

→§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must--

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States

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Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide--

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) [FN1] of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to--

(i) all individuals--

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV,

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or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) [FN2], 606(h) [FN2], or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) [FN2] of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)) and would continue to be paid but for the enactment of that section or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title),

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family; [FN3]

(V) who are qualified family members as defined in section 1396d(m)(1) of this title; [FN3]

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family; [FN4]

(ii) at the option of the State, to [FN5] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to [FN5] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment; [FN3]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

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(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title; [FN3]

(VIII) who is a child described in section 1396d(a)(i) of this title--

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter; [FN3]

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); [FN3]

(X) who are described in subsection (m)(1) of this section; [FN3]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title; [FN3]

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals); [FN3]

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

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(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title;

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State; or

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then--

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care

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facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(*ii*) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1396u-3 and 1396d(p)(4) of this title, for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with September 2004) for medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2) of this section) for qualified COBRA continuation beneficiaries described in subsection (u)(1) of this section; and

(G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI of this chapter [42 U.S.C.A. § 1381 et seq.] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals

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described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396o(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(o) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII of this chapter, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) of this section who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and section 1396o(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) of this section shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A) of this section, provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r-4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) of this section who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this section), (XIII) the medical assistance made available to an individual described in subsection (z)(1) of this section who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2) of this section), and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer;

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(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section [FN6] (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 1786 of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide--

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs; and

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII of this chapter and for payment of amounts under section 1396d(o)(3) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title;

(15) provide for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan in accordance with subsection (bb) of this section;

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(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,, [FN7] transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases--

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

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(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g) of this section and in section 1396n of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide--

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including--

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to

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pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)], a service benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State; and

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(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide--

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of--

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that--

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental

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diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that--

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which

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the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide--

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a-3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or

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arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1320a-7(b)(9) of this title;

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 or section 1320a-7a of this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan;

(43) provide for--

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and

(iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for

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the mentally retarded, or inpatient mental hospital services is made under the State plan--

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title;

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1396r-1 of this title and provide for making medical assistance for items and services described in subsection(a) of section 1396r-1a of this title available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1396r-1b of this title during a presumptive eligibility period in accordance with such section;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1396r-2 of this title;

(50) provide, in accordance with subsection (q) of this section, for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51) meet the requirements of section 1396r-5 of this title (relating to protection of community spouses);

(52) meet the requirements of section 1396r-6 of this title (relating to extension of eligibility for medical assistance);

(53) provide--

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical

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assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 1786 of this title), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1396r-8(k) of this title), comply with the applicable requirements of section 1396r-8 of this title;

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section--

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV of this chapter and which include facilities defined as disproportionate share hospitals under section 1396r-4(a)(1)(A) of this title and Federally-qualified health centers described in section 1396d(l)(2)(B) [FN8] of this title, and

(B) using applications which are other than those used for applications for aid under such part;

(56) provide, in accordance with subsection (s) of this section, for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title) receiving funds under the plan shall comply with the requirements of subsection (w) of this section;

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w) of this section;

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (x) of this section) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1396g-1 of this title;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1396s of this title;

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of section 1396u-1 of this title;

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(64) provide, not later than 1 year after August 5, 1997, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this subchapter;

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1395x(n) of this title, and the State shall not issue or renew such a supplier number for any such supplier unless--

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1320a-3(a)(3) of this title) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1320a-3(a)(2) of this title) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary under section 1395m(a)(16)(B) of this title and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section;

(66) provide for making eligibility determinations under section 1936u-5 of this section; and

(67) provide, with respect to services covered under the State plan (but not under subchapter XVIII of this chapter) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid

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or assistance under a State plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV of this chapter in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan--

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Lower payment levels or applying for benefits as condition of applying for, or receiving, medical assistance

Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if the State requires individuals described in subsection (l)(1) of this section to apply for assistance under the State program funded under part A of subchapter IV of this chapter as a condition of applying for or receiving medical assistance under this subchapter.

(d) Performance of medical or utilization review functions

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If a State contracts with an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, or a utilization and quality control peer review organization having a contract with the Secretary under part B of subchapter XI of this chapter for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by an entity or organization as the Secretary may prescribe.

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan; individuals enrolled with health maintenance organizations; persons deemed recipients of supplemental security income or State supplemental payments; entitlement for certain newborns; postpartum eligibility for pregnant women

(1)(A) Notwithstanding any other provision of this subchapter, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter during the period beginning on April 1, 1990, and ending on September 30, 2003. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV of this chapter and have earned income, see section 1396r-6 of this title.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), with a primary care case manager (as defined in section 1396d(t) of this title), or with an eligible organization with a contract under section 1395mm of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an

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individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who--

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1382c(a) of this title;

(B) with respect to whom there has been a determination by the State that--

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter,

shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter XVI of this chapter.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) of this section who, because of a change in

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income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) of this section and subsection (l)(1)(A) of this section without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r-1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (l)(1) of this section or paragraph (2) of section 1396d(n) of this title--

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1396b(a) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who--

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

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(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV of this chapter pursuant to section 602(a)(43) [FN2] of this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV of this chapter and such aid is terminated pursuant to section 602(a)(43) [FN2] of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1396e of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) of this section shall remain eligible for those benefits until the earlier of--

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

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(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section and section 1382h(b)(3) of this title and section 1396r-5 of this title, except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions

In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C) of this section.

(h) Payments for hospitals serving disproportionate number of low-income patients and for home and community care

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Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care.

(i) Termination of certification for participation of and suspension of State payments to intermediate care facilities for the mentally retarded

(1) In addition to any other authority under State law, where a State determines that a [FN9] intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies--

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this subchapter, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this subchapter, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Waiver or modification of subchapter requirements with respect to medical assistance program in American Samoa

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Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(f) of this title, or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of section 1396d(a) of this title.

(k) Repealed. Pub.L. 103-66, Title XIII, § 13611(d)(1)(C), Aug. 10, 1993, 107 Stat. 627

(l) Description of group

(1) Individuals described in this paragraph are--

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) of this section and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after--

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of July 1, 1988, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to

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provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than--

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of July 1, 1988, or

(II) if no such percentage is specified as of July 1, 1988, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of December 19, 1989, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than--

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of December 19, 1989, or

(II) if no such percentage is specified as of December 19, 1989, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17) of this section, for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section--

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under subchapter XVI of this chapter;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of subchapter IV of this chapter;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of subchapter IV of this chapter (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) of this section), and costs incurred for medical care or for any other type of remedial

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care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) of this section and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) of this section in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) of this section and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m) Description of individuals

(1) Individuals described in this paragraph are individuals--

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1382c(a)(3) of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph 2(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) of this section and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher

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than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A) of this section.

(C) The provisions of section 1396d(p)(2)(D) of this title shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1396d(p) of this title.

(3) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X) of this section--

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17) of this section, for qualified medicare beneficiaries described in section 1396d(p)(1) of this title--

(A) the income standard to be applied is the income standard described in section 1396d(p)(1)(B) of this title, and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(n) Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

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(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)--

(A) for purposes of applying any limitation under subchapter XVIII of this chapter on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII of this chapter plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396b(m)(1)(A) of this title for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII of this chapter shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

(o) Certain benefits disregarded for purposes of determining post-eligibility contributions

Notwithstanding any provision of subsection (a) of this section to the contrary, a State plan under this subchapter shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1382(e)(1) of this title to an individual who--

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p) Exclusion power of State; exclusion as prerequisite for medical assistance payments; "exclude" defined

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(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII of this chapter under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this title.

(2) In order for a State to receive payments for medical assistance under section 1396b(a) of this title, with respect to payments the State makes to a medicaid managed care organization (as defined in section 1396b(m) of this title) or to an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title, the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that--

(A) could be excluded under section 1320a-7(b)(8) of this title (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1320a-7(b)(8)(B) of this title, or

(C) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a-7 or 1320a-7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q) Minimum monthly personal needs allowance deduction; "institutionalized individual or couple" defined

(1)(A) In order to meet the requirement of subsection (a)(50) of this section, the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance--

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple--

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(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this subchapter throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph [FN10] is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r) Disregarding payments for certain medical expenses by institutionalized individuals

(1)(A) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and;

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran--

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title, a veteran's pension in excess of $90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of Title 38,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

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42 U.S.C.A. § 1396a

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) of this section or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology--

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI of this chapter, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10) of this section, methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years

In order to meet the requirements of subsection (a)(55) [FN11] of this section, the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1396r-4(b)(1) of this title, shall--

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Limitation on payments to States for expenditures attributable to taxes

Nothing in this subchapter (including sections 1396b(a) and 1396d(a) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

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(u) Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals--

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)).

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved,

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this subchapter resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) of this section and this subsection, the term "COBRA premiums" means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term "COBRA continuation coverage" means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [42 U.S.C.A. § 300bb-1 et seq.] section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1161 et seq.]

(4) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI) of this section--

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17) of this section, require or permit such treatment for other individuals.

(v) State agency disability and blindness determinations for medical assistance eligibility

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42 U.S.C.A. § 1396a

A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1382c(a) of this title.

(w) Maintenance of written policies and procedures respecting advance directives

(1) For purposes of subsection (a)(57) of this section and sections 1396b(m)(1)(A) and 1396r(c)(2)(E) of this title, the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization--

(A) to provide written information to each such individual concerning--

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual--

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

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(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a medicaid managed care organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(5) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(x) Physician identifier system; establishment

The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this subchapter.

(y) Intermediate sanctions for psychiatric hospitals

(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1396d(h) of this title) and further finds that the hospital's deficiencies--

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to

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any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this subchapter--

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1396b(a) of this title with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this subchapter.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if--

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z) Optional coverage of TB-related services

(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i) of this section--

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this subchapter with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) of this section may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this subchapter with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) of this section may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10) of this section, the term "TB-related services" means each of the following services relating to treatment of infection with tuberculosis:

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(A) Prescribed drugs.

(B) Physicians' services and services described in section 1396d(a)(2) of this title.

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in section 1396n(g)(2) of this title).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by out-patients, including services to observe directly the intake of prescribed drugs.

(aa) Certain breast or cervical cancer patients

Individuals described in this subsection are individuals who

(1) are not described in subsection (a)(10)(A)(i);

(2) have not attained age 65;

(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 300n of this title and need treatment for breast or cervical cancer; and

(4) are not otherwise covered under creditable coverage, as defined in section 300gg(c) of this title, but applied without regard to paragraph (1)(F) of such section.

(bb) Payment for services provided by Federally-qualified health centers and rural health clinics

(1) In general

Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by a Federally-qualified health center and services described in section 1396d(a)(2)(B) of this title furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State

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plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years

Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year--

(A) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics

In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by the center or services described in section 1396d(a)(2)(B) of this title furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care

(A) In general

In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1396u-2(a)(1)(B) of this title), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

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(B) Payment schedule

The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies

Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1396d(a)(2)(C) of this title or to a rural health clinic for services described in section 1396d(a)(2)(B) of this title in an amount which is determined under an alternative payment methodology that--

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

[FN1] See Codifications note set out under this section.

[FN2] See References in Text notes set out under this section.

[FN3] So in original. The semicolon probably should be a comma.

[FN4] So in original. Probably should be followed by "and".

[FN5] So in original. The word "to" probably should not appear.

[FN6] So in original. Probably should be followed by a comma.

[FN7] So in original.

[FN8] So in original. Probably should be section "1396d(l)(2)(B)".

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[FN9] So in original. Probably should be "an".

[FN10] So in original. The words "this paragraph" probably should be "this subsection".

[FN11] So in original. Probably should be subsection "(a)(56)".

REPEAL OF SUBSECTION (A)(29)

<Pub.L. 101-508, Title IV, § 4801(e)(11), (11)(A), Nov. 5, 1990, 104 Stat. 1388-217, repealed subsec. (a)(29) of this section effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title.>

Current through P.L. 108-270 (excluding P.L. 108-263 to 108-265) approved 7-7-04

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42 U.S.C.A. § 1396c

C
UNITED STATES CODE ANNOTATED
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7--SOCIAL SECURITY
SUBCHAPTER XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS
→§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds--

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Current through P.L. 108-270 (excluding P.L. 108-263 to 108-265) approved 7-7-04

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