10-1-1998

Children's Regulatory Law Reporter, Vol. 1, No. 2 (1998)

Children's Advocacy Institute, University of San Diego School of Law

CHILDREN'S REGULATORY LAW REPORTER

Children's Advocacy Institute Vol. 1, No. 2 (Fall 1998)

Comments from the Editor

With this second issue of the *Children's Regulatory Law Reporter (Children's Reporter),* we continue to report on the California regulatory process as it affects children. Although the *Children's Reporter* approaches the process from a legal perspective, we strive to present summaries that will be useful to policymakers, child advocates, community organizations, parents and all other interested parties.

This issue covers new regulations which were published or filed from January 1 through June 30, 1998, and includes follow-up actions through August 31, 1998. Additionally, this issue includes updates on regulations that had not completed the regulatory process in the time period of the last issue.

During the first six months of 1998, the decisions of the Managed Risk Medical Insurance Board (MRMIB) had a major impact on children's lives. MRMIB has the charge of designing and implementing California's new health insurance program, Healthy Families, for children whose family income falls between 100% and 200% of the federal poverty line. Because of the importance of this new program, we have featured an in-depth overview of that regulatory process beginning on this page.

In addition, the Department of Social Services (DSS) is now proposing rules to implement the state's CalWORKs welfare reform statute of 1997. Although DSS adopted or noticed most of these rules after the June 30 cutoff for this issue, because of their importance, we have included them in a special insert in this issue. Many of these rules are immediately effective on an "emergency" basis while their formal consideration for permanent adoption proceeds. As to each of these pending rules – as with all rules under the Administrative Procedure Act, public comments must be considered by the adopting agency within the time period prescribed by law. As to those rules which have been permanently adopted, California law allows any person to propose a new rule, amendment, or repeal of an existing rule, to the agency for possible further rulemaking proceedings. The opportunity for public involvement is great – and child advocates must ensure that adopted rules reflect the needs of children who cannot speak for themselves.

Margaret A. Dalton, Editor

CONTENTS

Healthy Families

As part of the Balanced Budget Act of 1997 (42 U.S.C. § 1396 *et seq.*), the federal government established the Children's Health Insurance Plan (CHIP), the most significant funding increase for children's health coverage since the enactment of Medicaid in 1965. CHIP provides $48 billion over ten years for states to cover uninsured children and for certain specified expansions of the Medicaid program. The monies are intended to cover uninsured children with family incomes too high for Medicaid but too low to afford private family coverage. Money will flow to the states through block grants, on a 65% federal - 35% state matching basis. California is entitled to one of the largest shares – $859 million in the first year alone, due to the state's large number of uninsured children and high poverty rates. In developing individual state plans, each state had the option of further expanding Medicaid (Medi-Cal in California), creating a new and separate state program, or a combination of the two.

During the last three weeks of the 1997 California legislative session, state lawmakers and Governor Pete Wilson chose to create a new and separate program, Healthy Families (AB 1126) (Villaraigosa) (Chapter 623, Statutes of 1997), to finance health insurance for up to 580,000 of California's 1.6 million uninsured children. The Legislature also passed, and Governor Wilson signed, a federally-mandated expansion of Medi-Cal to teenagers between the ages of 14 and 19 whose

family income is up to the federal poverty level (SB 903) (Lee) (Chapter 624, Statutes of 1997). (Regulations relating to the expansion of Medi-Cal are the responsibility of the Department of Health Services (DHS) and are covered in the Child Health section of this *Children's Reporter*.)

As required by CHIP, California submitted its Healthy Families plan to the federal Health Care Financing Administration (HCFA). On March 24, 1998, HCFA approved both the mandated plan for expansion of Medi-Cal and the Healthy Families plan, designed to expand coverage to children through age 18 whose family income is up to 200% of the federal poverty level. (But note the federal statute's allowance for coverage up to 250% to 300% of the poverty line for some of California's children; see also later discussion of Governor Wilson's retraction of coverage for many children living below 200% of the poverty line through a revised definition of income.)

Healthy Families provides subsidized health *insurance* coverage (not health *services*, per se) for children in families with incomes between 100% and 200% of the federal poverty level (between $13,650 and $27,300 per year for a family of three). Parents have a choice of plans, including coverage for dental, vision and mental health in addition to physical health services. Monthly premiums range from $4-7 per child (up to $14 per family for families between 100% and 150% of the federal poverty line) to $6-9 per child (up to $27 per family for families between 150% and 200% of the federal poverty line). In addition, co-payments are set at $5 per visit and per prescription; no co-payments may be charged for designated preventive services.

In California, the Managed Risk Medical Insurance Board (MRMIB) is the state agency responsible for drafting regulations for the implementation of Healthy Families. On February 20, 1998, MRMIB published notice of its intent to adopt sections 2699.6500 through 2699.6813, Title 10 of the California Code of Regulations (CCR), on an emergency basis, to implement the Healthy Families program. The regulations became effective on the same date. On March 13, 1998, MRMIB published notice of its intent to permanently adopt the regulations. MRMIB accepted public comment on the proposal until April 29, 1998, and held a series of eight public hearings throughout the state. MRMIB revised the proposed regulations and submitted them to OAL on June 5, 1998. OAL approved them on July 15, 1998, and they became effective on the same date (15 days after Healthy Families became operational).

The regulations, as permanently adopted, are divided into four articles: Article 1, Definitions; Article 2, Eligibility, Application, and Enrollment; Article 3, Health, Dental and Vision Benefits; and Article 4, Risk Categories and Family Contributions. For the purpose of easy reference, each Article is considered in order below.

Article 1, Definitions, includes one of the most controversial portions of the regulations, "income deductions" allowances (§ 2699.6400(k)(1)). As originally proposed in the emergency regulations, families qualified for certain income deductions in determining the gross family income for eligibility purposes. These deductions included work expenses of up to $90 per month for each working family member; child care expenses (up to $200 per month for each child under age two and up to $175 for each child over age two and for any disabled dependents); the amount paid by a family member per month for any court-ordered alimony or child support; child support payments received up to $50 for each applicable family member; and alimony payments received up to $50 for each applicable family member. HCFA had approved these income deductions as part of the federal government's approval of the Healthy Families plan. However, in early April 1998, Governor Pete Wilson proposed eliminating the income deductions from the regulations and requested HCFA to approve a corresponding amendment to the state's plan – a plan originally submitted by the administration's DHS. At its April 20 meeting and at the Governor's request, MRMIB approved the regulatory change (on a 3-2 vote) and removed the income deductions. The elimination of the deductions – vigorously opposed by child and health advocates – raises the total family income for consideration of eligibility, and thus denies health insurance coverage to thousands of previously-qualifying children. It also complicates the ability of families to shift from Medi-Cal to Healthy Families as family income rises, because the new Healthy Families rules no longer are consistent with Medi-Cal rules, which allow the deductions in computing family income. The poverty line assumes no child care costs, calculating minimum income necessary to house, clothe and feed a family in a typical state. Expenses apart from these necessities, required to earn income, are properly disregarded as disposable income for public medical coverage purposes in other programs. Hence, child care costs to allow employment, *et al.*, should not be included in determining eligibility for Healthy Families. Advocates also argued that failing to disregard such expenses discriminates against children in many families with the same disposable income but who must pay for child care or other expenses. Finally, critics of the Governor's plan pointed out that more than enough federal funds have been provided to cover all of these children – and many more – and that exclusion would lead to a California give-back of substantial federal funds for distribution to other states. Nevertheless, HCFA subsequently approved the State Plan Amendment, eliminating the use of income disregards for eligibility determination and temporarily ending the discussion.

Other changes in Article 1 include an expanded definition of the "Family Value Package" (§ 2699.6500 (i)) – one of two options families may choose (the other is the Community Provider Plan, see Article 4 discussion below). The Family Value Package is the combination of participating health, dental, and vision plans available to participating subscribers in each county, offering the lowest price or meeting other qualifying criteria. The rules prescribe a formula to determine network capacity; this is important because only those plans meeting stated price thresholds qualify.

Article 2, Eligibility, Application, and Enrollment, constitutes most of the rules relating to a family's use of the Healthy Families program. The Determination of Eligibility (§ 2699.6607(a)) sets forth the rules for the administrative completion of the application review process, requiring an eligibility determination within ten calendar days of receipt of the complete application unless documentation is not complete. However, if the program is unable to verify citizenship or qualifying immigration status within the ten-day period, the person is deemed to meet the criteria until such status is verified. The requirement to document status already has become an issue with child and health advocates; county officials are reporting a very low number of enrollees in San Diego and Kern Counties – both of which have high numbers of foreign-born parents with citizen children – because parents fear their status may be risked by applying for public benefits. The rules also contain a procedure for extending the ten-day determination period when the application is incomplete. If telephone notification is unsuccessful, the application will be returned with a notice that the applicant must submit clarifying information or documentation.

The complicated application process is another bar to participation in the program. Sections 2699.6600-.6605 contain over fifty rules applying to families attempting to qualify for Healthy Families coverage. The application itself, designed to be visually appealing and user-friendly, nevertheless requires a painstaking determination – using a three-step, four-page form – of which family members qualify for Medi-Cal, Healthy Families, or neither; a five-page Healthy Families application form including ten declarations which must be individually initialed (and copies made if applying for more than three children); proof of each child applicant's alien or citizenship status; proof of income; and an initial family contribution payment of at least one month. Applicants who pay in advance the amount of three months of family contributions shall receive the fourth consecutive month of coverage with no family contribution required (§ 2699.6809(b)). In the emergency regulations, the rules allowed for payment only by cashiers check or money order. This barrier to participation was adjusted somewhat in the permanent rules, which now allow applicants to submit the second or later family contribution payment by personal check, cashiers check, money order, credit card, or electronic fund transfer. In an attempt to encourage enrollment, the state has offered training for individuals who work with community-based organizations to participate and assist families in the application process. A person who receives training is certified, and the organization will receive $25 for each successfully completed application when pregnant women or children are enrolled in the program (§ 2699.6629). Even with that assistance in place, the complicated application effectively serves as a bar deterring all but the most motivated parents.

Enrollment includes an annual requalification for subscribers (§ 2699.6625), which compels applicants to requalify on an annual basis by providing to the program all information required to initially enroll. Other related sections cover disenrollment criteria, open enrollment (for changing from one health plan to another), and additional or transfer enrollments.

Article 3, Health, Dental and Vision, covers the scope of health benefits, including excluded benefits, and share of cost rules (§§ 2699.6700-.6721). Share of cost under Healthy Families includes a $5

copayment requirement for any of these services: outpatient professional (medical) and mental health, home health care, outpatient alcohol and drug services, and rehabilitative therapy. There is also a similar copayment for most prescription drugs. Preventive services as defined do not require a copayment. The share of cost requirement for outpatient services has a $250 ceiling in a benefit year. Child and health advocates have expressed serious concern with this high copayment cap, since otherwise qualifying families – some of whom may be just over the poverty line – may pay up to $250 per year to access medical care for illness or injury, in addition to the price of premiums. This barrier to treatment, particularly for families whose incomes are already at the lowest levels, is one which child advocates believe will make the program most prohibitive for many of the very families it was theoretically designed to help.

Article 4, Risk Categories and Family Contributions, covers rate restrictions for participating health plans as well as premium costs for families. Allowable rates are based on the geographic regions of the subscriber's residence, similar to other private health insurance coverage. Section 2699.6805 gives MRMIB the authority to designate a Community Provider Plan in each county, with some exceptions. The Families choosing the Community Provider Plan over the Family Value Package (see Article 1 discussion of the Family Value Package above) pay $3 less for each premium, per month, per subscriber. Community Provider Plans primarily consist of traditional safety net providers such as community clinics; in many cases they are the current provider of care for those families previously receiving any health care services.

The Healthy Families program theoretically became operational on July 1, 1998. As of this writing, a disappointingly small percentage of qualifying families have applied – less than 2% of those eligible. The concerns discussed above – including the cost of premiums and copayments, the complicated application and required documentation, issues for undocumented immigrants whose children are citizens, and the inherent complications in creating a new bureaucratic program – all likely contributed to this slow start. Outreach and education alone will not solve these issues. Further refinements of the program, especially a reconsideration of the family contribution through premiums and copayment and a simplified application form, are needed to jumpstart Healthy Families.

Impact on Children: Uninsured children are less likely to have regular health examinations, resulting in little early detection of problems. They lack a regular medical professional to monitor their development, and are three times more likely than an insured child to lack a regular source of care. Fewer immunizations, well baby checks, and genetic/chronic disease screenings are related consequences. Most uninsured children come from families where one or more parents work. These are families who are "playing by the rules" but often cannot afford basic health care services even when children are ill. The Healthy Families program does not provide those services; rather it offers "working poor" families an opportunity to purchase health insurance. Without adjustments to the program – including a simplified application process, a lowering or elimination of premiums and copayments, and some assurances for immigrants that applying for their children will not harm the parents' immigration status – Healthy Families will not come close to reaching its potential. Medical insurance coverage for children is not a welfare benefit. It is a public investment in the health and safety of our children by preventing and treating illness. It heals and protects. It is not a "perk," nor is it amenable to exploitation by its beneficiaries – children do not clamor to stand in long lines for shots that are not needed. No child in a state as wealthy as California should go without needed health care services. Over a million California children did not have health care coverage last year. Healthy Families should be redesigned to carry out the federal intent and accept all the offered funds to provide it.

Child Poverty

Child Support Collections

On April 29, 1998, DSS amended sections 12-501.2, 12-505, 12-510, and adopted new section 501.2(c)(1) of the Manual of Policies and Procedures (MPP), on an emergency basis, to comply with revised statutory authority for the Child Support Collection Program (Chapters 599 and 614, Statutes of 1997). Previously, local Family Support Divisions (FSD) of District Attorney offices had the option of referring delinquent child support obligations to the Franchise Tax Board (FTB) for collection. The emergency rules became effective on May 1, 1998.

The amended regulations now mandate FSDs enforcing child support obligations to refer all obligations that are at least ninety days delinquent to the FTB for collection. The FTB gives these delinquent obligations the high priority status of "tax liens."

On May 1, 1998, DSS opened a public comment period until June 17, 1998, and announced a June 17 public hearing in Sacramento on the proposed regulatory changes. At this writing, DSS has not submitted the permanent regulations to OAL.

Impact on Children: Only a small percentage of custodial parents receive the child support that courts have ordered. While strides have been made by many District Attorney offices through the efforts of Family Support Divisions, those entities lack the tracking and enforcement powers of the Franchise Tax Board. These regulations are a positive step toward increasing the amount of child support collected.

Child Support Commissioner System

AB 1058 (Speier) (Chapter 957, Statutes of 1996) established Family Code section 4251 which requires each Superior Court to provide an adequate number of commissioners for hearing child support cases. Additionally, Family Code section 4252 removes DSS' role in overseeing county plans of cooperation for child support commissioner systems by placing oversight of these systems with the California Judicial Council.

On February 27, 1998, DSS published notice of its intent to repeal sections 12-109.6, 12-109.7, 12-109.71, 12-109.72, and 12-109.73 of the MPP, relating to child support commissioner hearing systems. DSS accepted public comment on the proposed regulatory changes until April 15, 1998, and held a public hearing on the same date in Sacramento. DSS adopted the regulations and submitted them to OAL, which approved them on June 23, 1998. They were effective on July 1, 1998.

Impact on Children: DSS repealed these regulations because the California Judicial Council now has the responsibility for overseeing the child support hearing systems. These regulatory changes, as a result of legislative mandate, remove the option for counties to establish a child support hearing system presided over by a court commissioner, and now require them to do so.

Child Health

Infant Botulism Treatment and Prevention Program

On June 3, 1998, DHS adopted sections 3000.2, 3000.4, 3010, 3020, and 3030, Title 17 of the CCR, on an emergency basis, to establish an Infant Botulism Treatment and Prevention Unit for the production and distribution of Botulism Immune Globulin (BIG). Infant botulism is a life-threatening and paralytic disease that affects about 70-90 U.S. infants annually. Half of all cases occur in California. In 1992, DHS began enrollment in a clinical trial of the new drug, BIG, intended to shorten hospital stays and reduce hospital costs. The results were dramatic: BIG reduced the average length of an infant's hospital stay by half, reduced the average time on a breathing machine, and saw no allergic shocks or deaths. These proposed regulations establish a unit within DHS to distribute BIG, set up reporting requirements for hospitals, and specify fee amounts.

On June 19, 1998, DHS published notice of its intent to permanently adopt the amendments, and announced a public comment period until August 3, 1998. There was no hearing scheduled. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

Impact on Children: Infant botulism is an "orphan disease," one which affects fewer than 200,000 residents of the United States. With less than one hundred infants contracting this disease each year, it was not cost effective for pharmaceutical companies to develop a new drug such as BIG, since cost recovery would be impossible. A state-based program like this one benefits society and its very vulnerable infants. DHS took the lead in determining the efficacy of BIG through a clinical trial. This helps not only California infants, but all infants in the country who contract the serious disease of infant botulism and now stand a better chance of recovering. The DHS Infant Botulism Treatment and Prevention Unit makes good sense.

Childhood Lead Poisoning Prevention

Sections 105250 and 124160 of the Health and Safety Code require DHS to become an authorized state program as specified by the federal Environmental Protection Agency (EPA), and to adopt regulations governing the evaluation and abatement of lead hazards.

On March 30, 1998, DHS adopted sections 35010 through 36100, amended sections 35001 through 35099, and repealed section 35031, Title 17 of the CCR, on an emergency basis, to comply with the

Health and Safety Code requirement. The emergency regulations included language dealing with standards for accreditation of training programs, certification requirements for individuals conducting abatement programs, and work practice standards for lead abatement and hazard evaluation. EPA requires those elements for a state to become an authorized program.

On April 10, 1998, DHS noticed the emergency rules and announced a public comment period extending until the public hearing in Sacramento on May 27, 1998. The proposed regulations vary from the federal regulations as follows: section 35065 requires the worker training course to be 24 hours (the federal rule only requires 16); section 35066 allows certified workers to take a two-day supplemental course to become a certified Supervisor or Project Monitor (the federal rule has no such supplemental course option); section 35096(f) requires a refresher course every two years (federal regulations allow a three-year period); section 35001 defines abatement as any measure designed to reduce or eliminate lead hazards (the federal rule does not include reduction); sections 35035-6 define numerical standards for lead-contaminated dust and soil (the federal rules have no numerical standards); and sections 35037-8 define lead hazards and lead hazard evaluation (the federal rules have not yet defined these terms).

On July 20, 1998, DHS refiled the amendments on an emergency basis. They became effective July 29, 1998. At this writing, DHS has not submitted the permanent regulatory changes to OAL.

Impact on Children: Close to three million California families, with over one-quarter of a million children, live in homes with lead paint. A large amount of lead from vehicle exhaust and paint also contaminates the soil. The state's Childhood Lead Poisoning Prevention (CLPP) Fund supports the state's CLPP program. The Fund assesses fees from the largest environmental lead contributors to support follow-up wide-spread childhood lead screening tests, and the development of abatement policies. The regulatory changes codify program requirements. More significantly, the regulations meet federal standards – in a few cases exceeding them, and specifying parameters that were previously absent.

Child health advocates contend that brain damage from lead occurs at levels far below visible symptoms, that some children are subject to school dosages for many hours per day over most of the year, and that the total intake of lead is the greatest danger. Lead is not a typical poison. It is cumulative in nature, with new intake adding to previous ingestion, which means that continuing exposure to low levels of lead can result in significant exposure over time, according to the Natural Resources Defense Council.

From 1994 to 1998, DHS took samples of paint, soil, and drinking water from a cross-section of schools and child care centers. The survey concluded that 37% of public elementary schools have deteriorating lead-containing paint significant enough to pose a hazard. More alarming, 18% have lead levels in drinking water above the federal action level of 15 parts per billion (ppb) and 6% have soil lead levels above the federal action level of 400 ppb.

A 1995 study published in *Epidemiology* suggests that the 80 ug/dL level (which produces visible symptoms cited by the California Department of Health Services) is not the extent of the danger. Lead could account for a "tripling of the number of youngsters who need specialized educational services," since even low levels of lead in blood (10 ug/dL) can drop the IQ of young children measurably — and to below normal ranges.

Medi-Cal Specialty Mental Health Services

AB 757 (Polanco) (Chapter 633, Statutes of 1994) enacted laws for the provision of specialty mental health services to beneficiaries of Medi-Cal. On November 1, 1997, the Department of Mental Health (DMH) adopted new sections 1810.100 *et seq.*, Title 9 of the CCR, on an emergency basis, to implement AB 757. The new regulations implemented the second phase of Mental Health Managed Care, providing for the phased implementation of managed mental health care for Medi-Cal beneficiaries through fee-for-service or risk-based contracts with mental health plans.

Section 1830.210 applies to children; it deals specifically with beneficiaries under 21 years of age. The criteria for children thus differs from that used to determine the impairment and appropriateness of intervention of adult beneficiaries. For adults to receive mental health services through Medi-Cal, they must be diagnosed with one of the specified conditions, have a significant impairment or a probability of significant deterioration in an important area of life functioning, and have the expectation that the proposed service will significantly diminish the impairment or prevent significant deterioration of the person's life functioning. For children (and all persons under age 21) who do not meet the impairment standard, specialty mental health services are to be provided when certain other criteria are met. To qualify under the alternate criteria, a child must meet the same diagnosis criteria as an adult, but is then only required to have a condition that would *not* be responsive to physical health care-based treatment. However, this does not ensure coverage; wide discretion is left to the mental health provider to determine whether the proposed service is accessible and available as part of an existing specialty mental health service.

On November 14, 1997, DMH published notice of its intent to permanently adopt the emergency regulations. DMH accepted public comment until December 30, 1997, and held a public hearing on the same date in Sacramento. On January 9, 1998, DMH re-opened the public comment period from December 30, 1997 to January 15, 1998. DMH refiled the regulations on an emergency basis on March 3, 1998 and again on June 17, 1998, to allow time for revisions based on public comment. At this writing, DMH is completing new draft regulations for notice and publication.

Impact on Children: Establishing independent medical criteria for children is vital to the provision of quality care. Children are not just small adults; they have unique medical needs, particularly in the mental health area. These initially-proposed regulations take a step in the right direction in recognizing the high societal value of early treatment of mental illness. However, weighing such needs against physical treatment of an organic illness as an "either-or" proposition misunderstands the complex etiologies of mental illness or disability. The criteria for treatment should be based on a competent diagnosis and a professional judgment that treatment (in whatever form and coextensively applied if appropriate) has a "reasonable chance of improving" the child's mental health.

Dental Sealants

On April 10, 1998, DHS amended sections 51003, 51307 and 51506, Title 22 of the CCR, on an emergency basis, to bring California regulations in compliance with the federal Health Care Financing Administration's instructions on the scope of preventive dental services. The federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires participating states to offer eligible Medi-Cal beneficiaries dental services that meet "reasonable standards" of dental practice. The most important aspect of this prevention (aside from water fluoridation) is the use of dental sealants. Such sealants are available to protect the teeth of children against decay and are remarkably effective. However, only 10% of the 6- to 8-year-olds surveyed in California have received this inexpensive and cost-effective preventive treatment. In contrast, Ohio already has applied sealants to over one-quarter of its children.

Existing state regulations provide for dental sealants, but limit the placement of sealants without prior authorization to the first permanent molars in beneficiaries to age eight and the second permanent molars in beneficiaries to age fourteen. The amendments remove existing requirements for prior authorization of dental sealants, allowing the placement of sealants without prior authorization on permanent first and second molars to age 21; limit the sealant benefit to once every three years; and increase the maximum reimbursement to providers.

On April 10, 1998, DHS adopted the proposed regulatory changes on an emergency basis; they were effective on the same date. On April 24, 1998, DHS published notice of its intent to permanently adopt the amendments, and announced a public comment period until June 8, 1998. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

Impact on Children: The addition of more comprehensive coverage of dental sealants is helpful to children. However, given the low cost and substantial benefits, all permanent molars should be sealed prior to age twelve. Allowing managed care plans to provide only limited dental sealants, where the marginal cost of full treatment is insubstantial, has a leveraged negative impact on child and later adult dental health. The context of this under-reach was outlined by the Dental Health Foundation's September 18, 1997, published assessment of the dental health of California's children. The first-ever statewide assessment of the state's child oral health was conducted during the 1993-94 school year and used teams of dental examiners to survey a sample of 6,643 children in 156 schools in 10 geographic regions. The findings documented what was termed a "neglected epidemic" of oral disease, with the state's incidence of problems double that of the national average, and substantially deteriorated from 1987. The examinations found high levels of untreated tooth decay and even gum disease among preschool and school-aged California children. The report described the consequences as "significant pain, interference with eating, poor self-image, overuse of

emergency rooms, and loss of school time."

Expansion of Medi-Cal Children's Programs

As amended, Welfare and Institutions Code section 14148.75 (SB 903) (Lee) (Chapter 624, Statutes of 1997) allows DHS to waive the use of a resources standard for determining the eligibility of pregnant women, infants and children for certain Medi-Cal programs. A resources standard includes property and other assets as well as income in determining eligibility. Previously, the law had allowed such a waiver for pregnant women and infants, but did not allow the same disregard when determining eligibility for children.

On April 2, 1998, DHS amended section 50262.5, Title 22 of the CCR, on an emergency basis; on April 15, 1998, DHS refiled the amendment to correct a subsection number. As amended, section 50262.5 incorporates the waiver of a resource standard for eligibility purposes in the zero share of cost program for children between one and six years of age. The family income may not exceed 133% of the federal poverty line. On April 17, 1998, DHS published notice of its intent to permanently adopt the amendment, and announced a public comment period until June 1, 1998. There was no public hearing. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

In another expansion of children's coverage, the federal Balanced Budget Act of 1997, Pub. L. No. 105, allowed California to offer Medi-Cal eligibility to older children ages 14 to 19, if the family income is at or below 100% of the federal poverty line. On April 2, 1998, DHS amended section 50262.6, Title 22 of the CCR, on an emergency basis; on April 15, 1998, DHS refiled the amendment to correct a subsection number. As amended, section 50262.6 defines children as persons under 19 years of age (in accordance with federal law), effectively extending coverage for ages 14-19, and also allows for the waiving of the resources standard when determining eligibility for the program. On April 17, 1998, DHS published notice of its intent to permanently adopt the amendment, and announced a public comment period until June 1, 1998. There was no public hearing. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

Impact on Children: These regulatory changes are important expansions of medical health services, which eliminate gaps in coverage for some otherwise-qualifying children and youth ages 14-19. Waiving the use of a resources standard allows more children to qualify for Medi-Cal based on income; increasing benefits to age 19 means health coverage for older children during the critical adolescent years.

Orthodontic Services

DHS and the Legal Aid Society of San Diego entered into a settlement agreement in a class action (*Duran v. Belshe*, San Diego County Superior Court Case No. 674204) that stipulated that DHS would promulgate emergency regulations allowing the use of an expanded HLD Index (a standard for evaluating and determining the threshold need for orthodontic services and determining medical necessity). The regulations must comply with federal requirements for children in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

On January 12, 1998, DHS amended section 51003, Title 22 of the CCR, on an emergency basis to implement the settlement agreement. DHS opened a public comment period from March 23 until April 7, 1998; there was no public hearing. On April 10, 1998, DHS amended sections 51003 and 51506, Title 22 of the CCR, on an emergency basis, to further clarify language and for minor editing. As amended, these regulations will change the process by which providers obtain authorization to perform certain procedures needed to correct handicapping malocclusion (dental abnormalities). DHS made minor non-substantive changes and again amended the sections on an emergency basis effective May 21, 1998. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

Impact on Children: These changes bring California into compliance with the federal EPSDT program, thus providing an expanded standard for determining medical necessity for handicapping malocclusion.

Prenatal Care for Immigrants and Unqualified Aliens

The federal PRA prohibits states from providing state and local public benefits, including non-emergency pregnancy-related services, to persons who are non-qualified aliens and certain other aliens.

Prior to the enactment of the PRA, federal law required states to provide services for the treatment of emergency medical conditions, including emergency labor and delivery services, to any alien otherwise eligible for Medi-Cal regardless of whether that person could document

his or her immigration status. And since 1988, California has used state-only Medi-Cal funds to provide non-emergency pregnancy-related services to women without satisfactory immigration status as described in federal law. 42 U.S.C. § 1396b(v). With the enactment of the PRA, federal law now prohibits states from providing certain public benefits, including non-emergency pregnancy-related services, to ineligible persons as described above, unless the state enacts a law after the PRA enactment date that affirmatively provides for such eligibility.

On November 5, 1996, DHS added section 50302.1 to Title 22 of the CCR, on an emergency basis, to specify who is eligible to receive non-emergency pregnancy-related services; amend the *Manual of Criteria for Medi-Cal Authorization,* effective July 1997; and incorporate by reference section 51003, Title 22 of the CCR. These regulatory changes are intended to implement the requirements of the PRA; services will not be provided to persons who are ineligible under federal law. They also define the term "non-immigrant" in the same manner as does federal immigration law.

On November 13, 1996, the Western Center on Law and Poverty and others filed a lawsuit challenging the validity of the regulations, contending that the use of the emergency rulemaking process by DHS – under which regulations may be adopted without notice or comment – violates the Administrative Procedure Act (APA). In *Doe, et al. v. Wilson, et al.*, Nos. 982521 and 982522 (San Francisco Superior Court) (November 26, 1996), the trial court held that the state's required compliance with the new federal law did not justify the issuance of emergency regulations; the court issued a preliminary injunction barring DHS from enforcing the emergency regulations. As a result, DHS dropped the emergency rules and commenced the ordinary rulemaking process as required by the APA for non-emergency (permanent) regulations.

However, on August 25, 1997, the First District Court of Appeal vacated the order granting the preliminary injunction and remanded the matter to the trial court with instructions to deny the request for the preliminary injunction. *Doe, et al. v. Wilson, et al.*, 57 Cal. App. 4th 296 (1997). The appellate court found that DHS did not abuse its discretion in finding that an emergency existed in light of the passage by Congress and the signing by the President of the PRA. *Id.* at 306. Although DHS prevailed, it did not readopt the changes as emergency regulations because conclusion of the non-emergency regulatory process was near.

On December 20, 1996, DHS published notice of its intent to adopt new section 50302.1, Title 22 of the CCR. DHS accepted public comment on the proposal until February 19, 1997 and held public hearings on the proposed regulation on February 5, 1997 in Los Angeles and February 19, 1997 in Sacramento. DHS made post-hearing changes in the proposed regulation, and reopened the public comment period between July 15 and July 31, 1997. Following the comment period, DHS deleted some language and again reopened the public comment period between August 30, 1997 and September 16, 1997. DHS made some additional changes and again reopened the public comment period between October 15 and October 29, 1997. DHS re-submitted the regulatory changes to OAL on November 13, 1997; OAL approved them on December 1, 1997. The effective date of the new regulation was to be January 1, 1998 for new applicants and February 1, 1998 for the existing caseload. Due to a number of legal challenges by child and health advocates, the rules have not been implemented as of this writing. Most recently on June 10, 1998, the California Supreme Court refused to lift a March 5, 1998, Los Angeles Superior Court decision blocking DHS from denying prenatal services to nonqualified immigrants until a hearing on November 24. If DHS is successful at the hearing, the earliest date for implementation is expected to be April 1999.

The new rule implements the PRA's ban on non-emergency prenatal care assistance for non-qualified, non-immigrant aliens. Those barred from medical service assistance include all immigrants who are not lawfully admitted as a permanent resident, granted asylum or refugee status, paroled into the United States for more than one year, granted conditional entry, or whose deportation is being withheld. A final category of exemption primarily addresses children who have been subject to serious abuse. However, the rule narrows this exemption to those who have been battered or subject to extreme cruelty by family members, the benefits to be provided have a "substantial connection" to that abuse, and the alien has a petition pending for (or has been granted) status as a spouse or child of a United States citizen. Services may be granted only where the recipient does not live with the abuser.

The "substantial connection" required above is defined narrowly to include situations where medical coverage is lost because of the removal of the abused victim from the

abuser, or for medical care, mental health counseling or disability needs from the battery or cruelty, or to provide care for an unwanted pregnancy and child from the abuser's sexual assault or abuse of relationship (incest, statutory rape, molestation).

The rule specifies some of the procedural measures to assure prenatal care cut-offs as intended. "State only funded nonemergency, pregnancy related services" for any alien may be provided only upon declaration that she is a qualified alien as defined above, using the "Supplemental Alienage and Immigration Status Declaration" form of INS. Further, the alien must present documentation "issued by or acceptable to" INS as evidence of that declared status, and which must be submitted to INS for verification through that agency's Systematic Alien Verification of Entitlements program (a computer record index). The verification then may require a "secondary verification" when there is an instruction from the INS index to do so, the documents presented do not include an alien registration or admission number, or the numbered document does not match other documents, the number has not yet been issued, the document is a fee receipt for replacement of a lost document, or the document is "suspected of being counterfeit or to have been altered." In addition, a series of enumerated documents are excluded from verification status.

The rule provides that eligibility for state-funded prenatal care must await receipt of verification of an alien's declared status from the INS. Consistent with the statute, the rule excepts immunizations and communicable disease treatment.

The rule provides procedural due process in the form of a hearing pursuant to Welfare and Institutions Code section 10950 for those receiving prenatal care during the month in which the rule became effective and who are denied care as a result of the rules. That due process consists of a hearing on the narrow issue of whether the alien is a qualified alien eligible for services as described above. The rule enigmatically provides that "subject to Welfare and Institutions Code section 10950 . . . any alien [denied Medi-Cal benefits] . . . is entitled to a hearing." No details are provided.

Impact on Children: The elimination of non-emergency prenatal health care to "nonqualified aliens" (many but not all of whom are illegally in the United States) will result in increased complications during pregnancy which otherwise could have been detected during routine prenatal care visits. Some of these complications involve potentially fatal consequences (such as HIV transmission at birth, possibly preventable if HIV status is known). Other complications result in lifelong disabilities preventable through routine screening. Because children born in the United States are citizens at birth, failure to provide prenatal care will impose substantial medical, disability, communicable disease, education, and lost productivity costs many times the prenatal care expenses involved, according to the American Academy of Pediatrics and others. There is no evidence that the denial of prenatal care has a significant impact on illegal immigration incidence, or on pregnancy incidence among those in the United States. See *California Children's Budget 1997-98* at 4-12 to 4-14. Beyond these statutory consequences, the new rule narrowly defines exemptions, and imposes onerous proof requirements on lawful immigrants, discouraging prenatal care by those not intended to be barred and adding gratuitously to infant death and disability consequences.

Detection of Fluoride in Public Water

On March 28, 1997, in compliance with U.S. Environmental Protection Agency regulations under the Safe Drinking Water Act (42 U.S.C. § 300(f) *et seq.*), as well as Health and Safety Code sections 4026.7 and 4026.8, DHS published notice of its intent to adopt new sections 64400.47 and 64433-64434 and amend sections 64431 and 64432, Title 22 of the CCR. In these proposed changes, DHS seeks to provide a definition for the term "fluoridation" and establish a detection limit for fluoride, a naturally occurring chemical.

Specifically, these regulatory changes would define the term "fluoridation"; add fluoride to the maximum contaminant level list to address the natural occurrence of fluoride in sources of drinking water; add fluoride to the list of inorganic chemicals monitored to set a detection limit for purposes of reporting fluoride; specify exemptions and determine which systems are covered by the mandate to fluoridate when funds are made available; establish optimal fluoride levels for fluoridation systems; develop monitoring and compliance requirements associated with fluoridation; introduce the basic criteria for a fluoridation system; institute recordkeeping, reporting, and notification requirements related to fluoridation treatment; determine the fluoridation system operations contingency plan; and establish the water system priority funding schedule.

DHS accepted public comment until May 12, 1997; no hearing was held. OAL approved the regulatory changes on March 23, 1998; they became effective on April 22, 1998.

Impact on Children: Maintaining appropriate amounts of fluoride in public water sources will improve the oral health of children.

Surface Water Quality Criteria

In June 1989, the U.S. Environmental Protection Agency adopted regulations under the Safe Water Drinking Act (42 U.S.C. § 300(f) *et seq.*), intended to improve the microbiological quality of surface waters and groundwaters influenced by surface water. DHS adopted similar regulations at that time.

On May 23, 1997, DHS published notice of its intent to amend sections 64426.5, 64650, 64651.91, 64652, 64652.5, 64653, 65654, 64655, 64656, 64660, 64661, 64663 and 64666, Title 22 of the CCR. These changes would incorporate the federal provisions that allow water systems using surface water or groundwater under the direct influence of surface water to avoid the requirement for filtration under certain circumstances. In addition, DHS has incorporated a provision for taking an unfiltered surface water source out of service immediately if certain water quality criteria are not met.

DHS accepted public comment on the proposal until July 7, 1997; no hearing was held. DHS submitted the proposed regulations to OAL, which disapproved them on January 12, 1998, because they did not comply with the "clarity," "necessity," and "consistency" standards of the APA. DHS revised the regulations and resubmitted the changes to OAL; they were approved on June 8, 1998 and became effective on July 8, 1998.

Impact on Children: The regulations include a public notification requirement whenever water quality criteria are exceeded. Such consumer notification could be especially beneficial for children, whose immune systems often are weaker than those of adults.

Special Needs

Special Education Pupils Program

These regulations are intended to assure conformity with the federal Individuals with Disabilities Education Act (IDEA), 20 U.S.C. §1400 *et seq.*, and its implementing regulations as found in the Code of Federal Regulations. On June 26, 1998, the California Department of Education (CDE), Department of Developmental Services (DDS), DMH, and DSS amended sections 60000-60610 (non-inclusive), Title 2 of the CCR, on an emergency basis. They became effective July 1, 1998. Existing regulations vary in scope in addressing interagency responsibilities for providing services to children with disabilities. The proposed regulatory amendments clarify procedures and criteria in the administration of related services to assure consistency among the four agencies, and to more clearly delineate the provision of such services.

Section 60010, Education Definitions, establishes meanings for terms used by CDE. Some highlights include subsection (c), which defines the meaning of the term "assessment" and is meant to assist community mental health services staff; subsection (d), which defines the meaning of the term "assessment plan" to alert non-education agencies that they are subject to education's procedural requirements for related services; and subsection (e), which clarifies the term "confidentiality" to alert all professionals that implementation of the law requires each agency to conform with the confidentiality rules of the other agencies. Currently, professional staff are familiar with the confidentiality provisions governing their own areas of responsibility, but not of their broader procedural responsibilities under the new law. Subsection (i) defines the term "individualized education program" (IEP) to assist non-education agencies in understanding the scope of the responsibility; subsection (m) clarifies the term "necessary to benefit from special education" to insure that the primary focus of related services is the pupil's school performance; and subsection (r) defines the term "qualified" to include graduate students and interns when properly registered and supervised.

Section 60020, Mental Health Definitions, includes a definition of the term "expanded IEP team" in subsection (c); this clarifies the team's requirement to assess a pupil in all areas of suspected disability and to implement the placement of children identified as seriously emotionally disturbed in residential placements. This clarification is necessary because some local education agencies (LEAs) have been out of compliance for failure to properly constitute an expanded IEP team. This definition emphasizes that this is a shared agency responsibility.

Section 60025, Social Services Definitions, is intended to assist education agencies, mental health programs, and social services programs to achieve a common understanding of terms used by DSS in authorizing payments for residential placements. Without a common definition, there potentially are four different uses of the same terms and four different applications.

Section 60030, Local Mental Health and Education Interagency Agreement, describes the process for coordinating services with other public agencies that are funded to serve pupils with disabilities. Subsection (c) requires the local interagency agreement to identify a contact person for each agency that includes a delineation of procedures governing time lines, resolution of disputes, notification, development of mental health assessment plans, placement options, and cross training of education and mental health staff. Highlights include subsection (c)(1), which requires stronger interagency agreements to improve the timelines as required by law, and subsection (c)(3), which states that the LEA must give a complete referral package to the local mental health service; the package must include the results of the preliminary assessments, and other "relevant information" including reports completed by other agencies.

Subsection 60040, Referral to Community Mental Health Services for Related Services, specifies the process of preparation and submission of the referral package. Subsection (a)(2) specifies the requirements that an LEA must meet to refer a pupil to a community mental health service; these include written parental consent for referral, release and exchange of information, and for observation of a pupil by a mental health service. Subsection (a)(5) requires a LEA to attempt and document less restrictive interventions with a pupil before referring him or her for mental health intervention. This section clarifies that a LEA must provide assessments and designated instructional services within the educational system unless the interventions are clearly insufficient. Section 60045, Assessment to Determine the Need for Mental Health Services, specifies the components of the assessment process and plan. Section 60050, Individualized Education Program for Mental Health Services, changes current practice by counties to be consistent with the form utilized by schools in an IEP. Section 60100, Placement of a Pupil with a Disability Who is Seriously Emotionally Disturbed, includes a requirement in subsection (b)(1) that a representative of the local community mental health service be assigned to participate on the IEP team. Subsection (e) places the responsibility for finding the least restrictive, cost-effective residential placement alternative with the mental health case manager, although requiring that manager to consult with the IEP team's administrative designee when making the determination.

Section 60300 provides definitions of terms used both by the California Children's Services (CCS) program and the CDE. In the past, the two agencies used different terminology to describe similar functions, which could cause confusion to parents and others. Section 60320, Referral and Assessment, clarifies the application of procedures when the LEA makes a referral to CCS for an assessment based on the pupil's documented physical deficit. Subsection (a) changes the emphasis from a referral for a specific service to a referral for assessment in an area of suspected disability; this change puts California in conformity with federal regulations. Section 60325 proposes the procedure for the provision of occupational and/or physical therapy services; section 60330 identifies the LEA as the responsible party for providing space and equipment for medical therapy units and/or medical therapy unit satellites in a public school.

Section 60510 (inadvertently omitted from the emergency regulations but included in the Statement of Reasons for the permanent adoption process) prescribes the procedures for notification by an agency other than education to the LEA prior to the residential placement of a pupil with disabilities and before an educational placement is assured. Subsection (b)(1) mandates educational administrators to provide information to other agencies on the availability of residential and educational services, and to affirm the authority of the IEP team in this regard. Subsection (b)(2) states that a determination must be made that there is no appropriate public education program in the community before a pupil in a licensed children's institution is allowed to attend the education program at that site.

On July 24, 1998, DSS, DDS, CDE and DMH published notice of their intent to permanently adopt the emergency regulations. DSS is the lead agency for this proposed regulatory action. DSS accepted public comment until September 9, 1998, and held a public hearing on the same date in Sacramento. At this writing, DSS is considering the public comments prior to submitting the package to OAL.

Impact on Children: These regulations not only assure conformity with new federal requirements under IDEA, but attempt to provide uniformity among the various agencies that must work together to provide services for children with disabilities. Nearly one-half million California children have some type of disability. Learning disabilities continue to be the most prevalent problem, affecting about 5% of the state's children. Under federal law, all children are guaranteed a free and appropriate education. Students may be enrolled in special education due to a variety of disabilities; in the 1995-96 school year, about 11% (594,000) students were enrolled in special education in California public schools. Children with special needs are among our most vulnerable pupils. Coordinated early intervention and investment can turn an early expense into a successful investment.

Early Intervention Services

The Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1471 *et seq.*, specifies the need for early intervention services for eligible infants and toddlers. IDEA encourages states to establish comprehensive systems of early intervention services for infants and toddlers with disabilities or at high risk of delay. California's Part H program is called Early Start. Both DDS and CDE develop, approve, and implement regulations to comply with their respective mandates under IDEA.

On January 30, 1998, DDS readopted sections 52000, 52020, 52022, 52040, 52060, 52082, 52084, 52086, 52100, 52102, 52104, 52106, 52107-52122, 52140, 52160-62, 52164-75, Title 17 of the CCR, on an emergency basis; they became effective on January 31. DDS revised the regulations and reopened a public comment period until April 14, 1998. On June 1, 1998, DDS again readopted the regulatory changes on an emergency basis; they became effective the same day. On June 16, 1998, DDS submitted the proposed permanent regulations to OAL; they were approved on July 28, 1998, and became effective on August 27, 1998.

The regulations specify how state agencies must interact to accomplish an integrated comprehensive service system for infants and toddlers with developmental delays, high risk or established risk conditions. Early intervention services are available for children up to three years old who exhibit certain symptoms or are otherwise determined to be at risk of developmental delay or disability. However, parents often are unaware of the services, and these regulations attempt to alleviate that problem. The regulations specify that "child find" activities shall be conducted by regional centers and local education agencies to locate eligible children. Such activities may include assigning liaisons to local hospitals and hospitals with neonatal intensive care units; contacting local parent organizations and support groups; distributing early intervention materials to specified agencies and individuals; community-wide health and developmental screening; producing and distributing public service announcements and written public outreach materials; and making public presentations. The regulations also cover program and service components, procedures for development and implementation of an individualized family service plan, service coordination and interagency agreements, and procedural safeguards (including notice and consent requirements, access rights, the process for complaints, and mediation and due process procedures).

Impact on Children: These regulations clarify the complementary roles of state agencies, regional centers and local education agencies in providing critical intervention early in the lives of children with developmental delays. The regulations provide a framework for parents and child advocates to consider in assuring that all children receive the assistance they need.

Resource Specialist Caseload Waivers

On January 23, 1998, the State Board of Education (State Board) published notice of its intent to add section 3100, Title 5 of the CCR, to establish requirements for allowing waivers of the resource specialist caseload limits for special education programs. The proposed regulations will codify the procedures the State Board must follow in evaluating waiver requests for local education agencies and special education local plan areas. In the same notice, the State Board announced a public comment period extending until the public hearing in Sacramento on March 12, 1998.

The most frequently requested waiver in the area of special education is that of the maximum resource specialist caseload. Education Code section 56362(c) prescribes a ceiling of 28 pupils per resource specialist. The proposed regulations would limit the discretionary power of the State Board by setting the standards for consideration of waivers. The State Board could grant a waiver only if the waiver is necessary or beneficial either to the content and implementation of pupil's individualized education program and does not abrogate any right provided individuals with exceptional needs by specified federal law; or if the waiver does not hinder compliance with specified federal law. The new regulations set forth conditions to establish that the waiver request is "necessary or beneficial" as defined by Education Code section 56101. The State Board may only approve an effective period that does not exceed one school year and/or the school year in which it is submitted. The number of students to be served by a resource specialist under the waiver shall not exceed 32 (no more than four students over the maximum statutory caseload of 28 students). The waiver may not result in the same resource specialist having a caseload in excess of the statutory maximum for more than two school years. The regulations include safe-

guards to assure that the waiver will not hinder other statutory requirements. When the number of students exceeds 28, the affected resource specialist must agree to the increase; the specialist then will have the assistance of an instructional aide at least five hours daily. The proposed regulations also require the requesting agency to demonstrate that the excess resource specialist caseload results from extraordinary fiscal and/or programmatic conditions and that the conditions have been, or will be, resolved by the time the waiver expires.

On June 2, 1998, the State Board submitted the proposed regulation to OAL, which disapproved it on July 8, 1998, because it did not comply with the "clarity" standard. At this writing, the State Board has not resubmitted the regulation.

Impact on Children: These regulations do not speak to the already-high resource specialist caseload maximum of 28 students. Rather, the regulations codify the waiver procedure, adding a measure of clarity and predictability to an already-existing process. To the extent they do, the regulations are beneficial to children.

Personnel Standards for Nonpublic Schools and Agencies

SB 989 (Polanco) (Chapter 944, Statutes of 1996) directs the State Board to adopt regulations setting personnel standards for individuals employed by nonpublic schools and agencies. On July 18, 1997, CDE adopted sections 3060-3064, and amended sections 3001 and 3051, Title 5 of the CCR, on an emergency basis. These emergency regulations specify the personnel standards for individuals employed by nonpublic, nonsectarian schools and agencies for each type of service that local educational agencies are required by federal and state law to provide to pupils with disabilities. The regulations are divided into two principal sections – one setting standards for specialized instruction, and the other setting standards for related services.

The personnel standards, when applicable, are based on state-issued credentials and licenses, certificates of registration issued by professional, nongovernmental organizations, and degrees issued by accredited postsecondary educational institutions. To be eligible for certification, a nonpublic school or agency must employ personnel who are authorized by the Commission on Teacher Credentialing or the Business and Professions Code to provide the service rendered, or meet other personnel standards established by CDE to comply with federal and state law regarding the provision of services to individuals with exceptional needs.

On November 14, 1997, CDE readopted these sections on an emergency basis, to review the regulations along with others relating to special education and public schools. On April 16, 1998, and August 12, 1998, CDE again readopted the regulations on an emergency basis. At this writing, CDE is seeking to clarify one aspect of the regulations relating to certification requirements for behavior intervention specialists before opening the public comment period.

Impact on Children: These regulations attempt to ensure that children with special needs attending nonpublic schools will receive services from state-certified or licensed instructors. While certification is important, some parent and child advocates believe that the regulations as they stand do not provide sufficient flexibility for utilizing highly-trained instructors who may not be state-certified or licensed.

Alternative Community Treatment Facilities for Children

The intent of SB 282 (Morgan) (Chapter 1245, Statutes of 1993) is to establish a new community care licensing category in California ("Community Treatment Facility"), as an alternative to out-of-state or acute care placement and state hospitalization for seriously emotionally disturbed children and adolescents needing a greater level of care than can be provided in a group home, but in a less restrictive environment than a state or acute care institution. This bill requires DSS to adopt licensing regulations and DMH to adopt program standards to govern community treatment facilities.

On January 10, 1997, DSS published notice of its intent to amend sections 80001-84188 (non-inclusive), Title 22 of the CCR. The proposed regulations assign criteria and responsibilities for the licensure and operation of a community treatment facility, and establish standards for the new category. The standards address administrative proceedings, treatment tools, treatment staffing, and the use of psychotropic medication, discipline, and restraint in community treatment facilities. Those facilities are limited to serving only seriously emotionally disturbed children with a documented history of less restrictive mental health interventions and who may require periods of containment to participate in and benefit from mental health treatment.

DSS accepted public comment on the proposed regulations until February 27, 1997, and held public hearings on February 25 in Santa Ana, February 26 in Sacramento, and February 27 in San Jose. On January 26, 1998, DSS adopted the regulations on an emergency basis and submitted the regulations to OAL on February 6, 1998. OAL disapproved them on March 23, 1998, for minor modifications. DSS revised the regulations and resubmitted them to OAL; they were approved June 24, 1998, and became effective July 1, 1998.

Impact on Children: These regulations expand the alternatives for California's seriously emotionally disturbed children needing a greater level of care. The policies and procedures clarify when additional services should be considered for community treatment facility residents. Expanding placement options allows decisionmakers to consider variables including location, the best type of environment for the child, security and other important criteria.

Education

Safe Schools Assessment Program

Penal Code section 628 *et seq.* requires all school districts and county offices of education to submit crime data to CDE each year. On April 24, 1998, the State Board published notice of intent to amend sections 700-702, Title 5 of the CCR, to improve the completeness and accuracy of the school crime data reported.

Sections 700-702 provide the definitions of the crimes to be reported, and the guidelines and procedures for submitting complete and accurate school crime data. As amended, section 700(b)(10)(B) revised the definition of trespassing for consistency with Penal Code section 626.7. The original definition did not make a distinction between the type of persons asked to leave the school grounds. The proposed amendment revises the definition to clarify that parents or guardians of students attending school may return after seven days when asked to leave the school grounds; other persons may be charged with trespassing if they return to the school grounds within thirty days. Another amendment, section 702(b), adds language to ensure that local educational agencies comply with the requirement to report all crimes; this may include police reports and suspension reports as well as expulsion reports. Other proposed changes are non-substantive.

In its April 24 notice, the State Board announced a public comment period until June 11, 1998, and held a public hearing in Sacramento on the same date. The State Board of Education submitted the proposed regulatory changes to OAL, which approved them on August 4, 1998. They became effective the same date.

Impact on Children: School safety is a top concern of both educators and parents. While reporting crime does not in itself deter crime on school grounds, it is one method to ensure that problems are tracked consistently among schools in the state. These amendments clarify the process and should be helpful to administrators.

Class Size Reduction Program

SB 804 (O'Connell) (Chapter 298, Statutes of 1997) appropriated approximately $1.4 billion to expand the Class Size Reduction Program by providing funding to school districts to reduce class size in kindergarten and grades 1 to 3, inclusive, to no more than 20 pupils per certificated teacher. Education Code section 52126 requires the State Superintendent of Public Instruction to apportion to each applicant school district an amount equal to $800 per pupil enrolled in a reduced size class for the entire school day, or $400 per pupil enrolled in a class which is reduced for at least one-half of the school day. That section also specifies a reduced rate apportionment of $650 per pupil and $350 per pupil respectively, if a teacher for a new class is hired after November 1 of the school year or a pupil is enrolled in a reduced size class after February 16 of the school year. The Superintendent is to apportion funds based on the receipt of the actual enrollment in each participating class.

On December 1, 1997, the State Board amended section 15133, Title 5 of the CCR, on an emergency basis, to clarify the application of the statute when the funding is based upon the enrollment of students who arrive late in the school year or the employment of teachers who were hired in the latter part of the school year.

The proposed regulations clarify the law by identifying conditions under which the reduced rate of apportionment does not apply. The intent of the reduced rate apportionment is to preclude a school or school district from receiving full funding for the entire school year for a pupil enrolling late in the school year. The regulations allow school districts to avoid the reduced rate apportionment if a pupil enrolled after February 16 does not cause a net increase in a school district's enrollment. In other words, if the pupil enrolled after February 16 is replacing a pupil who withdrew from the reduced size class, the district will not be subject to the reduced funding.

As related to teachers, the reduced rate of apportionment was intended to provide an incentive for school districts to hire new teachers

to implement reduced class size prior to the deadline of February 16. The proposed regulations allow school districts to receive the higher rate of funding if a teacher hired after November 1 is replacing a previously hired teacher who has resigned from the school district or is on leave. It will allow school districts to replace a teacher after November 1 on a long-term basis (e.g., due to illness, maternity leave, resignation) without incurring the penalty of reduced funding.

On January 20, 1998, the State Board published notice of its intent to permanently adopt the regulatory changes. The State Board accepted public comment on the proposed action until March 12, 1998, and held a public hearing on the same date. The State Board adopted the amendments, which were approved by OAL on May 8, 1998 and became effective on the same date.

Impact on Children: The Class Size Reduction Program offers incentives to school districts to reduce class size, allowing children to receive more individualized attention. The regulations here provide additional specifics for school districts participating in the Class Size Reduction Program, enabling them to more accurately report enrollment for funding purposes.

Standardized Testing and Reporting Program (STAR)

SB 376 (Alpert) (Chapter 828, Statutes of 1997) established the Standardized Testing and Reporting (STAR) program. The STAR program replaces the Pupil Testing Incentive Program as a part of the statewide pupil assessment program. Education Code sections 60640(g) and (h) require the State Board to adopt regulations for conducting and administering the STAR program, and for providing minimum security procedures for test publishers and school districts to ensure the security and integrity of the test questions and materials. Education Code section 60643(c) requires CDE to develop, with the approval of the State Board, a standard agreement for use by the school districts with the publisher of the designated achievement test.

On January 2, 1998, CDE and the State Board adopted sections 850-874 (non-inclusive), Title 5 of the CCR, on an emergency basis, to implement the STAR program. Specifically, the new sections establish procedures for school districts to contract with publishers for the designated test and provide a standard agreement form; specify pupil information to be collected for analysis and establish procedures for reporting results to the parents and public while maintaining student privacy; set forth definitions and specify students to be tested and procedures for granting exemptions; and detail procedures for administering tests and protecting the integrity of the testing process under the STAR regulations.

For example, proposed section 852 prohibits school districts and their employees from soliciting or encouraging the parents of certain students to excuse a child the district believes will lower its overall test performance from any part of the test. Section 852 also reinforces that students with special needs are to be included in the testing program to the maximum extent possible. Proposed section 854 attempts to ensure that test results are a function of students' actual knowledge of the subject matter, rather than knowledge of the specific test, by prohibiting the use of commercial test preparation programs by school districts. The standard agreement form in proposed section 873 provides that school districts will be responsible for the cost of replacement materials if a district is negligent in safeguarding test materials. It also penalizes school districts for "excessive" supplemental orders of tests by imposing financial responsibility for such orders upon any district which fails to use 90% of the tests ordered.

On February 17, 1998, CDE and the State Board published notice of their intent to permanently adopt the regulations. CDE and the State Board accepted public comment on the proposed action until April 9, 1998, and held a public hearing on the same date. On May 5, 1998, CDE and the State Board readopted the regulations on an emergency basis; they were effective the same date. At this writing, CDE and the State Board have not submitted the regulatory changes to OAL.

Impact on Children: The proposed regulations appear to be intended to ensure that test results accurately portray individual student achievement as well as overall school scores, while still protecting student privacy. The regulations demonstrate a clear intent to provide an accurate measure of all students' progress, including those children with special needs and students in an alternative learning setting.

Child Protection

Child Abuse Reports and Recordkeeping

Penal Code section 11170 (a) requires DOJ to maintain an index of all reports of child abuse submitted pursuant to Penal Code section 11169. The statute requires DOJ to continually update the index and exclude any reports determined to be unfounded. Section 11170 (a) also specifies that DOJ may adopt rules governing recordkeeping and reporting.

On January 2, 1998, DOJ published notice of its intent to adopt sections 900-911, Title 11 of the CCR. The new sections codify the purpose of the Automated Child Abuse System index and the state's standard reporting form and aspects of the audit system. They also establish procedures for review and verification of reports including so-called "unfounded" reports and conflicting reports, and establish confirmation and notification procedures for various types of inquiries, both from public agencies as well as individuals.

DOJ accepted public comment until February 20, 1998, and held public hearings on February 24 and 25, 1998. In response to the comments received, DOJ amended the regulations to elaborate on the report procedures. DOJ adopted the amendments, which were approved by OAL on July 17, 1998 and became effective on the same date.

Impact on Children: These regulations apply a standard method in dealing with child abuse reports. If this standardization results in a more efficient method of reporting and recordkeeping, DOJ can better serve the various agencies and individuals working to protect children.

Group Homes that Accept Children under Six Years of Age

AB 1197 (Bates) (Chapter 1088, Statutes of 1993) requires DSS to assess the needs of children under six years of age in group homes, and develop standards to be incorporated into the group home program statement. On May 9, 1997, DSS published notice of its intent to amend sections 84000-84088 (non-inclusive), repeal sections 84009, 84044, 84076, and 84080, Title 22 of the CCR, and amend sections 31-002 to 31-420 (non-inclusive) and 11-400 and 11-402 of the MPP. These regulations are intended to implement AB 1197 by setting standards for the care of children under six years of age in group homes, establishing payment rates and qualifications of group home personnel, and setting forth services which should be provided to young children in group homes.

DSS' current regulations do not provide standards specific to the care of children under six years of age in group homes. The proposed regulations will establish standards to ensure that very young children are appropriately cared for in group home facilities. These regulations establish specific education and experience standards for facility personnel, additional health and safety requirements, and additional physical environment standards. In addition, because group homes for very young children are a component of the group home regulatory category, the regulations that apply to group homes for older children will also apply to group homes that care for very young children, unless specified otherwise. The proposed regulations set rates of payment for caregivers, clarify the personnel requirements and duties of caregiving staff, and address the services required to meet the specific needs of children under six years of age in group homes.

DSS accepted public comment on its proposed regulations until June 26, 1997, and held public hearings on June 23, 24, 25, and 26, 1997. DSS then re-opened the comment period from September 3 to October 15, 1997. DSS then submitted the regulatory changes to OAL, which disapproved them on October 17, 1997, because they did not comply with the "clarity" standard of the Administrative Procedure Act. DSS then revised the Statement of Reasons and the proposed regulatory language; in a December 10, 1997, notice, DSS re-opened the comment period from December 11 to December 26, 1997. DSS then resubmitted the regulatory changes to OAL, which disapproved them on May 14, 1998; sections 84000-84088 (non-inclusive) were disapproved for numerous reasons including an incomplete record, incorrect cites, and the need for clarification sections; sections 31-002 to 31-420 (non-inclusive) were disapproved for not complying with the "clarity" and "necessity" standards; and sections 11-400 and 11-402 were disapproved for not complying with the "clarity" standard. DSS re-opened the comment period from August 17 to September 2, 1998.

Impact on Children: Safeguards, guidelines, and specifications are important to ensure quality care for children of any age placed in group homes, but particularly so for these youngest children. At this writing, more than one year has passed without updated regulations in this important area.

Use of Manual Restraints in Group Homes

On August 29, 1997, DSS published notice of its intent to adopt sections 84001, 84022, 84061, and 84800-84808 (non-inclusive), Title 22 of the CCR. These regulations formalize the existing DSS Community Care Licensing Division policy regarding the use of manual restraints in group homes when an assaultive child is threatening to endanger or injure himself, herself or others, and in "runaway" situations. The proposed regulations use the term "emergency intervention" to include the use

of non-physical interventions as well as the use of manual restraints. The least restrictive form of intervention must be used first; more restrictive interventions are to be used only after the less restrictive methods have proven ineffective. For purposes of these regulations, the use of a protective separation room is considered a form of manual restraint.

DSS accepted public comment on the proposal until October 16, 1997, and held public hearings on October 14, 15, and 16, 1997. Following the public hearing, DSS modified the proposed regulations and reopened the public comment period from May 28 until June 12, 1998. At this writing, DSS has not submitted the regulations to OAL.

Impact on Children: At this time, neither general licensing requirements nor specific regulations for group homes address the use of behavior management techniques in such homes. The adoption of specific regulations that address the use of manual restraints should enable DSS to set parameters for group home staff in restraining these children, and enable it to sanction a facility which inappropriately restrains a child.

Juvenile Justice

Disciplinary Decision Making System

On April 21, 1998, Department of Youth Authority (DYA) published its notice of intent to amend sections 4634, 4636, 4641, 4642, 4643, 4644, 4645, 4647, 4648, 4649, 4650, 4652, and 4653 and to repeal section 4654, Title 15 of the CCR, to address the Disciplinary Decision Making System in the DYA population. The proposed regulatory changes adjust DYA procedures for documentation, review and action when a ward has violated a departmental or institutional rule or policy.

Changes in the procedures for "action" affect the wards in a number of ways. Section 4643 acknowledges the unwillingness of wards to come forward as witnesses and testify against other wards; it is amended to allow a written statement as sufficient evidence. Section 4654 was repealed because DYA does not believe that a second level of appeal is necessary for wards appealing a behavior disciplinary action. The first level of appeal authorizes the superintendent to review the appeal; the second level of appeal allowed for a review by the deputy director's office. DYA maintains that a right to a second appeal creates undue time delays and unnecessarily increases staff workload. Several other sections were amended to extend, from 12 working days to 24 calendar days, the amount of time allowed DYA before a hearing must be held in various disciplinary actions.

DYA accepted public comment on the proposed changes until May 26, 1998, and held a public hearing on May 27, 1998 in Sacramento. At this writing, DYA has not submitted the proposed regulations to OAL.

Impact on Children: While some of the amended regulations may benefit wards, many others appear to be designed to cut costs and streamline DYA operations. While wards do not have the same level of rights as other youths who are not incarcerated, careful scrutiny needs to be given to regulatory changes that involve disciplinary decisionmaking and streamlining of the appeal process.

Youthful Offender Parole Board Review

The Youthful Offender Parole Board (Parole Board) is the authority for youth committed by the courts to the DYA. On February 20, 1998, the Parole Board published notice of its intent to amend sections 4900, 4928, 4941, 4945, 4951, 4952, 4953, 4954, 4955, 4956, 4957, 4964, 4966, 4967, 4972, 4974, 4978, 4979, 4980, 4995, 4996, and 4997, Title 15 of the CCR, primarily to address issues relating to the procedures and rules for hearings.

While several nonsubstantive changes were made as part of this regulatory package, others are more complex. Section 4966 eliminates the "special service designation" when referring a ward to parole. Under current rules, a ward who was deemed to need increased parole supervision due to a prior history of violence or commitment for a serious offense would be labeled "special service," and the Parole Board might impose special conditions for parole. The term "special service" is no longer utilized by the Parole Board, but it is unclear in these regulations how and under what circumstances a similar designation may occur, if at all.

Section 4964 outlines the procedures for releasing wards to other jurisdictions. The proposed amendment would repeal this section because the Parole Board deems it nonregulatory.

Section 4967 outlines the procedures for out-of-state referrals. The Parole Board's proposed amendment would repeal this section because DYA has sole responsibility for such referrals.

The Parole Board accepted public comment on the proposed regulatory changes until April 30, 1998, and held a public hearing on that date in Sacramento. At this writing, the Parole Board has not submitted the proposed amendments to OAL.

Impact on Children: The Parole Board conducts almost 26,000 hearings per year. These proposed regulatory changes follow a major undertaking of the Parole Board to "clarify, make specific, and streamline its policies and procedures." It remains to be seen whether the amended rules enhance one of the Parole Board's major objectives, that of prescribing effective treatment programs for youth.

Restitution Deductions from Ward Trust Accounts

AB 1132 (Alby) (Chapter 266, Statutes of 1997) authorizes the Director of the Youth Authority (Director) to deduct from a ward's trust account up to 50% of the restitution amount owed. In addition, AB 1132 authorizes the Director to deduct an administrative fee of 10% of the amount transferred to the victim.

On February 20, 1998, DYA published notice of its intent to adopt new section 4720.1, Title 15 of the CCR, to require the Director to deduct the balance owed on a restitution order or restitution fine from the trust account deposits of a ward – up to 50% of the amount, and to transfer that amount directly to the victim or the State Board of Control for deposit in the Restitution Fund. The amount deducted shall be credited first to the amount owing on the restitution order, and then to the amount owing on any restitution fine. The regulatory change also identifies funds or deposits that are exempt from restitution and administrative fee deductions, including Social Security benefits and DYA transfers of money that would result in multiple deductions from the same funds. Formerly, the Director could release any trust funds of a ward committed to the authority when authorized by the ward.

DYA accepted public comment on the proposed regulatory change until April 6, 1998, and held a public hearing on April 8, 1998, in Sacramento. DYA received no comments on this regulation, and there was no testimony at the public hearing. DYA submitted the proposed regulation to OAL, which approved it on May 13, 1998; it was effective on the same date.

Impact on Children: Fines and victim restitution are frequently waived due to the belief that restitution cannot be collected. This new regulation increases the amount of financial resources available to victims of crimes and the State Restitution Fund, potentially enhancing the ability to assist victims in receiving financial compensation for their losses as a result of crime.

Limitation on Parole Services for Aliens

Section 411 of the Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires states to adopt regulations governing the denial of public benefits to parolees identified as illegal aliens.

On June 27, 1997, DYA published notice of its intent to adopt new section 4830.1, Title 15 of the CCR. This regulation identifies those benefits which may not be afforded to parolees identified as illegal aliens and ensures that DYA works with the Immigration and Naturalization Service to determine verification of individuals who are not in this country legally.

The proposed regulation requires DYA to deny parole service to ineligible aliens unless they are, as defined by federal law, "qualified aliens," "non-immigrant aliens," or "aliens paroled into the United States for less than one year." These parole services include bus passes, mental health treatment and services, parenting education, job placement, cash assistance, and clothing assistance.

DYA accepted public comment on the proposal until August 29, 1997, and held a public hearing on the proposed regulation on September 3, 1997. OAL approved the regulatory change on March 26, 1998; it became effective immediately.

Impact on Children: This regulation could have a serious effect on youth who need public assistance during rehabilitation. This denial of services is maximized if the youth's immigrant family also is ineligible for public assistance.

The California Regulatory Process

The Administrative Procedure Act (APA), Government Code section 11340 *et seq.*, prescribes the process that most state agencies must undertake in order to adopt regulations (also called "rules") which are binding and have the force of law. This process is commonly called "rulemaking," and the APA guarantees an opportunity for public knowledge of and input in an agency's rulemaking decisions.

For purposes of the APA, the term "regulation" is broadly defined as "every rule, regulation, order or standard of general application . . . adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure . . . ." Government Code section 11342(g). Agency policies relating strictly to internal management are exempt from the APA rulemaking process.

The APA requires the rulemaking agency to publish a notice of its proposed regulatory change in the *California Regulatory Notice Register*, a weekly statewide publication, at least 45 days prior to the agency's hearing or decision to adopt the change (which may be the adoption of a new regulation or an amendment or repeal of an existing regulation). The notice must include a reference to the agency's legal authority for adopting the regulatory change, an "informative digest" containing a concise and clear summary of what the regulatory change would do, the deadline for submission of written comments on the agency's proposal, and the name and telephone number of an agency contact person who will provide the agency's initial statement of reasons for proposing the change, the exact text of the proposed change, and further information about the proposal and the procedures for its adoption. The notice may also include the date, time, and place of a public hearing to be held by the agency for receipt of oral testimony on the proposed regulatory change. Public hearings are generally optional; however, an interested member of the public can compel an agency to hold a public hearing on proposed regulatory changes by requesting a hearing in writing no later than 15 days prior to the close of the written comment period. Government Code section 11346.8(a).

Following the close of the written comment period, the agency must formally adopt the proposed regulatory changes and prepare the final "rulemaking file." Among other things, the rulemaking file – which is a public document – must contain a final statement of reasons, a summary of each comment made on the proposed regulatory changes, and a response to each comment.

The rulemaking file is submitted to the Office of Administrative Law (OAL), an independent state agency authorized to review agency regulations for compliance with the procedural requirements of the APA and for six specified criteria – authority, clarity, necessity, consistency, reference, and nonduplication. OAL must approve or disapprove the proposed regulatory changes within thirty working days of submission of the rulemaking file. If OAL approves the regulatory changes, it forwards them to the Secretary of State for filing and publication in the California Code of Regulations, the official state compilation of agency regulations. If OAL disapproves the regulatory changes, it returns them to the agency with a statement of reasons; the agency has 120 days within which to correct the deficiencies cited by OAL and resubmit the rulemaking file to OAL.

An agency may temporarily avoid the APA rulemaking process by adopting regulations on an emergency basis, but only if the agency makes a finding that the regulatory changes are "necessary for the immediate preservation of the public peace, health and safety or general welfare . . . ." Government Code section 11346.1(b). OAL must review the emergency regulations – both for an appropriate "emergency" justification and for compliance with the six criteria – within ten days of their submission to the office. Government Code section 11349.6(b). Emergency regulations are effective for only 120 days.

Interested persons may petition the agency to conduct rulemaking. Under Government Code section 11340.6 *et seq.*, any person may file a written petition requesting the adoption, amendment, or repeal of a regulation. Within 30 days, the agency must notify the petitioner in writing indicating whether (and why) it has denied the petition, or granting the petition and scheduling a public hearing on the matter.

References: Government Code section 11340 *et seq.*; Robert Fellmeth and Ralph Folsom, *California Administrative and Antitrust Law: Regulation of Business, Trades and Professions* (Butterworth Legal Publishers, 1991); Robert Fellmeth and Thomas Papageorge, *California White Collar Crime* (Butterworth Legal Publishers, 1995).

Agency Descriptions

Following are general descriptions of the California agencies whose regulatory decisions affecting children are discussed in this issue:

Department of Developmental Services

The Department of Developmental Services (DDS) has jurisdiction over laws relating to the care, custody, and treatment of developmentally disabled persons. DDS is responsible for ensuring that persons with developmental disabilities receive the services and support they need to lead more independent, productive and normal lives, and to make choices and decisions about their own lives. DDS executes its responsibilities through 21 community-based, nonprofit corporations known as regional centers, and through five state-operated developmental centers. DDS' enabling act is found at section 4400 *et seq.* of the Welfare and Institutions Code; DDS regulations appear in Title 17 of the CCR. *For more information on DDS regulations appearing in this issue, contact David Judd, Regulations Analyst, 916-654-2257.*

State Board of Education and Department of Education

The California State Board of Education (State Board) adopts regulations for the government of the day and evening elementary schools, the day and evening secondary schools, and the technical and vocational schools of the state. The State Board is the governing and policy body of the California Department of Education (CDE). CDE assists educators and parents to develop children's potential in a learning environment. The goals of CDE are to set high content and performance standards for all students; build partnerships with parents, communities, service agencies and businesses; move critical decisions to the school and district level; and create a department that supports student success. CDE regulations cover public schools, some state-sponsored preschool programs, and some aspects of programs in private schools. The CDE's enabling act is found at section 33300 *et seq.* of the Education Code; CDE regulations appear in Title 5 of the CCR. *For more information on CDE regulations in this issue, contact Peggy Peters, CDE Audit Response Coordinator, 916-657-4440.*

Department of Health Services

The California Department of Health Services (DHS) is one of thirteen departments that constitute the state's Health and Welfare Agency. DHS is a statewide agency designed to protect and improve the health of all Californians; its responsibilities include public health, and the licensing and certification of health facilities (except community care facility licensing). DHS' mission is to reduce the occurrence of preventable disease, disability, and premature death among Californians; close the gaps in health status and access to care among the state's diverse population subgroups; and improve the quality and cultural competence of its operations, services, and programs. Because health conditions and habits often begin in childhood, this agency's decisions can impact children far beyond their early years. DHS' enabling act is found at section 100100 *et seq.* of the Health and Safety Code; DHS' regulations appear in Titles 17 and 22 of the CCR. *For more information on DHS regulations in this issue, contact Allison Branscombe, Chief, DHS Office of Regulations, 916-654-0381.*

Department of Mental Health

The Department of Mental Health (DMH) has jurisdiction over the laws relating to the care, custody, and treatment of mentally disordered persons. DMH may disseminate education information relating to the prevention, diagnosis and treatment of mental disorder; conduct educational and related work to encourage the development of proper mental health facilities throughout the state; coordinate state activities involving other departments and outside agencies and organizations whose actions affect mentally ill persons. DMH provides services in the following four broad areas: system leadership for state and local county mental health departments; system oversight, evaluation and monitoring; administration of federal funds; operation of four state hospitals (Atascadero, Metropolitan, Napa and Patton) and an Acute Psychiatric Program at the California Medical Facility and Vacaville. DMH's enabling act is found at section 4000 *et seq.* of the Welfare and Institutions Code; DMH regulations appear in Title 9 of the CCR. *For more information on DMH regulations appearing in this issue, contact David Nishimura, Staff Services Manager, Office of Regulations, 916-654-2631.*

Department of Social Services

The California Department of Social Services (DSS) is one of thirteen departments that constitute the state's Health and Welfare Agency. DSS administers four major program areas: welfare, social services, community care licensing, and disability evaluation. DSS' goal is to strengthen and encourage individual responsibility and independence for families. Virtually every action taken by DSS has a consequence impacting California's children. DSS' enabling act is found at section 10550 *et seq.* of the Welfare and Institutions Code; DSS' regulations appear in Title 22 of the CCR. *For more information on DSS regulations in this issue, contact Frank R. Vitulli, Chief, DSS Office of Regulations Development, 916-657-1937.*

Department of the Youth Authority

State law mandates the California Department of the Youth Authority (DYA) to provide a range of training and treatment services for youthful offenders committed by the courts; help local justice system agencies in their efforts to combat crime and delinquency; and encourage the development of state and local crime and delinquency prevention programs. DYA's offender population is housed in eleven institutions, four rural youth conservation camps, and two institution-based camps; its facilities provide academic education and treatment for drug and alcohol abuse. Personal responsibility and

public service are major components of DYA's program strategy. DYA's enabling act is found at section 1710 *et seq.* of the Welfare and Institutions Code; DYA regulations appear in Title 15 of the CCR. *For more information on DYA regulations in this issue, contact Reeshemah Davis, Youth Authority Regulations Coordinator, 916-262-1437.*

Regulatory Key

BOC: Board of Control

CCR: California Code of Regulations

CDE: California Department of Education

DDS: Department of Developmental Services

DHS: Department of Health Services

DMH: Department of Mental Health

DSS: Department of Social Services

DYA: Department of Youth Authority

MPP: The Department of Social Services' Manual of Policies and Procedures

MRMIB: Managed Risk Medical Insurance Board

OAL: Office of Administrative Law

Parole Board: Youth Offender Parole Board

State Board: State Board of Education

Other Information Sources

The *California Children's Budget,* published annually by the Children's Advocacy Institute and cited herein, is another source of information on the status of children in California. It analyzes the California state budget in eight areas relevant to children's needs: child poverty, nutrition, health, special needs, child care, education, abuse and neglect, and delinquency. The *California Children's Budget 1998-99* can be accessed via the Web at <www.acusd.edu/childrensissues/report>.

CHILDREN'S REGULATORY LAW REPORTER

Editor-in-Chief

Margaret A. Dalton
Project Director
Information Clearinghouse on Children

Associate Editor

Kim Parks

Research and Writing Assistants
Priscilla Day
Liza Genrich
Lucy Lin
Roseanne Myers
Elizabeth Nguyen

Children's Advocacy Institute
Robert C. Fellmeth, Executive Director
Elisa D'Angelo Weichel, Administrative Director

Information Clearinghouse on Children (ICC)
5998 Alcalá Park
San Diego, CA 92110
(619) 260-4279
(619) 260-4753 - Fax
childrensissues@acusd.edu
www.acusd.edu/childrensissues

San Diego Office
University of San Diego
5998 Alcalá Park
San Diego, CA 92110
(619) 260-4806
(619) 260-4753 - Fax

Sacramento Office
926 J Street, Suite 709
Sacramento, CA 95814
(916) 444-3875
(916) 444-6611 - Fax

University of San Diego

The Children's Advocacy Institute is part of the Center for Public Interest Law at the University of San Diego School of Law. The Information Clearinghouse on Children (ICC) is a project of the Children's Advocacy Institute. The ICC is funded in part by The California Wellness Foundation and by The Maximilian E. & Marion O. Hoffman Foundation, Inc.