Senate Budget and Fiscal Review—John Laird, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Caroline Menjivar, Chair
Senator Shannon Grove
Senator Dr. Akilah Weber Pierson

Wednesday, August 12th, 2026
9:30 am
1021 O Street – Room 1200

Consultants: Elizabeth Freeman and Scott Ogus

PUBLIC COMMENT

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0000 MULTIPLE DEPARTMENTS

Issue 1: Be Home Soon California – Proposed HCBS Reforms

Local Assistance and Trailer Bill Language – Legislative Proposal. The Legislature's version of the budget included Be Home Soon California, an all-of-government, "whatever-it-takes" approach to keeping California's older adults and people with disabilities safely at home in the community with family and caregivers. The proposal estimated annual General Fund savings of $625.7 million when fully implemented based on the lower costs of safely maintaining Medi-Cal members in the community, rather than in costly institutional care in skilled nursing facilities and hospitals. The proposal assumed approximately 15,000 fewer individuals referred to skilled nursing facilities and instead stabilized at home or in a community-based care setting. The proposal was deferred during finalization of the 2026 Budget Act.

Background – Home- and Community-Based Services in California. Federal Medicaid home- and community-based services waivers allow the Medi-Cal program to develop alternatives for individuals who would otherwise require care in a nursing facility or hospital. These waivers allow for services to be offered in either a home or community setting. California's waiver authorities are offered under Section 1915(c) of the Social Security Act, which also requires that the services offered must cost no more than the alternative institutional level of care and participants must have full-scope Medi-Cal eligibility.

Home and Community-Based Alternatives Waiver. The Home- and Community-Based Alternatives (HCBA) Waiver provides Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility Level of Care (LOC), with the option of returning to or remaining in a home or home-like setting in the community in lieu of institutionalization. DHCS contracts with waiver agencies for the purpose of performing waiver administration functions and directing the comprehensive care management waiver service. The waiver agencies are responsible for functions including: participant enrollment, LOC evaluations, plan of treatment and person-centered care and service plan review and approval, waiver service authorization, utilization management, provider enrollment and network development, quality assurance activities and reporting to DHCS, billing the fiscal intermediary, and provider claims adjudication.

Assisted Living Waiver. The Assisted Living Waiver provides comprehensive care, including 24 hour care and supervision, for older adults and people with disabilities residing in licensed board and care facilities or publicly subsidized housing. To be eligible to receive services in the waiver, an individual must be: 1) age 21 or older; 2) have full-scope Medi-Cal eligibility with no share of cost; 3) have a nursing facility level of care needs; 4) be willing and able to reside safely in an assisted living facility or public subsidized housing. The waiver is available in fifteen counties, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma. The waiver provides the following services for participants: care coordination; nursing facility transition coordination; residential rehabilitation; homemaker, chore, and laundry services; personal care and 24 hour protective supervision services; personalized behavioral plans with trained staff support; meals; 24 hour awake staff; licensed nursing staff; and transportation to medical appointments and services. The waiver does not provide support for the payment of room and board costs for participants. Those who receive Supplemental Security Income

(SSI) pay a room and board rate set annually by the Department of Social Services (CDSS). Individuals that do not receive SSI must pay a room and board rate set by the provider that can be adjusted at any time, potentially leading to eviction.

Multipurpose Senior Services Program (MSSP). The MSSP Waiver provides home- and community-based services to Medi-Cal eligible individuals 60 years of age or older, or with disabilities, as an alternative to nursing facility placement. To be eligible for the program, participants must be age 60 years or older, have a nursing facility level of care, not be enrolled in another waiver program, and reside in a county with an MSSP site. MSSP services include: 1) case management, 2) personal care services, 3) respite care, environmental accessibility adaptations, minor home repair, transportation, chore services, personal emergency response system/communication device, adult day care, protective supervision, meal services, social reassurance/therapeutic counseling, money management, and communication services (translation/interpretation).

In-Home Supportive Services (IHSS). IHSS is a Medi-Cal program administered by CDSS that allows low-income individuals who are blind, over 65, or have disabilities to receive personal care and assistance with daily living in their own home by a provider of their choice, delaying or avoiding more expensive institutional settings. Eligibility is based on Medi-Cal eligibility and assessed need for supportive services. The statewide IHSS caseload for 2026-27 is approximately 875,179 individuals.

Social workers employed by county welfare departments conduct an in-home assessment of an individual's needs in order to determine the amount and type of service hours to be provided. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider—oftentimes a family member or relative.

IHSS costs are shared between federal, state, and local governments. Approximately 98 percent of the IHSS caseload receives federal financial participation, with the majority of the caseload receiving about 50 percent federal financial participation, about four percent receiving 90 percent federal financial participation, and about two percent in the IHSS Residual program receiving only state funding.

Longstanding federal and state policy promotes home- and community-based services such as IHSS as an effective and low-cost alternative to institutional care for individuals with disabilities who can remain safely in their own homes with a tailored level of assistance. As the Department of Health Care Services (DHCS) noted in a February letter to the federal Center for Medicare and Medicaid Services (CMS):

"A focus on gross IHSS spending obscures the far more relevant fiscal comparison: the cost of institutional care versus home-and community-based alternatives. In California, the average annual cost of a long-term stay in a skilled nursing facility (SNF) for an individual is approximately $137,000, compared with roughly $30,000 per year to serve an individual through IHSS. Each successful diversion from institutional care to IHSS avoids approximately $107,000 annually in Medicaid spending—savings shared by California and the federal government alike. This cost differential underscores why IHSS growth represents fiscal prudence, not excess."

Other home- and community-based services options provided through other authorities include:

California Community Transition (CCT) Program. In 2007, California was awarded federal grant funding to implement California's Money Follows the Person (MFP) Rebalancing Demonstration, known as the CCT Demonstration Project. CCT targets Medicaid beneficiaries of all ages who have a skilled nursing facility level of care need, who have continuously resided in an in-patient facility for 60 days or longer, and who want to return home or to a community-based setting. Members are enrolled in the demonstration for a maximum of 365 days post-transition, but also receive transition coordination services prior to leaving the inpatient facility. Services are provided through CCT Lead Organizations who work with participants, support networks, and providers to facilitate and monitor transitions from facilities to community settings; conduct assessments to determine levels of care; implement person-centered support services; and work to identify and coordinate services from multiple delivery systems to maintain the stability of home- and community-based placements.

Community-Based Adult Services (CBAS). CBAS provides daytime support to older adults and people with disabilities so they can remain safely in their homes. The program enables caregivers to work while still supporting their loved ones. CBAS services include: 1) individual assessment; 2) professional nursing services; 3) physical, occupational, and speech therapy; 4) mental health services; 5) therapeutic activities; 6) social services; 7) personal care; 8) a meal; 9) nutritional counseling; 10) transportation to and from the CBAS center. CBAS is a required benefit in 28 counties through Medi-Cal managed care. The other 30 counties may offer CBAS as an optional benefit if a CBAS center is available. Only Tulare County has provided CBAS as an optional benefit. In addition, closures in Marin and Sonoma counties have resulted in no CBAS services available in those two counties, despite their status as mandatory counties.

Program for All-Inclusive Care for the Elderly. Programs for All-Inclusive Care for the Elderly (PACE) provide care to California's frail population as an alternative to institutionalization by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. These services are provided to beneficiaries while still residing in a home- or community-based setting, rather than a skilled nursing facility or other institutional setting. Eligible PACE participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. PACE programs are the sole provider of Medicare and Medi-Cal services for participants.

Be Home Soon California – A Different Approach to Home- and Community-Based Services. The Legislature's version of the budget included General Fund savings and placeholder trailer bill to support reforms to the home- and community-based services continuum designed to allow older adults and people with disabilities to remain at home or in the community and reduce costs in the Medi-Cal program, known as Be Home Soon California. Be Home Soon California prioritizes streamlining access to care options to stabilize home- and community-based placements of older adults and people with disabilities and avoid unnecessary stays in skilled nursing facilities and hospitals. This approach accounts for the costs of providing additional services, as well as the savings to the Medi-Cal program from unnecessary, high-cost utilization. The Be Home Soon California plan includes the following components:

Home- and Community-Based Waiver Reforms

1) *Eliminate Caps, Waitlists, and Cost Neutrality for Waivers* – Transition the Assisted Living Waiver (ALW), the Home- and Community-Based Alternatives (HCBA) Waiver, and the Multipurpose Senior Services Program (MSSP) into a 1915(i) waiver, which would remove caps on enrollment and the resulting waitlists. As of December 2025, the ALW had a waitlist of 18,365 and the HCBA Waiver had a waitlist of 6,091, despite waiver slots being available but held back in service of cost neutrality requirements.

2) *Leverage Existing CalAIM Tools* – Waiver agencies and other enhanced care management (ECM) providers should leverage this benefit as a tool for waiver navigation. Medi-Cal managed care plans will need to more fully develop their provider networks for the institutional transitions community supports services to ensure they are able to manage transitions and discharge planning.

3) *Incentive Payments and Rate Increases* – Medi-Cal managed care plans will receive incentive payments for successful transitions out of institutional care, as well as penalties for unnecessarily extending time spent in a hospital or skilled nursing facility (see aid code change provisions under "Advanced Transition and Discharge Planning" below). In addition, certain home- and community-based services (HCBS) provider types may receive rate increases to ensure adequate placement and service availability.

4) *Preserve Access to Low-Cost, Community-Based Adult Services (CBAS) Centers* – Convene state agencies to adopt solutions to preserve access to CBAS centers, including efficiencies in the 1115 waiver and other program changes to prevent closures and ensure sustainable statewide access to CBAS centers. CBAS Centers offer cost-effective, community-based alternatives to nursing homes for older and disabled Medi-Cal adults at a fraction of nursing home costs.

Advanced Transition and Discharge Planning

1) *Survey and Assessment* – Require Minimum Data Set (MDS) 3.0 Section Q responses be shared with Medi-Cal managed care plans and DHCS as a condition of reimbursement to skilled nursing facilities. Managed care plans will be required, within 30 days of being notified that an individual wishes to explore returning home or to the community, to connect with local contact agencies to conduct an assessment of the individual to determine what supports would be necessary to arrange for a safe transition. After a determination that an individual may be safely transitioned to a home or community setting, the managed care plan will have 90 days to arrange for the transition. After 90 days, the individual will be reclassified into the equivalent non-LTC aid code, reducing payments to the managed care plan to those consistent with the new aid code.

2) *Presumptive Medi-Cal Eligibility for Prompt Access to Home- and Community-Based Services (HCBS)* – Provide presumptive eligibility for Medi-Cal and coverage for individuals in need of home- and community-based services when applying for those services. Waiver agencies and other HCBS

providers would be allowed to make presumptive eligibility determinations, with participation conditioned on a reasonable agreement rate between presumptive eligibility determinations and reconciled eligibility determinations. This reform allows agencies to immediately initiate provisional services for HCBS programs, such as in-home supportive services, assisted living, and others, to support stabilizing individuals in the community and preventing or delaying admission to institutional care.

3) *Increase Access to Private Duty Nursing* – Increase private duty nursing (PDN) reimbursement by 40 percent to increase availability of home nursing for individuals with high health care needs awaiting discharge from hospitals. In addition, ensure hospitals with patients who could be discharged with private duty nursing or other supports coordinate with Medi-Cal managed care plans to more aggressively coordinate discharge planning to ensure patients get home as soon as possible. The 2026 Budget Act included $30 million in 2026-27 to increase reimbursement for PDNs.

Eligibility and Waiver Enrollment Reforms

1) *Share of Cost Reform* – Increase the Maintenance Need Income Level to 138 percent of the federal poverty level to provide access to stabilizing care, such as assisted living and other supports, to keep individuals safely at home or in the community, rather than waiting until they are at their most expensive, as skilled nursing facility residents, to enroll them in Medi-Cal.

2) *Home Upkeep Allowance/Housing Stability Reform* – Ensure a six-month stay in a skilled nursing facility does not become a forever stay by implementing a "whatever-it-takes" approach to maintain an individual's existing housing arrangements, including increasing the home upkeep allowance for short-term institutional stays to the full cost of maintaining existing housing, as well as care coordination and environmental modifications to ensure housing remains accessible post-hospitalization or post-LTC stay.

3) *Other Financial Reforms* – Set the personal needs allowance to the same amount allowable for SSI recipients receiving non-medical out of home care, provide room and board rate protection for individuals in the ALW, and allow individuals accessing long-term services and supports to use anticipated monthly medical expenses rather than actual expenses to meet share of cost requirements.

Panel Discussion. The subcommittee has requested the following panelists to discuss the Be Home Soon California proposal and other HCBS reforms during the hearing:

Kate Meyers
Senior Program Officer, Advancing People-Centered Care
California Health Care Foundation

Hagar Dickman

Director, CA Long-Term Services and Supports Advocacy
Justice in Aging

Beatriz Saki
Director of Policy, Compliance, and Strategic Initiatives
East Bay Innovations

Amber King
Vice President, Legislative Affairs
LeadingAge California

Kate Laddish
President
California IHSS Consumer Alliance

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested panelists and DHCS to respond to the following:

California Health Care Foundation:

1. Please provide a brief overview of the system of home- and community-based services (HCBS) available in the Medi-Cal programs.

2. How does the availability of HCBS support independent living and prevent or delay referral to higher acuity institutional care?

3. What are the primary barriers experienced by Medi-Cal members trying to access necessary HCBS?

4. How do these barriers differ by region (e.g. rural, urban) and demographics, and what improvements could help make availability of these benefits more uniform statewide?

5. How does the division of responsibilities for various aspects of the HCBS system across multiple state departments, counties, and other entities impact the ability of consumers to access services?

6. How prepared are the state's HCBS and long-term services and supports systems for the coming demographic surge of older Californians? What are the implications for the Medi-Cal program and IHSS?

Justice in Aging:

7. Please provide an overview of the significant reforms included in the "Be Home Soon" proposal and how they fit together to fill gaps in the continuum of home- and community-based care in Medi-Cal.

8. What are the primary barriers that older Californians and those with disabilities experience in getting access to necessary home- and community-based care?

9. How does a lack of access, or delayed access, to home- and community-based services lead to declines in health status and destabilization of housing and other settings for independent living in a home or community setting? How does this impact costs to the overall health and human services system and to public benefit programs like Medi-Cal and IHSS?

10. What is the typical experience of an individual on a waitlist for an HCBS waiver slot? How acute is the typical need for waiver services at the time of application, and how long are individuals typically waiting before they receive services?

11. How can gaps in access to care in one program (e.g. IHSS) impact demand and need for other home- and community-based services?

East Bay Innovations:

12. Please describe the work that your organization does to help individuals transitioning from higher acuity institutional settings to a home- or community-based setting, and to help stabilize services and supports to help individuals age safely at home.

13. What are the primary challenges that an individual experiences when trying to access services that can aid a transition or stable living placement?

14. What are some examples of gaps in access to services that can lead a transition to be unsuccessful or, alternatively, that can lead to a destabilization of the individual's ability to live independently and safely at home or in the community?

15. What reforms should the state consider to help individuals avoid unnecessary utilization of higher acuity institutional care, and what safeguards should be included to ensure that individuals receive all the services necessary to ensure transitions are safe and consistent with the individual's wishes?

LeadingAge California:

16. Please describe how your member organizations help stabilize individuals in home- or community-based settings and avoid or delay higher acuity institutional care.

17. What are the primary barriers that individuals experience when trying to receive services from one of your member organizations?

18. How long does it take for an individual in need of home- or community-based services to be determined eligible and receive services? What other delays are built into the system that delay access to necessary care?

19. What are the most common reasons that a home- or community-based placement is unsuccessful? What reforms should the state consider to address the barriers and help maintain individuals in a home- or community-based setting?

California IHSS Consumer Alliance:

20. How can gaining access to IHSS (and other similar home-and-community based services) impact the lives of people with disabilities or seniors who need support to remain in the home?

21. Conversely, what are the negative impacts of delays or barriers to accessing IHSS and similar HCBS services? How do these delays affect people's lives?

22. What are the particular barriers individuals face in gaining access to IHSS and HCBS when they are transitioning or attempting to transition home from an institutional setting such as a hospital or nursing home?

23. What individual and system-level outcomes occur when people are able to receive support to live independently at home relative to institutional care?

DHCS:

24. Please provide a brief response to the reforms contained in the Be Home Soon California proposal.

25. What is the current waitlist for each of the home- and community-based waiver programs? What is the average length of time it takes for individuals to receive services after having been placed on a waitlist for each program?

26. If home- and community-based services have demonstrated that they reduce cost growth in the Medi-Cal program, why has the state not sought to maximize the use of these programs to both control cost growth and provide beneficiaries with the option to age with dignity at home or in the community?

27. What actions has the department taken to date to prepare for the demographic surge of older adults that will need long term services in supports in the Medi-Cal program in the coming years? How does the department intend to address the expected significant cost growth in the program related to these demographic realities?

Issue 2: Oversight Item: Child Welfare Services – California Automated Response and Engagement System (CWS-CARES)

Panel Discussion. The Subcommittee has requested the following individuals to participate in a panel discussion on this informational item:

- Xin Ma, Fiscal & Policy Analyst, Legislative Analyst's Office (LAO)
- Jennifer Troia, Director, and Dianna Wagner, Assistant Deputy Director, Children and Family Services Division, California Department of Social Services (CDSS)
- Carlos Marquez III, Executive Director, County Welfare Directors Association (CWDA)
- Brandon Hansard, Chief Deputy Director, CalHHS Office of Technology and Solutions Integration (OTSI)
- Kevin P. Kelly, California Lead Client Partner, Deloitte
- Allen Sheldon, KPMG Lead Partner, State of California
- Lourdes Morales, Department of Finance (DOF)

Background: CWS-CARES Project. Child Welfare Services – California Automated Response and Engagement System (CWS-CARES) is a statewide case management and data solution for child welfare services to replace the state's current child welfare case management system, known as CWS/CMS. The replacement of the current CWS/CMS system (which was initially implemented in 1997) is mandatory to meet federal child welfare case management system requirements (the current system is not compliant with federal requirements and risks loss of federal child welfare funding).

In addition to achieving federal compliance, CWS-CARES is intended to improve child welfare case management by allowing key members of the Child and Family Team (CFT) to have direct access to a child's case plan, providing timelier service delivery, allowing social workers to spend less time doing data entry and more time working directly with families, tracking individual costs and outcomes, and increasing process and system efficiency, resiliency, quality, and maintainability across the state. The project is led by the Department of Social Services (CDSS) and the California Health and Human Services Agency (CalHHS) Office of Technology and Solutions Integration (OTSI) in coordination with other state, county, local, and tribal government entities.

According to OTSI, CWS-CARES version 1 (V1) will launch statewide on October 26, 2026, replacing the current IT system. The second version (V2) will launch in April 2028. Project costs are shared between the state and federal government, and timely project delivery is critical to maintaining federal financial participation funding and avoiding large state repayments and federal non-compliance penalties.

The total approved multi-year baseline cost of the CWS-CARES Project is $1.7 billion ($850 million General Fund). Costs for planning, development, and implementation of a federally compliant system are eligible for 50 percent federal financial participation.

Key child welfare reforms rely on successful rollout of CWS-CARES. The Foster Care Tiered Rate Structure needs to be automated in CWS-CARES. Additionally, implementation of the Families First Prevention Services Act (FFPSA), which allows states to claim federal funding for prevention services, hinges on the successful implementation of CWS-CARES. This federal law requires tracking of per-child

prevention spending (which is not available in the state's current child welfare IT system.) Until CARES is operational, California cannot access federal funds for prevention services provided to children and families at risk of entering the foster care system.

CWS-CARES Project has experienced multiple starts and stops. According to the Legislative Analyst's Office (LAO), "CWS-CARES remains the costliest and longest running IT project still in the state's current IT project portfolio."[1]

The project was originally approved by the state in 2013. Since original approval, the project cost has increased by $1.3 billion ($659 million General Fund) and the scheduled completion date has shifted from September 2017 to October 2026, as multiple iterations of project plans have adopted different approaches to development, causing significant delays and costs to the state.[2] The project plans have been officially updated six times, with the total project cost increasing at each update.

Project Cost. The approved baseline cost of the project is $1.7 billion ($850 million General Fund) over the lifetime of the project. The bulk of project costs are for contract services associated with the project's design, development, and implementation efforts and to support CARES-Live (a subset of functionalities that were launched during prior iterations of the project and are currently operational, including the state's Child and Adolescent Needs and Strengths assessment tool.)

The project underspent legislative appropriations in 2023-24 (by about 24 percent) and 2024-25 (by about 14 percent). As a result, the 2025 Budget Act made a number of changes to improve accountability and provide more accurate appropriations. These changes included withholding 10 percent of funding based on historical underspending, using prior year unspent funds to offset costs, and conditioning expenditures on project continuation approval from the Department of Technology (CDT). Additionally, any funding augmentation must be based on a definition of satisfactory progress, as defined, by CDT and the Department of Finance (DOF).

2026 Budget Act. The 2026 Budget Act approved $357.3 million ($180 million General Fund) for OTSI and CDSS to continue funding for CWS-CARES in 2026-27 in accordance with project costs under Special Project Report (SPR) 6.

The main project cost category is contract services, which involves 14 project contractors responsible for development, project support, project management, operations, and consulting. $228.7 million of the $357.3 million total funds for the project in 2026-27 support contractors. Another $9.56 million is for county consulting.

Other 2026-27 costs include state operations (99 permanent staff at OTSI and 13 permanent positions at CDSS, in addition to 5 limited-term positions) totaling approximately $20 million; hardware and software (such as Salesforce subscriptions) totaling approximately $39.78 million; operating expenses and equipment totaling approximately $22.39 million; core constituent participation (engagement with counties and tribes to achieve user-centered design) totaling approximately $36.25 million; and

[1] LAO, "The 2025-26 Budget: CWS-CARES," March 5, 2025.
[2] LAO.

independent project oversight consultant contract services using CDT, totaling $800,000. The chart below provides a breakdown of 2026-27 total fund costs:

Budget Category	2026-27 Proposed CWS-CARES Costs	2026-27 Proposed CARES-Live Costs	2026-27 Total Proposed Costs
CWS-CARES Project			
OSI Personal Services	15,674,835	1,732,421	17,407,256
Hardware/Software	39,139,813	643,942	39,783,755
Contract Services	235,548,281	2,737,256	238,285,538
CARES Development Services	200,145,654	-	200,145,654
Project Support Contracts	16,253,893	2,444,442	18,698,335
Project Management Services	3,933,518	32,720	3,966,238
Operations	5,920,140	-	5,920,140
County Consultant Services	9,295,077	260,094	9,555,170
OE&E	17,278,421	4,321,425	21,599,846
OSI Other OE&E (Gen Exp., Travel, & Facilities)	2,713,240	299,874	3,013,114
DGS Fees	1,987,718	219,687	2,207,405
Enterprise Services	7,124,578	787,426	7,912,004
Data Center Services	5,452,885	3,014,437	8,467,323
Total OTSI Spending Authority	307,641,350	9,435,044	317,076,394
CWS-CARES Project			-
CDSS Personal Services	2,410,000	-	2,410,000
CDSS Other OE&E (Gen Exp., Travel, & Facilities)	779,000	-	779,000
Core Constituent Participation	36,250,596	-	36,250,596
IPOC Contract Services	800,000	-	800,000
Total CDSS Local Assistance	40,239,596	-	40,239,596

OTSI and CDSS are required to provide monthly written reports and briefings to legislative staff regarding project progress.

Project health rated as "red." The CWS-CARES project is officially rated as "red" by CDT due to timeline compression, quality assurance bottlenecks, and ongoing backlogs.[3] CDT key questions of "is the project on track to achieve the objectives in the approved timeframe?" and "is the project on track to achieve the objectives within the approved budget" are labeled "uncertain" as of June 2026.

Milestones are one of the primary measures of project scope completion used by the CWS-CARES Project. The latest project plan, SPR 6, identifies 37 milestones for the project to complete CWS-CARES V1, with each milestone representing a core set of child welfare functionalities (for example investigations, case plan, court hearings, adoptions, and resource family approval).

Final months of project completion, testing, and training are highly compressed. In the fall of 2025, the federal Administration for Children and Families (ACF) did not approve California's annual planning update, causing the CARES project to make several significant changes in advance of the anticipated October 2026 launch. Among other things, the federal government rejected the state's plan to conduct a production pilot with a few counties prior to the launch. Instead, the state pivoted to create a "Production Simulation" environment for users in all counties to test and be trained in the new CARES system and identify any defects or deficiencies prior to the October 2026 launch. In the spring of 2026, the

[3] Child Welfare Services-California Automated Response and Engagement System (CWS-CARES) - IT Project Tracking - California Department of Technology - California Department of Technology - State of California

Administration worked to execute a new contract with KPMG for the Production Simulation (implementation services) and training for all users to occur between May and October of 2026.

As of the Administration's June 2026 monthly update to the Legislature, 16 of the 37 milestones had not been completed with their development progress rated as "red." The Administration has noted that since the June 2026 monthly update, five of those 16 milestones closed over the course of July. According to CDT, all remaining milestones were due to be completed in the December 2025- January 2026 timeframe. CDT notes that the backlog of product and data conversion defects are impacting Production Simulation activities.[4] At the same time that development is being completed and system flaws are being identified and remedied, county child welfare staff statewide are training in a "production simulation" environment in order to achieve readiness to perform daily social work by the time of system Go-Live in October 2026.

Critical Issues Raised by Counties in July 2026. In a July 13 letter to the Legislature, the County Welfare Directors Association (CWDA) raised critical concerns and asserted that "moving forward with the planned October 26, 2026 launch date is no longer a viable option compatible with child safety. The CWS-CARES system is underperforming and incomplete, with project milestones and deliverables significantly behind schedule with less than four months out from the system's planned launch."

CWDA asserts that should the planned Go-live date go unchanged, "the implementation of an unfinished and untested system will trigger immediate, cascading impacts" across multiple areas. Key concerns include identified elements of essential functionality for which no workaround exists; incomplete data conversion; significant delays to complete a Child Protective Services hotline call; and testing and quality control measures resulting in county staff resorting to pen and paper tracking of mandated reports, investigation findings, and monthly contacts. CWDA states that these issues pose direct risks to child safety.

Questions. The Subcommittee requests the Administration and panelists respond to the following:

1. Please provide a general update on the health and progress of the CWS-CARES Project.

2. Please summarize key design decisions and changes to the project that have occurred within the last 12 months and how these changes have affected the project plan and implementation, including the plan and schedule for training system users.

3. What is the Project's plan and timeline for delivering project milestones, converting data, resolving defects, and training system users prior to Go-Live in October 2026?

4. Counties state that a myriad of design flaws that pose direct risks to child safety are not scheduled to be fixed by the October 26, 2026 Go-Live. Please describe the Project's approach to addressing any identified risks to child safety. Please provide concrete examples of functionality that has been identified as essential and how it will be addressed and functionality that has been identified as non-essential and how it will be addressed differently.

[4] Child Welfare Services-California Automated Response and Engagement System (CWS-CARES) - IT Project Tracking - California Department of Technology - California Department of Technology - State of California

5. How will the state determine whether the project is ready to go live in the coming months? On what criteria would that determination be based?

6. What is the Administration's plan to achieve county readiness by training system users prior to Go-Live? How does the criteria for a Go-Live decision factor in training and county readiness?

Subcommittee Staff Comment and Recommendation – Informational item.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 3: Open August Trailer Bill – Department of Social Services

Open August Issue – Department of Social Services (CDSS) Trailer Bills. This issue covers CDSS trailer bills from the Administration that were proposed as part of the Governor's May Revision and were deferred during the finalization of the 2026 Budget Act:

1. **Child Care Single Rate Structure Age Groupings and Inclusion Framework.** This proposal would establish legislative intent regarding some elements of a policy framework for the future child care Single Rate Structure. These policies reflect recommendations from the Joint Labor Management Committee (JLMC) between the state and CCPU submitted in December 2025.

   Age Groupings. The trailer bill proposes to specify legislative intent for age groupings under the single rate structure as follows:

   - Children under 2 years: infant rate
   - Age 2: toddler rate
   - Ages 3-6 (not enrolled in first grade): preschool rate
   - Ages 5 and older (enrolled in first grade): school-age rate

   Inclusion Rate. The trailer bill establishes legislative intent that an enhanced rate for inclusion of children with special needs shall be administered as a per-child amount, with programs able to claim reimbursement for enhanced services that they deliver. The trailer bill establishes documentation (such as an individual program plan or similar plans) needed to receive an enhanced inclusion rate for a child.

   CDSS states that these changes will support the establishment of a policy framework which is needed to better assess impacts on state and contractor automation systems and begin any automation preparatory activities.

2. **Amended Definitions for Immigrant Youth.** Currently, CDSS serves immigrant youth through the Children's Holistic Immigration Representation Project (CHIRP), which has been funded on a one-time basis in recent budget acts, and the general Youth Legal Services program, which receives approximately $3 million annually. CHIRP is a comprehensive model that pairs legal representation with social worker support.

   Trailer bill language enacted as part of the 2026 Budget Act in AB 152 (Committee on Budget), Chapter 26, Statutes of 2026, allows youth receiving services through the Youth Legal Services program to also receive social services support and updated demographic reporting requirements.

   CDSS proposes an addition to this language to allow a portion of immigration legal services funding to support a consultant to develop a service framework that best meets the needs of children and youth in the Youth Legal Services and CHIRP program. The framework will include strategies, metrics, and outcomes that improve legal and social service delivery. The independent

consulting firm will develop a framework in collaboration with CDSS, and experts including child welfare experts, legal representatives, health providers, and educators.

CDSS states that the purpose of the proposed service framework is to establish a standardized, evidence-informed structure for how services are delivered to children and youth participating in this program. CDSS states that local variations in programming can lead to inconsistent service access, quality, and legal support for youth across the state; this framework would allow CDSS and partner agencies to evaluate service effectiveness, identify gaps, and promote consistent quality of care and legal support.

CDSS proposes to use existing funds appropriated for Immigration Legal Services in the 2026 Budget Act to implement the third-party evaluation. The exact cost of this assessment is not known, however CDSS states that informal estimates could range between $250,000 to $500,000. CDSS states that the department does not currently have the level of technical, research-focused staffing needed to independently produce an evidence-based framework within the required timelines. The department additionally emphasizes the need for an independent, neutral contractor to ensure an objective outcome.

Subcommittee Staff Comment and Recommendation – Hold Open.

Questions. The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of the Child Care Single Rate Structure and Inclusion Framework proposal. How will this proposal concretely move the state forward in actual implementation of a single rate structure for the state's child care programs?

    a. The Legislature has proposed establishing a deadline of July 1, 2028 for automation activities related to the single rate structure to be complete. What is the Administration's perspective on the establishment of a clear automation deadline?

    b. In addition to the two policies included in the trailer bill proposal, establishing age groupings and an inclusion framework for the single rate structure, what additional policy decisions are necessary before automation activities for the single rate structure can begin in earnest? What are the mechanisms for those policy decisions to be made?

    c. What options are available to the Legislature for (A) simplifying the existing child care rate structure and (B) pursuing targeted rate increases to bring the state closer to a single rate structure that reflects the true cost of care, in the interim while preparatory and automation activities, which could take several years, occur?

2. Please provide an overview of the department's proposal to conduct a third-party evaluation of the service framework for Youth Legal Services and CHIRP, including the anticipated cost of the proposed service framework. What specific program appropriation will the funds for the service framework be used? What are the anticipated outcomes of this process, and why is it necessary to bring on a third-party consultant to develop the service framework?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 4: The Role of 988 in the Behavioral Health Continuum

Local Assistance and Trailer Bill Language Proposals – Open Issues and Legislative Proposals. DHCS proposed trailer bill language to establish various criteria, quality standards, oversight and monitoring of 988 Crisis Centers, as well as other changes to governance and awareness of the 988 system. This proposed trailer bill language was deferred during the finalization of the 2026 Budget Act.

In addition, the Legislature's version of the budget included expenditure authority of $150 million from the 988 State Suicide and Behavioral Health Crisis Services Fund (988 Fund) to support maintenance of the community-based mobile crisis services benefit in the Medi-Cal program ($125 million), additional funding for 988 Crisis Centers ($20 million), and support for the California "Press 3" option for LGBTQ+ suicide prevention ($5 million). The 2026 Budget Act included General Fund expenditure authority of $42.2 million to continue the community-based mobile crisis services benefit in Medi-Cal until June 30, 2027. The balance of the Legislature's proposals were deferred during the finalization of the 2026 Budget Act.

Background – 988 and the Behavioral Health Continuum. The National Suicide Hotline Designation Act of 2020 designated 988 as the new three-digit number for the national suicide prevention and mental health crisis hotline. To support the 988 system, the act authorized states to impose a fee on access lines for providing 988 related services. Revenue from the fee must be held in a designated account to be spent only in support of 988 services, including 1) ensuring the efficient and effective routing of calls made to the 988 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and 2) the provision of acute mental health crisis outreach and stabilization by directly responding to the 988 national suicide prevention and mental health crisis hotline.

The Miles Hall Lifeline and Suicide Prevention Act, AB 988 (Bauer-Kahan), Chapter 747, Statutes of 2022, implemented the 988 system in California, establishing 988 as the three-digit number for the National Suicide Prevention Hotline, which is now known as the 988 Suicide and Crisis Lifeline. Among other provisions, AB 988 requires the following:

- Requires the California Governor's Office of Emergency Services (CalOES) to appoint a 988 system director and convene an advisory board to guide how 988 is implemented and made interoperable with 911, including the creation of a new surcharge for 988 to fund the crisis services.
- Requires CalHHS to participate in the State 988 Technical Advisory Board convened by CalOES no less than quarterly until December 31, 2028.
- Requires CalHHS to convene a state 988 policy advisory group to advise on a set of recommendations for the implementation and administration of the five-year implementation plan for the 988 System;
- Requires health plan and insurer coverage of 988 center services when medically necessary and without prior authorization;
- Establishes a 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month, and for years beginning January 1, 2025, at an amount based on a specified formula, but not greater than $0.30 per access line per month;

- States the intent of the Legislature that, by June 30, 2024, CalHHS and CalOES develop a plan for the statewide coordination of 988, 911, and behavioral health crisis services.
- Specifies the plan will be based on a five-year implementation plan that includes a landscape analysis of existing services and describes how to expand, improve, and link services with the goal of fully implementing the 988 system by January 1, 2030.

DHCS contracts with an administrative entity, Advocates for Human Potential, to subcontract California's 988 Crisis Centers and provides funding for 988 services through the 988 Fund, which receives revenue from the 988 surcharge, currently set at $0.05 per access line per month. The state's eleven 988 Crisis Centers are as follows:

- Buckelew Programs (Novato)
- Kings View (Fresno)
- Contra Costa Crisis Center (Walnut Creek)
- Crisis Support Services of Alameda County (Oakland)
- Didi Hirsch Mental Health Services (Century City)
- Kern Behavioral and Recovery Services (Bakersfield)
- United Behavioral Health/Optum (San Diego)
- San Francisco Suicide Prevention – Felton Institute (San Francisco)
- County of Santa Clara Behavioral Health Services (San Jose)
- Family Service Agency of the Central Coast (Santa Cruz)
- Wellspace Health (Sacramento)

According to DHCS and the Crisis Centers, California is experiencing significant growth in 988 contact volume as the system has been implemented. At the time of implementation in July 2022, California averaged approximately 33,000 contacts per month. From May 2024 through April 2025, total monthly 988 contacts averaged 52,000, a 57 percent increase. Based on this higher contact volume, DHCS estimates its minimum funding need for 988 Crisis Center operations in 2026-27 would be $32 million from the 988 Fund. Currently, DHCS has a $12.5 million local assistance appropriation for 988 centers. The Crisis Centers report their total funding needs for operations at $105 million.

988 Five Year Implementation Plan. In December 2024, CalHHS released *Building California's Comprehensive 988 System: A Strategic Blueprint*, which was the five year implementation plan for 988 required by AB 988. The plan, developed by the 988 Policy Advisory Group, included a set of Foundational Principles for a comprehensive 988 crisis system:

1) All Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender, gender identity, disability status, sexual orientation), should have timely access to quality crisis care.

2) Californians should have timely access to 988 through phone, text, and chat 24 hours a day, seven days a week, with contacts answered, whenever possible, in-state by 988 Crisis Centers with knowledge of how to connect with local resources.

3) Individuals in crisis should have access to timely therapeutic and appropriate care (and reduce unnecessary law enforcement involvement where possible).

4) Individuals seeking help should be connected to a crisis care continuum that prioritizes community-based support and focuses on preventing further crises and trauma.

The plan also made the following recommendations in four main categories:

Goal A: Increase Public Awareness of and Trust in 988 and Behavioral Health Crisis Services

- *Recommendation A1.* Coordinate statewide behavioral health crisis communications strategies informed by the 988 Suicide and Crisis Lifeline and Substance Abuse and Mental Health Services Administration (SAMHSA)

- *Recommendation A2.* Engage key partners in developing and disseminating statewide and regional communications strategies regarding behavioral health crisis services including 988 and other support lines (e.g. 211, County Access Lines, CalHOPE Red Line, and other Warm Lines)

- *Recommendation A3.* Monitor the success and impact of communications strategies.

Goal B: Establish the Systems, Inclusive of Technology, Policies, and Practices, To Connect Help Seekers to the Appropriate Call/Chat/Text Takers

- *Recommendation B1.* Support the technology to route 988 contacts safely and efficiently anywhere in California, including to mobile crisis dispatch.

- *Recommendation B2.* Promote coordination and communications across state technology implementation partners to ensure alignment of technology, policy, and practice.

Goal C: Support the 988 System in Delivering a High-Quality Response

- *Recommendation C1.* Support 988 Crisis Centers in meeting current national standards in preparation for meeting future statewide standards and California's vision for a comprehensive crisis care continuum.

- *Recommendation C2.* Building on national standards and best practices to ensure trauma-informed, person-centered, and culturally responsive care, establish state-specific standards for staffing and training to equip 988 Crisis Centers to respond to suicide, mental health, and substance use-related 988 contacts.

- *Recommendation C3.* Establish a process to review, designate, and re-designate California 988 Crisis Centers.

Goal D: Increase Coordination of Behavioral Health Crisis Services

- *Recommendation D1.* Coordinate state, tribal, county, and regional behavioral health along with payers, providers, and cross-sector partners to connect individuals in behavioral health crises to immediate and ongoing care.

- *Recommendation D2.* Support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally responsive crisis response, including mobile crisis dispatch, when appropriate.

- *Recommendation D3.* Continue to assist communities in expanding the range of facilities and services to individuals before, during, and after a behavioral health crisis.

- *Recommendation D4.* Develop more options or expand existing options for transporting individuals in crisis to a safe place to be.

Cross Cutting Recommendations – Equity, Funding and Sustainability, Data and Metrics, and Peer Supports

- *Equity.* Prioritize inclusion and equity in crisis care service delivery for populations that may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and/or need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs.

- *Funding and Sustainability.* Continue to implement strategies to support sustainable crisis systems at the local level that are connected to broader behavioral health transformation efforts, including behavioral health parity.

- *Data and Metrics.* Establish data systems and data standards to support monitoring of 988 and the behavioral health crisis care continuum's performance.

- *Peer Supports.* Integrate peer support across the crisis care continuum to support person-centered, culturally responsive, and recovery-oriented care.

Background – Community-Based Mobile Crisis Response. Section 9813 of the federal American Rescue Plan Act of 2021 authorizes state Medicaid programs to provide qualifying community-based mobile crisis intervention services for a period of up to five years, beginning April 1, 2022, and ending March 31, 2027. States that implement the mobile crisis intervention benefit receive an 85 percent federal match for reimbursement of these services for the first three years of the five year period. The 2022 Budget Act authorized DHCS to implement this benefit in the Medi-Cal program beginning January 1, 2023.

Mobile crisis intervention services are intended to provide rapid response, individual assessment, and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals with behavioral health conditions. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes three core components of a robust crisis system: 1) a 24 hour clinically staffed call center that can serve as a the hub of an integrated mental health

crisis system, 2) mobile crisis response teams that can respond rather than law enforcement, and 3) crisis receiving and stabilization facilities that provide short-term services and can be accessed readily rather than relying on emergency departments or hospital environments.

The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 million General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources as part of the Behavioral Health Continuum Infrastructure Program (BHCIP). Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million.

According to CalHHS, as of September 2024 the state had funded more than 450 Crisis Care Mobile Units (CCMU) through BHCIP. As of December 2024, 48 counties were approved to provide mobile crisis services under the Medi-Cal Mobile Crisis benefit, covering 98 percent of Medi-Cal members statewide. When the enhanced federal match under the American Rescue Plan Act expires at the end of March 2027, DHCS is proposing to transition the Medi-Cal Mobile Crisis benefit to a voluntary, county-funded service.

2026 Budget Act Augmentations to Support 988 and Mobile Crisis. The Governor's January budget proposed trailer bill language to repeal the statewide mobile crisis benefit in the Medi-Cal program when it was scheduled to expire in April 2027, and instead transition mobile crisis services to a voluntary, county funded benefit program.

The Legislature's version of the budget rejected the elimination of the statewide mobile crisis benefit and included expenditure authority from the State Suicide and Behavioral Health Crisis Services Fund (988 Fund) to support maintenance of the community-based mobile crisis services benefit in the Medi-Cal program ($125 million), additional funding for 988 Crisis Centers ($20 million), and support for the California "Press 3" option for LGBTQ+ suicide prevention ($5 million).

The 2026 Budget Act included General Fund expenditure authority of $42.2 million to continue the community-based mobile crisis services benefit in Medi-Cal until June 30, 2027. The balance of the Legislature's proposals were deferred during the finalization of the 2026 Budget Act.

Open Issues – 988 Call Center Oversight, Funding, Mobile Crisis, and the "Press 3" Option. The remaining issues deferred during the finalization of the 2026 Budget Act include the following:

- 988 Suicide and Crisis Lifeline Trailer Bill Language – The Administration proposed trailer bill language with the following components for the California Health and Human Services Agency (CalHHS), DHCS, the California Department of Public Health (CDPH), the California Governor's Office of Emergency Services (CalOES), and the Emergency Medical Services Authority (EMSA):

    - *CalHHS 988 Five-Year Plan Recommendations* – The proposed language would authorize CalHHS to develop recommendations, as outlined in the AB 988 Five Year Implementation Plan, and clarify notice requirements among state partners.

- *DHCS Standards, Criteria, and Oversight of 988 Crisis Centers*. The proposed language would authorize DHCS to establish a process and standard criteria for entities to apply for approval as designated 988 centers, establish quality standards 988 centers must meet to maintain designation, implement comprehensive oversight and monitoring of designated 988 centers, and oversee funding of centers and mobile crisis team.

- *CDPH Messaging and Data Collection.* The proposed language would authorize CDPH to oversee statewide 988 public messaging and public health data collection and surveillance related to 988.

- *CalOES Surcharge and Funding Distribution.* The proposed language would require CalOES to consult CalHHS and DHCS when determining 988 surcharge amounts and allocate and distribute funds to 988 centers and designated 988 centers for the acquisition of technology and equipment.

- *EMSA Statewide Training and Protocol Standards, and Quality Monitoring.* The proposed language would add EMSA as a participant in the state 988 advisory group, and authorizes EMSA to establish statewide training and protocol standards and a quality monitoring program for transfers, medical triage, and response to warm handoff for medical and behavioral health calls.

- Funding for Call Centers, "Press 3" and Mobile Crisis – The Legislature's version of the budget included expenditure authority from the 988 Fund of $150 million to support continuation of the community-based mobile crisis services benefit in Medi-Cal ($125 million), additional funding for 988 Crisis Centers ($20 million), and funding to implement the California "Press 3" option ($5 million).

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the current version of the Administration's trailer bill language proposal for the 988 system.

2. How is the Administration currently utilizing 988 Fund revenue to support 988 Crisis Centers?

3. What resources are available for LGBTQ+ individuals calling 988 since the elimination of the federal "Press 3" option? How could California help address the loss of this resource?

Issue 5: Medi-Cal Provider Oversight

Trailer Bill Language Proposal – May Revision. DHCS proposes trailer bill language to expand the department's authority to suspend providers and withhold payments in response to credible evidence of fraud.

Background. According to DHCS, on January 27, 2026, the federal Centers for Medicare and Medicaid Services (CMS) submitted a letter requesting the department provide a comprehensive program integrity plan, and requested detailed information about enrollment processes, payment suspension, program affiliation, and circumstances in which DHCS terminates provider enrollment. Although DHCS' response letter to CMS indicated that existing protocols are robust, the department proposes trailer bill language that would implement several targeted enhancements that would bolster the department's efforts to prevent and detect fraud and hold bad actors accountable.

Trailer Bill Language Proposal. DHCS proposes trailer bill language to expand the department's authority to suspend providers and withhold payments in response to credible evidence of fraud. Specifically, the language would:

1) Authorize DHCS to deny an application or terminate enrollment when a provider discloses an affiliation within the previous five years with a person or entity that the department determines poses an undue risk of fraud, waste, or abuse to the Medi-Cal program.

2) Expand existing provider integrity provisions to apply to any provider status, rather than provisional status in existing law, clarifies that termination of enrollment status results in deactivation and removal from Medi-Cal, expands the situations under which DHCS can take action against providers under investigation for fraud or abuse.

3) Prohibits reapplication for all provider types upon denial of application, with different periods of prohibition based on the reason for application denial (e.g. incomplete application, conviction of fraud/abuse, etc.)

4) Clarify DHCS authority to suspend providers under investigation by any state, local, or federal agency for fraud or abuse and implement suspension upon issuance of the written notice, rather than the 15 day period in existing law.

5) Expand DHCS authority to impose provider enrollment moratoria on clinics, health facilities, exempt clinics, and certain licensed or certified practitioners.

6) Add the Restricted Provider Database to the list of DHCS published exclusion tools and authorize provider suspension if provider submits claims for services provided by suspended providers in the database.

7) Clarify initiation of payment suspension is upon DHCS verification of a credible allegation of fraud and harmonize the state definition of a credible allegation of fraud with federal regulations.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this trailer bill language proposal.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 6: Open August Trailer Bill – Department of Developmental Services

Open August Issue – Department of Developmental Services (DDS) Trailer Bills. This issue covers three DDS trailer bill proposals from the Administration that were proposed as part of the Governor's May Revision and were deferred during the finalization of the 2026 Budget Act:

1. **Merge Community Placement Plan and Community Resource Development Plan to Align with current developmental services delivery system.** This proposal combines the Community Placement Plan (CPP) and the Community Resource Development Plan (CRDP) into one unified program.

   Under existing law, DDS annually establishes policies and procedures for regional centers to develop and submit annual CPP and CRDP funding proposals.

   WIC section 4418.25 prioritizes CPP funding to support the closure of developmental centers and creation of services for individuals transitioning from restrictive settings. The Agnews, Lanterman, Sonoma, and Fairview Developmental Centers all have closed, with final transitions completed in 2020. This language no longer reflects the needs of California's developmental services delivery system.

   WIC Section 4679 established CRDP funding to address the needs of individuals with intellectual and developmental disabilities living in the community. It prioritizes the development of services that reduce reliance on the secure treatment program at Porterville Developmental Center, institutions for mental disease, out-of-state resources, and other restrictive settings. This language better reflects current conditions and evolving priorities in California's developmental services system. The 2025 establishment of the Provider Directory provides further insights into the geographical availability of services, so DDS can be more directive about the development of provider capacity to close gaps in access and availability.

   DDS states that merging and consolidating these two programs will align current law with the needs of the community. Updating WIC section 4418.25 to remove outdated references to CPP and its focus on developmental center closures, and modernizing WIC section 4679, will streamline ongoing efforts to develop service options for individuals in or diverted from restrictive settings or to address broader community needs.

   Subsequent revisions offered by the Senate more explicitly include housing options such as supported living as part of the CRDP, reinstate language that focuses CRDP funding on individuals transitioning from highly restrictive settings, establishes DDS oversight of local Regional Center CRDP plans, add public and legislative reporting requirements, and make other technical changes.

2. **State-operated Transitional and Rehabilitative Services.** This proposal would place time limits on the length of stay at Canyon Springs Community Facility (CS) and Porterville Developmental Center (PDC).

CS is a state-operated facility licensed for 63 individuals and staffed to support an average of 56 individuals. As of December 2025, the facility's average census at CS was 34 individuals. Admissions to CS are permitted only through transfers from PDC under WIC section 6500(a)(1) court commitments, which are determined through clinical certification and judicial review. CS does not currently impose limits on lengths of stay, and transitions depend on a regional center's ability to identify or develop appropriate community resources. As of January 2026, individuals served at CS had an average stay of 4 years, ranging between 8 days to 19 years.

PDC is a state-operated secure treatment facility for 469 beds, with 99 beds in suspense and an average census of 166 individuals. Admissions to PDC occur under Penal Code section 1370.1 court commitments. After two years, individuals with intellectual and developmental disabilities who do not complete "competency restoration" training (after being determined Incompetent to Stand Trial) and who continue to pose a danger to themselves or others, may be civilly committed to the facility as a WIC section 6500(a)(1). As of December 2025, 72 individuals with WIC section 6500(a)(1) commitments resided at PDC, with an average stay of 5.5 years, ranging from 7 months to 26 years.

According to DDS, the absence of time limits on stays at these two facilities has led the developmental services system to rely on CS and PDC for long-term residential placements rather than prioritizing transitional and community-based options. As a result, some individuals remain in highly restrictive settings for extended periods, well beyond what is necessary for rehabilitation and transition.

A full continuum of care is essential to meet the needs of individuals with complex forensic backgrounds. The proposed changes will realign the purpose and programming of CS and PDC WIC section 6500(a)(1) placements with their intended roles as therapeutic and rehabilitative step-down settings. By establishing clear transition timelines and expectations, CS and PDC will function as transitional programs that provide the support, training, and preparation necessary for individuals to reintegrate successfully. This approach makes sure that people are safe, equipped, and stable for community living, while preventing the use of these facilities as long-term placement options.

Funding and a robust resource development plan to support transitions from facilities such as PDC and CS already exist. The purpose of Community Placement Plan (CPP)/ Community Resource Development Plan (CRDP) funding is to enhance the capacity of the community service delivery system and to reduce reliance on developmental centers, Institutions for Mental Disease (IMD) and other highly restrictive settings. CPP/CRDP is funded at $78 million per year for resources to:

- Facilitate transitions to the community from a developmental center, an IMD, a skilled nursing facility, or out-of-state.

- Assess needs of individuals through comprehensive assessments.

- Establish resources in the community for individuals transitioning from another environment.

- Collaborate with the regional centers, regional projects and other team members in transitional activities.

- Stabilize current community living arrangements.

The $78 million ongoing funds direct services, start-up funds for specialized residential and non-residential services, placement funds to support costs with individuals moving into less restrictive settings, and staff.

Under this proposal, starting July 1, 2031, no one can be committed to PDC under a WIC section 6500(a)(1) commitment for more than 24 months from that date forward. Anyone who is already living at PDC on or before July 1, 2031, cannot stay there past July 1, 2034. A WIC 6500(a)(1) commitment order for placement at CS lasts for one year unless the regional center asks the court to extend it. To request an extension, the regional center must explain why the person still needs to be there and provide an updated assessment and plan. No one can remain at CS more than 24 months after July 1, 2027, unless a specific legal exception applies. In addition, this proposal removes various obsolete language and makes technical clarifications.

Subsequent revisions to this proposal offered by the Senate include extending the right of return to both PDC and CS, inclusion of individuals' attorneys in transition planning, development of an implementation plan with robust stakeholder engagement, and quarterly reporting to the Legislature regarding implementation of the time limitations established under this proposal.

3. **Equitable Access to Intake and Services.** This proposal has been revised since its introduction in the Governor's May Revision. It has been retitled "Equitable Access to Intake and Services" and requires legislative approval prior to the adoption and implementation of any new assessment. This proposal contains two key components: (A) Standardizing Intake Eligibility Assessment Process and (2) Modernizing Strengths and Needs Evaluation.

   (A) ***Standardizing Intake Eligibility Assessment Processes***. To become eligible for Lanterman Act services, a regional center must determine that an individual has a "developmental disability" that is considered a "substantial disability." According to DDS, regional centers do not currently use a standardized method for assessing developmental disability or substantial disability, resulting in variability in intake processes across the State. DDS states that through the implementation of SB 138 (Senate Budget and Fiscal Review,) Chapter 192, Statutes of 2023, it has become clear that a critical part of the requirements to standardize intake is to specifically standardize the methods for assessing developmental disability or substantial disability.

   DDS states that this proposal does not change the definitions of developmental disability or substantial disability, which are defined in statute. It also does not change eligibility for people already served by regional centers. Instead, it standardizes the intake eligibility assessment processes and methods used to determine if individuals meet those definitions, thereby improving consistency, equity, and transparency in access to the regional center system. Where someone lives, and which regional center serves that area, should not make a difference in someone's eligibility.

Establishing standardized methods for determining whether an individual meets the criteria of "developmental disability" that constitutes a "substantial disability" is necessary for equity and consistency in the individual and family experience with the intake process. Current differences in regional center intake eligibility assessment practices create inconsistency and risk leaving individuals and families uncertain about eligibility determinations, as well as outcomes that vary depending on the regional center. A standardized approach is essential for equitable access to the regional center system.

DDS states that standardizing the intake eligibility assessment process will increase transparency, establish standard protocols for clinicians and regional centers, and increase overall equity in the regional center system.

(B) ***Modernizing Strengths and Needs Evaluation***. According to DDS, after a person is found eligible, some regional centers rely on the Client Diagnostic and Evaluation Report (CDER) to document diagnoses and evaluate daily living skills. The CDER is outdated, inconsistently applied, and is not a standardized clinical instrument. This makes it difficult to accurately get a picture of an individual's developmental needs. The CDER has not been meaningfully updated since 1977. As a result, services and supports may not align with actual needs, limiting the ability to understand whether services are effective or equitable.

A modern, person-centered, validated evaluation would support consistent and transparent identification of strengths and needs statewide, strengthen alignment between evaluated needs and Individual Program Plans (IPPs), improve insight into patterns of underservice, and support more reliable planning and developing service providers across regional centers. Importantly, this proposal does not determine which or how many services someone would receive, but would identify areas that should be considered in the IPP planning process.

According to DDS, a strengths and needs evaluation is essential because it establishes a consistent, equitable, and evidence-based way for the developmental services system to understand each person's unique strengths and needs, regardless of where they live. It addresses longstanding inequities caused by inconsistent CDER practices, and supports planning teams and person-centered planning, with trustworthy information. By standardizing how strengths and needs are identified and discussed, the evaluation helps align statewide practices, improve transparency, and strengthen the connection between individual needs and the supports and services provided to meet them.

DDS states that modernizing strengths and needs evaluation will strengthen the IPP process by guiding (but not unilaterally determining) service provision, and support capacity development and data informed investments by providing DDS with comprehensive data on strengths and needs across life domains.

As revised, the trailer bill allows DDS to develop the proposed assessments and evaluation in collaboration with stakeholders, but requires legislative approval prior to the adoption and implementation of those tools.

Subcommittee Staff Comment and Recommendation – Informational Item.

Questions. The Subcommittee requests DDS respond to the following:

1. Please provide an overview of the three trailer bill proposals included in this item.

0000 MULTIPLE DEPARTMENTS – NOT FOR PRESENTATION

Issue 7: Technical Cleanup and Other Open Issues - Health

Technical Cleanup and Other Open Issues – August Issues. The Administration and the Legislature are considering the following technical cleanup and other adjustments to health-related items included in the 2026 Budget Act:

Department of Health Care Access and Information (HCAI)

- *Uncompensated Care Program.* Budget bill language to provide grant making authority to HCAI for distribution of the funds in the program.

- *Community Health Workers/Promotoras Training.* Net-zero allocation of $750,000 General Fund from local assistance to state operations for administration of the training program.

- *CalRx Epinephrine and Tuberculosis Drugs.* Net-zero allocation of $775,000 General Fund from local assistance to state operations for administration of these programs.

DHCS

- *House Resolution 1 Implementation.* Trailer bill language to address drafting errors in the language adopted in the 2026 Budget Act.

- *Hearing Aid Coverage for Children Program.* Net-zero technical adjustment attributing to the correct items of appropriation the assumed $2.6 million General Fund savings from adoption of a large group mandate for hearing aid coverage.

- *Allcove Youth Mental Health Services.* Budget bill language to specify allocation of funding for allcove youth mental health services.

CDPH

- *Foundation for a Better Life.* Budget bill language to extend encumbrance and expenditure authority until June 30, 2028, for funding included in the 2026 Budget Act for the Foundation for a Better Life.

- *Governor's Council on Physical Fitness and Mental Well-Being.* Budget bill language to allocate $5 million General Fund for the Governor's Council on Physical Fitness and Well-Being.

Subcommittee Staff Comment and Recommendation—Hold Open.

Issue 8: Technical Cleanup and Other Open Issues – Human Services

Technical Cleanup and Other Open Issues – August Issues. The Administration and the Legislature are considering the following technical cleanup and other adjustments to human services-related items included in the 2026 Budget Act:

California Department of Social Services (CDSS)

- Technical changes to appropriations for Housing and Disability Advocacy Program, Home Safe, and Bringing Families Home to extend the availability of state operations funding by one year to align with the liquidation period for appropriated funds.

- Increase funding for CDSS by $267,000 General Fund and $467,000 federal funds for automation to comply with federal law changes related to the CalFresh Elderly Simplified Application Project (ESAP) population redefinition and for the Trafficking and Crime Victim Assistance Program (TCVAP) eligibility extension.

- Clarify various provisional budget bill language items.

- Technical update to cost estimates associated with the 22,770 new child care spaces to account for department estimates of ongoing Cost of Care Plus rates.

- Technical update to the number of child care spaces supported by the federal fund and Proposition 64 backfill included in SB 111. The total number of spaces is 2,893 in 2026-27 and 2,856 ongoing for voucher slots.

Department of Community Services and Development (CSD)

- Provisional budget bill language allowing the Department of Finance to authorize up to $5 million to cover state operations costs for CSD to cover state operations costs not covered under the department's annual federal awards.

Subcommittee Staff Comment and Recommendation – Hold Open.