

SUBCOMMITTEE NO. 3

Agenda

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



Thursday, May 7, 2026
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Elizabeth Freeman

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PUBLIC COMMENT ON ISSUES 3-13

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

5180 CALIFORNIA DEPARTMENT OF SOCIAL SERVICES**Issue 1: IHSS Overview and Governor's Proposed Reductions**

Panel Discussion. The Subcommittee has invited the following individuals to participate in this discussion:

- Thomas Locke, Department of Finance
- Jennifer Troia, Director, and Leora Filoseno, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal & Policy Analyst, Legislative Analyst's Office
- Carlos Marquez, Executive Director, County Welfare Directors Association
- Service Employees International Union
- Michelle Rousey, Consumer Advocate
- Hagar Dickman, Director of Long-Term Services and Supports Advocacy, Justice in Aging

Governor's Budget – In-Home Supportive Services. In-Home Supportive Services (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 Governor's proposed 2026-27 budget for IHSS includes \$33.5 billion (\$12.5 billion General Fund) to serve a projected caseload of 875,344 individuals. This represents about a 10 percent increase from the revised estimates for 2025-26, driven largely by growth in overall IHSS caseload (eight percent), as well as growth in average hours per case and cost per hour of care. (The main drivers of increases in IHSS program costs over time are summarized further below in this issue and analyzed in detail in a recent analysis by the Legislative Analyst's Office).¹

Governor's Budget proposes three cuts to IHSS programs. The Governor's budget proposes three cuts to IHSS:

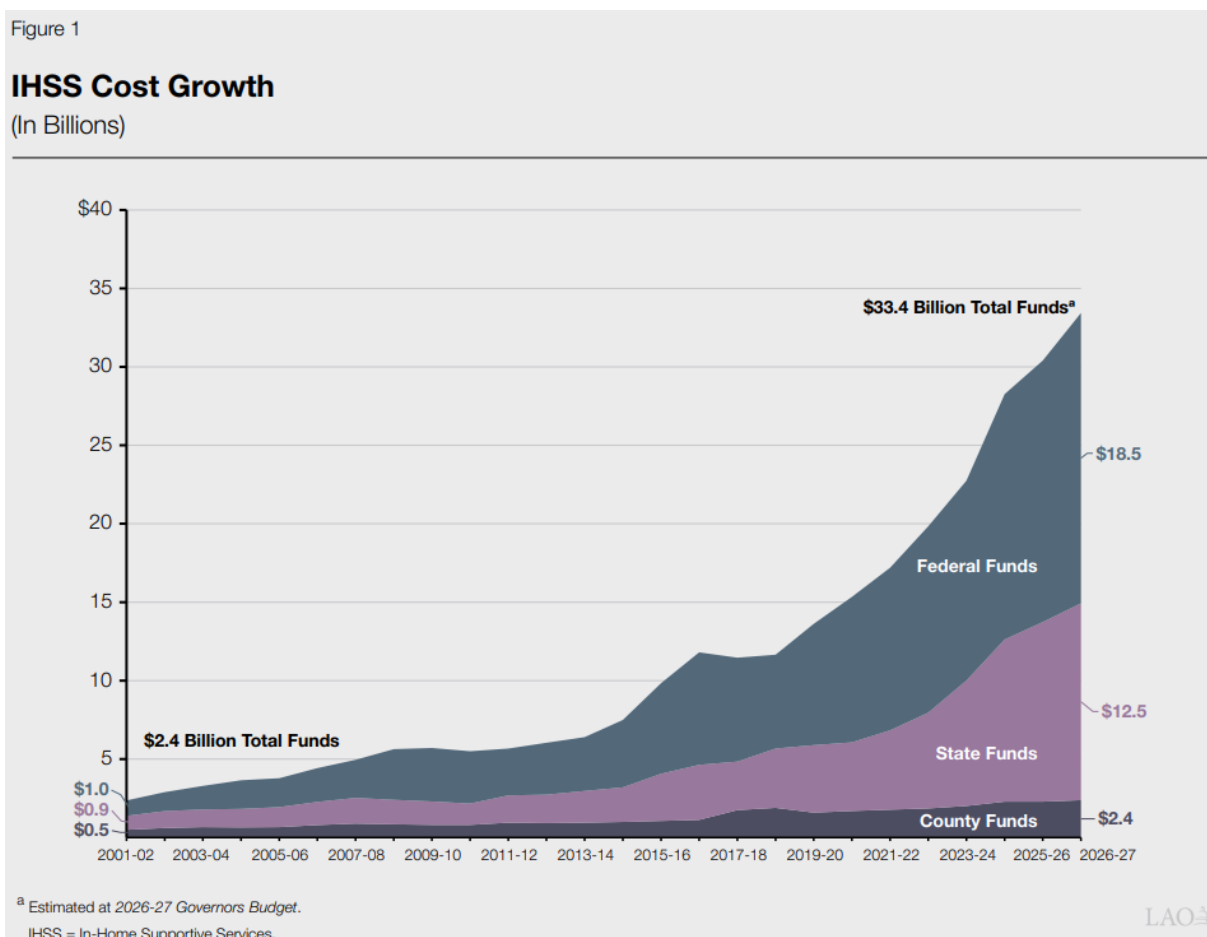
1. **Shift costs of growth in IHSS hours per case to counties.** A reduction of \$233.6 million General Fund to remove the state's share of cost associated with any growth in IHSS hours per case, beginning in 2027-28. The General Fund savings associated with this proposal grow to \$805 million by 2029-30.
2. **Eliminate the IHSS Back-up provider system.** A reduction of \$3.5 million General Fund to eliminate the IHSS Permanent Back-up Provider system, which provides back-up care when a person's regular provider is temporarily unavailable.
3. **Align IHSS termination with Medi-Cal termination.** A reduction of \$86 million General Fund to conform the termination of IHSS to the termination of Medi-Cal consistently across all counties.

¹ Legislative Analyst's Office (LAO), [The 2026-27 Budget: In-Home Supportive Services](#), March 2026.

Background: 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. IHSS caseload in 2025-26 is 810,336 and is projected at 875,344 for 2026-27 (an eight percent increase).

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. The average number of hours that will be provided to the estimated 875,344 IHSS recipients is projected to be 127 hours per person per month in 2026-27 (an increase from 125.1 hours per person per month in 2025-26).²

IHSS cost growth. 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. As the Legislative Analyst’s Office (LAO) has noted, IHSS program costs have increased significantly over the last 20 years, driven by growth in caseload, cost per hour of care, and average hours per case.



² LAO.

Several factors contribute to growing caseload and costs in the IHSS program. First, sweeping demographic shifts have increased the population eligible for IHSS. As the LAO notes, “from 2015 to 2024, the number of individuals in the state aged 65 and over has increased by 29 percent, while the overall population has increased by a little over two percent. Further, the number of Californians with a disability has increased by 14 percent. More specifically, those 65 and over with a disability impacting independent living has increased by 17 percent. The share of IHSS recipients over age 65, however, has remained a relatively consistent share of the overall IHSS population.” Moreover, children and adults with disabilities make up a substantial portion of the IHSS caseload; approximately 154,000 individuals with intellectual and developmental disabilities (I/DD) receive IHSS. That caseload is growing significantly every year, driven largely by increases in children with autism (the number of individuals served by regional centers with a diagnosis of autism spectrum disorder has grown by 141 percent in the last 10 years).

Second, 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 recent 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.”³

Governor’s budget proposed cuts to IHSS. The three cuts to IHSS proposed in the Governor’s budget are described below.

1. **Shift costs of growth in IHSS hours per case to counties**

The Governor’s budget proposes a reduction of \$233.6 million General Fund in 2027-28, growing to over \$800 million by 2029-30, to remove the state’s responsibility to pay for costs associated with the growth in average hours per IHSS case. This means that beginning in 2027-28, any nonfederal costs associated with hours about the statewide average from 2026-27 would be paid for by counties instead of the state General Fund.

Proposed trailer bill language. Trailer bill language requires CDSS to establish a statewide baseline of authorized hours per case in May 2027 and annually thereafter. Any costs above that established baseline would be borne 100 percent by counties in the subsequent fiscal year, with the total costs distributed across counties proportionally based on each county’s caseload (not based on each county’s average hours per case).

³ Letter from DHCS to CMS, “California’s Response to CMS’ Request for Program Integrity Action Plan,” February 17, 2026.

The trailer bill language requires CDSS to work with the County Welfare Directors Association (CWDA) to develop guidance to implement this proposal. The trailer bill language also instructs counties to continue to apply IHSS assessment tools (known as functional index rankings and statewide hourly task guidelines) to determine individual recipients' authorized hours consistent with existing law.

Growth in IHSS hours per case. IHSS recipients are authorized a certain number of hours of assistance, up to a maximum of 283 hours per month, based on a comprehensive county social worker assessment using standardized statewide tools. As a result, the number of hours per month assigned to each IHSS recipient varies based on that person's individual needs.

As the LAO notes in their analysis,⁴ the growth in average monthly hours per IHSS case is one of the three primary drivers of increased IHSS program costs over time. Those three cost drivers are overall caseload growth, the increase in cost per hour of IHSS services, and the increase in average authorized hours per case. The average number of hours per case has increased steadily since 2014 by about two percent per year. This makes average hours per month the least significant of the three main cost drivers; the LAO estimates that overall caseload growth accounts for about 50 percent of the growth in IHSS costs; cost of IHSS services per hour (including factors such as minimum wage increases) accounts for about 40 percent of this growth, and authorized hours per case growth accounts for the remaining roughly 10 percent. For a comprehensive breakdown of the drivers of IHSS cost growth, see the LAO analysis.⁵

Assessment of IHSS hours. County social workers use two statewide standardized tools to annually assess IHSS recipients' authorized monthly hours based on individual needs and circumstances. These tools are known as the Functional Index Ranking and the Hourly Task Guidelines. The Functional Index (FI) ranking measures a person's level of impairment to perform activities of daily living on a living on a six-point scale. According to the LAO, "An FI ranking of 1 is the lowest impairment level and notes that a recipient is independent and able to perform a task without another person's assistance. An FI ranking of 5 notes that a recipient cannot perform a task with or without another person's assistance and an FI ranking of 6 signifies a recipient requires paramedical services (meaning that, in order to provide the service, a provider must be trained and overseen by a licensed health care professional). The weighted average of the FI rankings for each assessed task are then used to create an overall FI score."

County social workers then use the Hourly Task Guidelines (HTG) to determine the amount of hours to authorize for each IHSS task. The HTG generally provides a range of hours that a social worker can allocate for each task, based on the recipients' FI ranking and their individual circumstances. Because the HTG provide for a range of hours within each FI ranking (three to seven hours, for example), a person's authorized hours could increase while their FI ranking remains flat. If a person's circumstances change their hours could adjust accordingly—a necessary flexibility for people who are aging at home. For more details on how FI rankings and HTG function, see the LAO analysis.

Administration's rationale for this proposal. The Administration states that this proposal is intended to help ensure accurate assessments. The Administration states that over the last several years, the average authorized hours per case began to grow year over year while FI rankings have generally remained flat. The Administration also states that this increase has been more significant since adjustments were made

⁴ LAO.

⁵ Legislative Analyst's Office (LAO), [The 2026-27 Budget: In-Home Supportive Services](#), March 2026.

to the state and county cost-sharing ratio, which requires the state to support a larger share of IHSS program costs.

Proposal shifts costs to counties regardless of individual county average hours per case. The Administration's stated rationale for this proposal is to help ensure accurate and consistent IHSS hours assessments from counties. This implies that IHSS average cost per case are growing at a higher rate than they should be and that shifting any increases above the 2026-27 average baseline would create a financial incentive for counties to assess hours more accurately, as county costs today are largely unaffected by the growth in average hours per case.

However, the Administration's proposal distributes the net cost associated with any increase in statewide hours per case proportionally across counties based on county caseload. This means that each county would pay a share of the total cost regardless of any changes in authorized hours or assessment practices in that county, and regardless of whether the county's average hours per case is above or below the baseline average. As a county's share of this cost would depend solely on the county's share of the IHSS caseload and not the level of authorized hours in that county, it is unclear how this proposal is attached to the Administration's goal of incentivizing accurate assessments. Moreover, this proposed reduction is not paired with any proposed changes to the state assessment tools, policy associated with the use of those tools, or data that supports the state's rationale that the steady increase in hours per case is not due to other factors.

Potential drivers of increased hours per case. The only evidence the Administration has presented to indicate that there could be an issue with how counties are assessing and authorizing hours per case is that average hours have grown while FI rankings have remained flat for many years. However, changes to authorized hours do not necessarily indicate that assessments are being done inaccurately. Other factors (described below) may help explain why average authorized hours per case could be increasing independently from FI rankings.

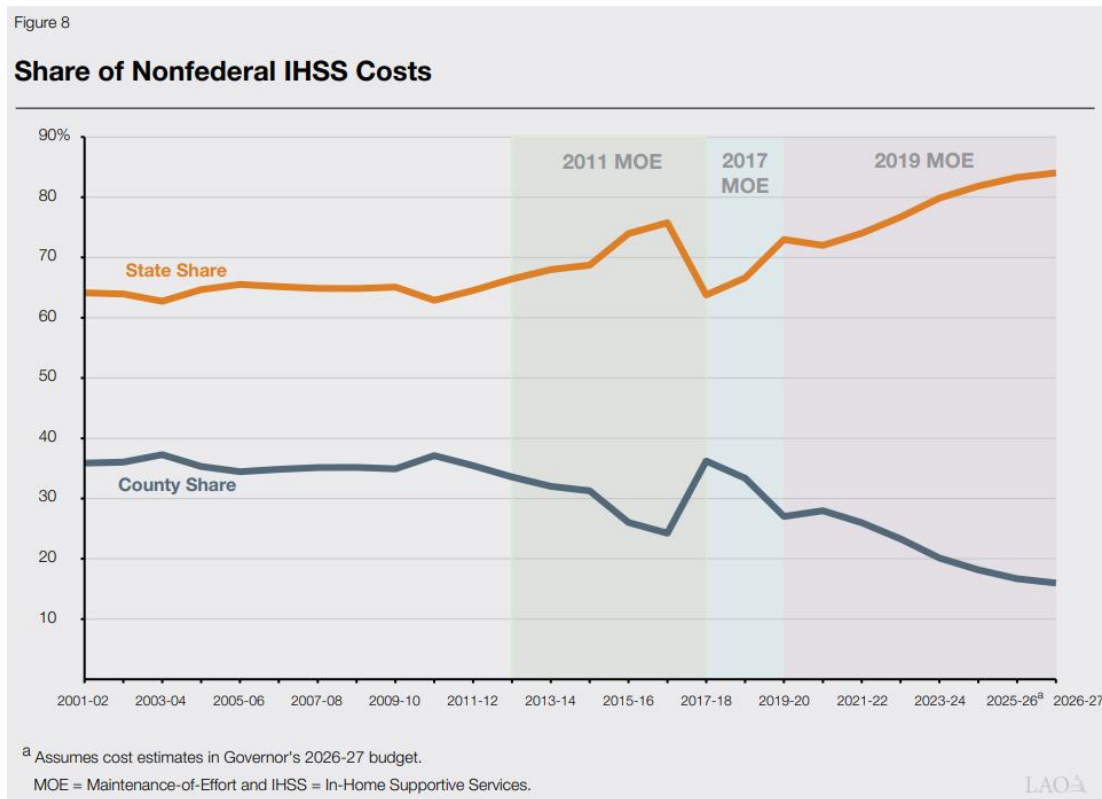
- **Growth in protective supervision caseload.** Some IHSS recipients are determined to require "protective supervision" to remain safely in their own homes. According to the LAO, protective supervision allows individuals who are determined by a medical professional to be non-self-directing and needing 24-hour-a-day supervision to receive the maximum amount of hours (195 hours per month if non-severely impaired, 283 hours if severely impaired). Importantly, protective supervision does not have an FI ranking, meaning that protective supervision increases hours, but not FI scores. The percentage of the IHSS caseload receiving protective supervision has steadily increased, from 8.7 percent in 2019 to 10.9 percent in 2025. (In 2000, only four percent of the caseload received protective supervision).
- **Growth in minor caseload.** The percentage of the IHSS caseload under age 18 has also steadily increased, from 7.4 percent in 2019 to 11.1 percent in 2025. Children make up a significant share of the protective supervision caseload; the share of protective supervision recipients under age 18 grew from 11 percent to 37 percent between 2000 and 2017.
- **Growth in severely impaired caseload.** IHSS recipients considered severely impaired generally qualify for a higher maximum number of hours (up to 283 hours per month). The percentage of the IHSS caseload determined to be severely impaired has also increased significantly (from 30.3

percent in 2019 to 37.3 percent in 2025) while the percentage of the caseload determined non-severely impaired has declined from 69.4 percent in 2019 to 62.4 percent in 2025.

However, the portion of the caseload over age 75 has been decreasing slightly, from 36.3 percent in 2019 to 34.5 percent in 2026.

State and county cost-sharing in IHSS. Cost-sharing for the nonfederal share of IHSS costs is driven by a Maintenance of Effort (MOE) between the state and counties that was last updated in 2019. Historically, counties paid 35 percent of the nonfederal share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs.⁶ The cost-sharing ratio between the state and counties has changed several times over the last roughly 15 years, and these various changes are detailed in the LAO analysis.⁷ The current 2019 MOE that governs IHSS cost sharing fixed overall county costs at \$1.6 billion, set to increase annually by the counties’ share of costs from locally negotiated wage increases and an annual adjustment factor of four percent.

One of the effects of the 2019 MOE is that the annual IHSS MOE growth factor of four percent is far less than the overall growth in overall IHSS program costs due to factors such as caseload growth, growth in cost per hour, and growth in hours per case. This means that as IHSS costs continue to increase, the state General Fund has shouldered a disproportionate share of cost growth relative to counties (as shown in the LAO chart below).



⁶ LAO.

⁷ LAO.

The Administration has stated that this proposal does not impact the 2019 MOE. However, the proposal essentially creates a new county cost responsibility outside of the MOE structure. Although the state has absorbed a disproportionate share of cost growth under the 2019 MOE relative to counties, this does not indicate that counties are able to absorb these costs. The County Welfare Directors Association (CWDA) has noted that the 2019 IHSS MOE costs already absorb approximately 81 percent of social services realignment funding in 2024-25, leaving little for other human services programs such as CalFresh administration, and that in the last two years realignment revenues have failed to keep pace even with the cost growth under the IHSS MOE. These cost pressures are compounded by increased county costs due to H.R. 1.

Details of cost shift will impact savings estimate. The Administration has also stated that it will continue to work through the details of the proposal, in particular, the establishment of the statewide average hours per case baseline that would determine the total cost shift to counties each year. For example, the Administration has suggested that the state could work with counties to determine some level of allowable growth in average hours per case by selecting a baseline slightly above the statewide average in 2026-27. To the extent that the Administration makes this type of upward modification to the average baseline, this would erode the Administration's estimated General Fund savings (\$233.6 million 2027-28 growing to over \$800 million in 2028-29).

Stakeholder opposition. This proposal has wide opposition from the range of IHSS stakeholders such as counties, SEIU California and UDW California, Disability Rights California, Justice in Aging, the California Association of Public Authorities, and the National Health Law Program, among others. These stakeholders note that the steady growth in hours per IHSS case is to be expected given the growing aging population, and that shifting costs to counties creates incentives for counties to reduce or deny hours that clients genuinely need. Stakeholders also note that this cost shift would occur at a time when counties are facing billions of dollars in increased health and human services costs because of H.R. 1.

2. Proposal to eliminate IHSS Back-up Provider System.

The Governor's budget proposes a reduction of \$3.5 million General Fund to eliminate the IHSS Back-up Provider system, which provides back-up care when a person's regular provider is temporarily unavailable.

Proposed trailer bill language. The proposed trailer bill language repeals existing law that establishes and governs the use of the IHSS Back-up Provider System.

Back-up Provider System. During the COVID-19 pandemic, CDSS implemented an emergency Back-up Provider System for IHSS recipients. This system provided a pay differential of \$2 above the county negotiated wage for back-up providers. The 2021 and 2022 Budget Acts created a framework to make the Back-up Provider System permanent.

Administration's rationale for this proposal. The Administration states that in the few years that the permanent Back-up Provider System has been implemented, the program has not been utilized by many recipients and administrative costs are higher than service costs.

Back-up Provider System utilization. As noted by the LAO, expenditures for the Back-up Provider System in 2023 and 2024 have consistently come in lower than expected.⁸ Only \$900,000 total funds from October 2022 through June 2024 have been spent on the \$2 differential for back-up provider services. The Governor’s budget estimates that the program will cost \$4.5 million General Fund in 2025-26, with the majority of the funding supporting administration (\$4.2 million) relative to the pay differential for services (\$298,000).

In-Home Supportive services (IHSS)

Back-Up Provider System (BUPS)

| Services | IHSS Monthly Avg Paid Caseload | Avg/Monthly Paid Backup Providers (BUPS) | Avg/Monthly Paid Hours (BUPS) | Total Service Expenditures (BUPS) | BUPS Revised Budget ^C | BUPS Utilization Rate |
|---|--------------------------------|--|-------------------------------|-----------------------------------|----------------------------------|-----------------------|
| Avg Monthly FY 2022-23 ^A | 619,277 | 45 | 1,404 | \$ 250,307 | \$ 34,343,000 | 1% |
| Avg Monthly FY 2023-24 | 663,930 | 93 | 2,407 | \$ 565,329 | \$ 18,395,000 | 3% |
| Avg Monthly FY 2024-25 | 732,270 | 116 | 2,535 | \$ 641,061 | \$ 955,000 | 67% |
| Avg Monthly July 2025 - Dec 2025 ^B | 786,519 | 124 | 2,342 | \$ 295,193 | \$ 678,000 | 44% |

Notes

A) FY 2022–23 BUPS data reflects Oct 2022 - June 2023

B) FY 2025–26 caseload and hourly data reflect activity from July 2025 through December 2025.

C) Total funding reflects state General Fund and federal reimbursements included in prior May Revisions for FY 2022-23, FY 2023-24, FY 2024-25, and 2026-27 Governor's Budget for FY 2025-26.

D) Includes federal reimbursement and state General Fund expenditures.

The chart above, provided by CDSS, demonstrates system utilization over the last three years. Note that utilization in this case is defined by service expenditures relative to the budget appropriation. Because the Back-up Provider System is a relatively new program, estimates have been revised downward in recent years. This is not necessarily evidence that the system is not needed as much as it is evidence that initial estimates of utilization and spending were too high and that there could be barriers to utilization, such as lack of consumer awareness or lack of available providers.

Because the Back-up Provider System is a new program, the relatively low spending and utilization raise questions about if the program is functioning well for consumers. For example, are IHSS clients who call the county in need of a back-up provider assigned to an available provider in a timely manner, or are they expected to call a long list of names in order to ascertain if a back-up provider is available and willing to provide them with care? Data from the IHSS Public Authorities shows that many requests for back-up care go unfulfilled.

Stakeholder opposition. Disability advocates, counties, and labor organizations representing IHSS workers oppose this proposal. These stakeholders note that back-up care is a vital safety net for IHSS recipients who experience urgent care needs when their regular provider is temporarily unavailable, preventing unnecessary use of emergency services like 911 and the Emergency Room.

3. Proposal to align IHSS termination with Medi-Cal termination.

The Governor’s budget proposes a reduction of \$86 million General Fund in 2026-27 to conform the termination of IHSS to the termination of Medi-Cal consistently across all counties.

⁸ LAO.

IHSS Residual Program. IHSS is a Medi-Cal benefit. In order to receive IHSS, recipients must maintain Medi-Cal eligibility. The state also operates the IHSS Residual program, a small but fully state-funded portion of the IHSS caseload. The portion of the IHSS caseload on the IHSS Residual program (approximately two percent of the caseload) are ineligible for federal Medicaid funding either because of immigration status or because they were terminated from Medi-Cal due to ineligibility (failing to complete Medi-Cal redetermination on time, for example). This proposal only affects the portion of the IHSS Residual caseload who receive state-only IHSS due to termination from Medi-Cal.

Inconsistent application of IHSS Residual program. There are inconsistent practices across counties in how IHSS cases are treated when an IHSS recipient is terminated from Medi-Cal. In some cases, the person is manually terminated from IHSS (this is because eligibility for IHSS is attached to an individual's eligibility for Medi-Cal). When an individual is manually terminated from IHSS, their IHSS provider will not receive payments for IHSS care until the person reinstates Medi-Cal eligibility. If Medi-Cal eligibility is reinstated within 90 days, payments for IHSS can resume as normal and the state can retroactively draw down federal funds to reimburse providers for services during the time period that Medi-Cal has lapsed.⁹

In other counties or cases, the person who is terminated from Medi-Cal is automatically defaulted into the IHSS Residual program until the county worker updates their case. This means that a recipient's IHSS provider can continue to receive payments on time, but that the state General Fund is responsible for all costs and cannot draw down federal funds unless the person is reenrolled in Medi-Cal, even retroactively. There is no statutory limit on how long an IHSS recipient may remain in the IHSS Residual program.

The Governor's proposal would automate the process for IHSS termination when any individual is terminated from Medi-Cal. This means that people who are discontinued from Medi-Cal (for example, due to no longer being eligible or not completing redetermination paperwork), will be automatically disenrolled from IHSS. IHSS recipients would then have 90 days to reinstate Medi-Cal. Upon reinstatement of Medi-Cal, the person's provider would be paid for all hours worked during that time period, and the state would be able to draw down federal funds for those hours.

Estimate assumes all individuals would regain eligibility and maintain services. The Administration assumes that all individuals who may be enrolled in the IHSS Residual program pursuant to current practices would regain Medi-Cal eligibility. Therefore, the Administration's estimate of \$86 million in General Fund savings does not reflect a loss of actual IHSS services. Rather, this estimate represents the amount of federal funds that could be recouped when IHSS recipients temporarily lose Medi-Cal eligibility and then regain eligibility without being enrolled into the state-only IHSS Residual program as part of this process.

The Administration estimates that the total number of IHSS recipients who would experience a gap in IHSS eligibility due to Medi-Cal termination is 10,396 in 2026-27. The Administration assumes that all of these individuals would regain Medi-Cal eligibility and receive retroactive funding for IHSS services under this proposal. According to CDSS, historical program data show that over 90 percent of IHSS recipients who become ineligible for IHSS due to Medi-Cal termination are reinstated. It takes an average of 28 days for a case that has defaulted into the IHSS Residual program to revert to a federally eligible Medi-Cal status.

⁹ LAO.

Stakeholder concerns and alternatives. Several stakeholders including labor unions representing IHSS workers and counties oppose this proposal. Many organizations have also pointed out that when IHSS recipients receive a Medi-Cal termination notice, that notice does not explicitly connect the termination of Medi-Cal to the loss of IHSS services. Recipients may not understand that that eligibility for IHSS is directly tied to their Medi-Cal eligibility and that termination from Medi-Cal means termination of IHSS services. The LAO has suggested alternatives to this proposal, including better communication to recipients to provide clear written notice that any loss of Medi-Cal eligibility could result in a loss of IHSS services. Justice in Aging and the National Health Law Program as well as UDW and SEIU California have similarly suggested improving the connection between IHSS and Medi-Cal in notices to recipients as well as other changes such as maximizing access to aid paid pending an appeal and adding assistance with reading mail as an IHSS service.

Other alternatives raised by the LAO include providing administrative funding to prevent Medi-Cal disenrollments in the first place; excluding certain populations from automatic termination; and allowing for a standardized grace period for individuals to default into the IHSS Residual program pending Medi-Cal reinstatement.

Lastly, the LAO notes that due to H.R. 1, about 42,000 average monthly IHSS cases will have to renew Medi-Cal eligibility every six months instead of every 12 months due to H.R. 1.¹⁰ This has the potential to expand the population of IHSS recipients who may temporarily lose and regain Medi-Cal eligibility every year and who could be affected by this proposal.

2025 Budget Act. The 2025 Budget Act included the following significant changes to the IHSS program:

- **Reinstatement of the Medi-Cal Asset Limit.** The IHSS budget conformed to the action under the Department of Health Care Services to reinstate the prior Medi-Cal asset limit of \$130,000 for individuals and \$65,000 for each additional household member. This results in estimated savings for IHSS of \$16 million General Fund in 2025-26, \$220.3 million General Fund in 2026-27, and \$317.2 million General Fund in 2027-28.
- **Community First Choice Option (CFCO) Late Penalties.** The budget requires counties to share 50 percent of penalty costs related to late reassessments for Community First Choice Option IHSS cases in 2025-26, resulting in savings of \$40.5 million General Fund. In 2026-27, the budget passes 100 percent of late penalties on to counties, resulting in estimated savings of \$81 million General Fund in 2025-26, \$87.4 million in 2026-27, \$94.4 million in 2027-28, and \$101.8 million in 2028-29. This reduction included corresponding trailer bill language.
- **IHSS Collective Bargaining and Overtime.** Trailer bill language made multiple changes related to IHSS program providers, including streamlining the process toward reaching collective bargaining agreements, codifying into state law overtime payment requirements required by federal law, and permitting alternatives to avoid disruption of payroll and deduction processing for the payoff of IHSS provider wages. These changes were included in the Labor trailer bill, SB 156 (Committee on Budget and Fiscal Review), Chapter 110, Statutes of 2025.

¹⁰ LAO.

Outcomes of CFCO penalty share. As a result of the 2025 Budget Act requirement that counties pay for 50 percent of penalty costs associated with late reassessments for CFCO cases, CDSS reports that the number of late reassessments has declined significantly. Statewide, the number of overdue CFCO reassessments has declined from over 30,000 per month to less than 5,000 per month since the penalty was introduced. CDSS is working with specific counties that have a high percentage of overdue reassessments on training and caseload management to help those counties avoid penalties.

Counties state that the CFCO penalty structure is exacerbating applications backlogs and county understaffing issues, as the prioritization of CFCO reassessments to avoid penalties has come at the expense of processing of new applications. According to CWDA, “the latest data from CDSS shows the number of late applications processed has grown from over 1,600 applications in July 2025 to over 4,600 applications as of December 2025.” Counties also estimate that due to the significant progress in timely processing of CFCO reassessments, the actual General Fund costs associated with any penalties incurred will be much lower than expected. CWDA is requesting to maintain the 50 percent state/county CFCO penalty share in 2026-27, rather than moving to a 100 percent county share. (See Issue #13 for a stakeholder proposal on this topic).

Subcommittee Staff Comment and Recommendation – Hold Open. The Senate budget plan proposes rejecting the three cuts to IHSS proposed in the Governor’s budget.

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

1. Please provide an overview of the Governor’s proposed budget for IHSS in 2026-27, including a summary of caseload and caseload growth. What are the outcomes of the CFCO penalty structure share enacted in the 2025 Budget Act and are those outcomes coming at the expense of timely application processing for new IHSS applicants?
2. **Shift costs associated with growth in IHSS average hours per case to counties.** Please describe this proposal and address the questions below before the Subcommittee moves to the other panelists.
 - a. What is the goal of this proposal and how did the Administration estimate the associated General Fund savings?
 - b. How does making counties pay a share of the overall costs associated with any growth in hours based on their caseloads achieve the Administration’s stated goal of improving assessment accuracy?
 - c. What evidence is available that the steady growth in average hours per case is a result of county assessment practices rather than other factors such as demographic shifts?
 - d. How does the Administration expect that counties would behave if this proposal were to take effect? For example, does the Administration expect that hours per case would decline on average?
3. **Eliminate the IHSS Back-up Provider System** Please describe this proposal and address the questions below before the Subcommittee moves to the other panelists.
 - a. What is the goal of this proposal and how did the Administration estimate the associated General Fund savings?
 - b. From a consumer perspective, how does the IHSS Back-up Provider System function today? What program features may drive lower than expected utilization?

- c. What does the Administration anticipate will be the outcomes of eliminating this system? If eliminated, what options would IHSS consumers have when their caregiver is temporarily unavailable?

- 4. **Proposal to align IHSS termination with Medi-Cal termination.** Please describe this proposal and address the questions below before the Subcommittee moves to the other panelists.
 - a. What is the goal of this proposal and how did the Administration estimate the associated General Fund savings?
 - b. What does the Administration anticipate will be the outcomes of automating IHSS termination with Medi-Cal termination?

Issue 2: IHSS For-Profit Organization Policy

Trailer Bill Language – Governor’s Budget. The Governor’s budget proposes trailer bill language to define rules for for-profit organizations that represent IHSS applicants and recipients in administrative hearings. These rules include establishing a maximum fee IHSS recipients and applicants can be charged and permitting the state to suspend and penalize for-profit organizations for malpractice.

Background. IHSS applicants and recipients have the right to request an administrative hearing if they disagree with an adverse action, including a denial, a termination, or a reduction in hours, and to representation by an advocate or an attorney during the appeal and hearing process. IHSS recipients are also able to assign an individual, which could include an advocate or an attorney, to be their Authorized Representative for the purpose of acting on the behalf of the IHSS recipient to assist in the management of program services.

CDSS understands that both non-profit and for-profit non-attorney advocates can represent IHSS applicants and recipients. However, CDSS has found that many for-profit organizations are charging IHSS applicants and recipients upwards of \$10,000-\$20,000, sometimes more, to represent them. Unlike licensed attorneys, these for-profit advocates do not have any guardrails ensuring their ethical behavior and there are no legal protections for IHSS applicants and beneficiaries in these circumstances.

Proposed trailer bill language. The proposed trailer bill language includes the following:

- Establishes that a for-profit organization acting as an authorized representative for an IHSS applicant or recipient has a fiduciary relationship with the individual and is subject to relevant requirements governing fiduciary relationships, such as the duty to act in the best interest of the applicant or recipient.
- Limits fees that a for-profit organization may charge to 10 percent of the total past-due benefits or \$500, whichever is more, not to exceed \$2,500.
- Prohibits a for-profit organization from sharing or receiving any fees directly or indirectly paid to a licensed attorney.
- Prohibits a for-profit organization from charging a fee for any purpose other than representing an individual in an administrative hearing.
- Requires CDSS to develop a standard form for use by for-profit organizations that includes specified information, including contact information, fee information, and a disclosure that the person is not an attorney. Requires the for-profit organization and the individual sign this form.
- Requires the for-profit organization to disclose certain information to the county, such as if the for-profit organization provided a referral for or issued a medical opinion.
- Prohibits for-profit organizations from accepting referral fees from medical or vocational professionals on matters related to the individuals’ IHSS eligibility.

- Establishes a standard of conduct that for-profit organizations must comply with when acting as a person's authorized representative. These standards include being forthright and professional; cooperating with the county; maintaining prompt communication; not threatening, coercing, or misleading the individual; and not acting independently of the individual.
- Permits CDSS to suspend (for up to one year) or disqualify (for up to 10 years) a for-profit organization from acting as an authorized representative in any capacity for any individual if they violate these standards.
- Allows CDSS or a county to refer any suspected fraud involving the provision of IHSS to the Department of Health Care Services Audits and Investigations for further investigation.
- Requires CDSS to develop educational materials to assist applicants and recipients in identifying no-cost advocacy resources to assist with IHSS program navigation.

According to CDSS, these changes will help ensure IHSS applicants and recipients are protected when they decide to hire a for-profit advocate to represent them in IHSS administrative appeal processes. CDSS states that the proposal mirrors similar federal rules that were implemented by the Social Security Administration for Supplemental Security Income to address unethical activities.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.
2. What is the extent of the problem that this proposal intends to address?

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES**Issue 3: Department of Developmental Services Budget Overview**

Department of Developmental Services – Governor’s Budget. The Governor’s budget includes \$21.1 billion (\$13.5 billion General Fund) for the Department of Developmental Services (DDS) in 2026-27, a net increase of \$2.42 billion (13 percent) over the updated 2025-26 budget. The majority of the DDS budget, \$20.6 billion (\$13 billion General Fund) consists of the Community Services Program, or regional center budget, which includes services paid by regional centers to service providers on behalf of each person with intellectual or developmental disabilities (I/DD), known as purchase of services. The remaining components of the DDS budget include state-operated facilities at \$293 million (\$263 million General Fund) and DDS headquarters at \$183 million (\$118 million General Fund). California uses the Home- and Community-Based Services (HCBS) Waiver to receive federal reimbursement for most regional center services (\$7.4 billion federal reimbursements in 2026-27). The Governor’s budget projects a caseload of 526,848 individuals, about a 7.6 percent increase from the revised 2025-26 caseload. The Governor’s budget includes the following significant budget adjustments for DDS in 2026-27:

- Proposals to fund the Life Outcomes Improvement System (LOIS) and a new federally compliant grievance process, covered in issues #5 and #9 of this agenda.
- The transfer of 70 positions and associated dollars within DDS to support department-wide operations and address programmatic needs, including autism and employment services.
- A decrease of \$8.1 million General Fund, reflecting the cold shutdown of Fairview Developmental Center while the property’s disposition process continues.

Background: Department of Developmental Services. DDS is responsible for administering the Lanterman Developmental Disabilities Services Act (Lanterman Act). Under the Lanterman Act, individuals with I/DD are entitled to an array of services and supports sufficiently complete to meet their individual needs and choices, regardless of age or degree of disability, and at each stage of life. Additionally, the Early Start Program provides for the delivery of services to infants and toddlers at risk of a developmental disability. Services provided to Californians with I/DD under the Lanterman Act are provided at no cost to individuals with qualifying disabilities regardless of income.

DDS carries out its responsibilities through contracts with 21 community-based non-profits known as regional centers, as well as through state-operated homes and facilities. Regional centers are fixed points of contacts for all individuals with I/DD. The regional centers coordinate services for each individual with I/DD through an Individual Program Plan (IPP), and work with local service providers to purchase services and supports to carry out the IPP.

Major DDS programs include the following:

- **Early Start Caseload.** The Early Start program is California’s early intervention program for infants and toddlers ages 0-3 with developmental delays who are at risk of having a developmental disability. The 2026-27 Governor’s Budget projects an Early Start caseload of 56,073. Early Start services are coordinated through regional centers.

- **Lanterman Act Caseload.** Californians with I/DD ages three and over receive services through the general Lanterman Act program. Under the Lanterman Act, services are an entitlement for all Californians with I/DD. Regional centers coordinate services according to an individual's IPP, and those services are delivered by service providers, known as vendors. Common services and supports include: supported living services, housing/residential services, independent living services, respite, personal assistance, employment services, transportation, adult day programs, and others. Total Lanterman Act caseload projected in the 2026-27 Governor's budget is 452,615 individuals; plus an additional 18,160 children ages 3-4 who have been determined provisionally eligible for regional center services.
- **Self-Determination Program.** The Self-Determination Program is a voluntary program for Californians receiving Lanterman Act services. In the Self-Determination program, the individual with I/DD and their planning team create a spending plan that allows them to purchase services and supports from organizations or individuals of their choice, instead of receiving services only through vendors contracted with the regional center, under certain conditions. The Governor's budget projects an average monthly caseload of 11,526 individuals enrolled in the Self-Determination Program in 2026-27.
- **State-Operated Facilities.** In the last decade, the state largely closed down the remaining Developmental Centers, large institutional settings that previously housed thousands of Californians with I/DD. Today, only one Developmental Center is still in operation: Porterville Developmental Center in Tulare County, a secure facility which houses individuals who have been found incompetent to stand trial due to I/DD or are determined by a court to be dangerous to themselves or others and have been civilly committed to the facility. Fairview Developmental Center in Orange County is in cold shutdown pending long-term planning and no longer houses any individuals. DDS also operates a 55-bed Intermediate Care Facility known as Canyon Springs, which largely serves as crisis stabilization for individuals stepping down from other highly restrictive settings like Porterville Developmental Center. DDS also directly operates seven small specialized residential homes across the state for individuals in acute crisis, known as STAR Homes. The 2023 Budget Act approved the development of three new residential homes, similar to STAR homes, on Fairview property. The 2026-27 Governor's budget supports capacity for 302 individuals in state-operated facilities.

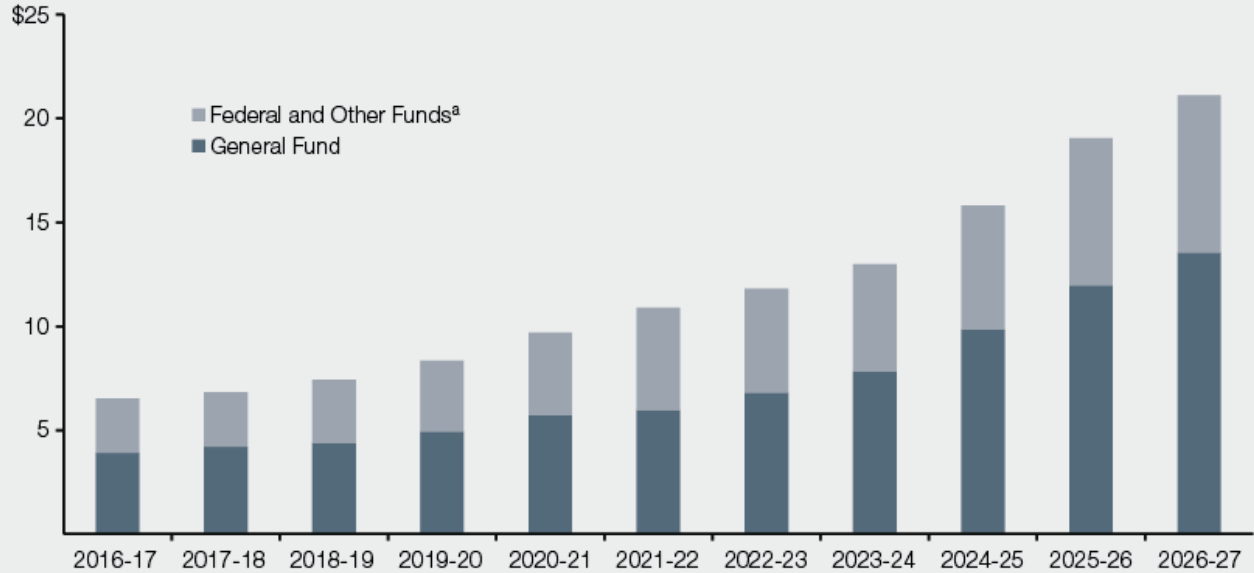
Budget Growth. The DDS budget continues to experience significant year-over-year growth, with the 2026-27 Governor's proposed budget projecting a nearly 13 percent increase from the revised 2025-26 budget. According to the LAO, there are four main drivers of year-over-year cost growth in the DDS budget: caseload, available services, utilization of services, and rates paid for services.¹¹ The LAO also notes that because the Lanterman Act creates an entitlement to services for all Californians with I/DD, "the Legislature generally has relatively limited discretion to control spending growth by adjusting caseload or utilization."¹²

¹¹ LAO, "[The 2026-27 Budget: Department of Developmental Services.](#)" March 13, 2026.

¹² LAO.

Figure 1

Department of Developmental Services Spending Continues to Grow Rapidly
(In Billions)



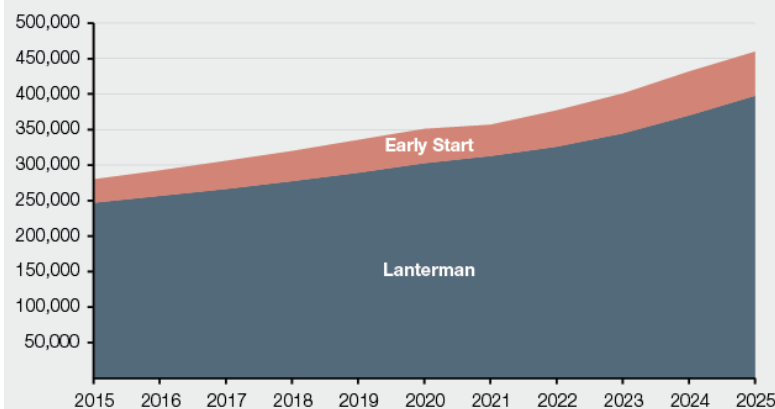
^a The bulk is federal Medicaid funding, with minor other federal and state special funds.
Note: 2024-25 and 2025-26 amounts are estimated; 2026-27 amounts are proposed.

LAOA

Caseload has increased significantly over the last ten years, with the LAO finding an average annual caseload growth rate of about five percent from 2015-2025.¹³ This is largely driven by increasing diagnoses of qualifying I/DD.

Figure 2

DDS Caseload Has Increased Steadily



Note: Values represent point in time caseload totals from January of each year, rather than annual averages.
Early Start reflects birth through 35 months. Lanterman reflects ages three and older. Data do not include Provisional Eligibility.

LAOA

¹³ LAO.

In particular, DDS has noted an increase in the share of autism and a decrease in diagnoses of intellectual disability. The share of individuals in the DDS caseload diagnosed with autism increased from about 30 percent in 2016-17 to about 40 percent in 2024-25, a trend not unique to California. Other drivers include a growth in the infant and toddler Early Start population (which has experienced annual growth of about 6.5 percent from 2015 to 2025), as outreach and access to diagnostic screenings have improved over time. Longer lifespans for people with I/DD is also a contributing factor. For a comprehensive analysis of the cost drivers of the DDS budget, including caseload, rates for services, and utilization, see the LAO analysis.¹⁴ A summary of the Governor’s proposed 2026-27 budget for DDS is below.

Program Highlights
(Dollars in Thousands)

| | FY 2025-26 | FY 2026-27 | Difference |
|---|---------------------|---------------------|--------------------|
| Community Services Program | | | |
| Regional Centers | \$18,196,079 | \$20,632,003 | \$2,435,924 |
| Total, Community Services | \$18,196,079 | \$20,632,003 | \$2,435,924 |
| General Fund | \$11,546,678 | \$13,154,785 | \$1,608,107 |
| Program Development Fund | \$434 | \$0 | (\$434) |
| Developmental Disabilities Services Account | \$150 | \$150 | \$0 |
| Federal Trust Fund | \$55,482 | \$55,399 | (\$83) |
| Reimbursements | \$6,592,595 | \$7,420,929 | \$828,334 |
| Behavioral Health Services Fund | \$740 | \$740 | \$0 |
| State Operated Services | | | |
| Personal Services | \$262,685 | \$244,015 | (\$18,670) |
| Operating Expense & Equipment | \$41,920 | \$49,267 | \$7,347 |
| Total, State Operated Services | \$304,605 | \$293,282 | (\$11,323) |
| General Fund | \$274,363 | \$263,784 | (\$10,579) |
| Lottery Education Fund | \$141 | \$141 | \$0 |
| Reimbursements | \$30,101 | \$29,357 | (\$744) |
| Headquarters Support | | | |
| Personal Services | \$132,934 | \$140,097 | \$7,163 |
| Operating Expense & Equipment | \$41,235 | \$43,143 | \$1,908 |
| Total, Headquarters Support | \$174,169 | \$183,240 | \$9,071 |
| General Fund | \$111,277 | \$118,365 | \$7,088 |
| Federal Trust Fund | \$4,116 | \$4,167 | \$51 |
| Program Development Fund | \$461 | \$461 | \$0 |
| Reimbursements | \$57,799 | \$59,731 | \$1,932 |
| Behavioral Health Services Fund | \$516 | \$516 | \$0 |
| Total, All Programs | \$18,674,853 | \$21,108,525 | \$2,433,672 |
| Total Funding | | | |
| General Fund | \$11,932,318 | \$13,536,934 | \$1,604,616 |
| Federal Trust Fund | \$59,598 | \$59,566 | (\$32) |
| Lottery Education Fund | \$141 | \$141 | \$0 |
| Program Development Fund | \$895 | \$461 | (\$434) |
| Developmental Disabilities Services Account | \$150 | \$150 | \$0 |
| Reimbursements | \$6,680,495 | \$7,510,017 | \$829,522 |
| Behavioral Health Services Fund | \$1,256 | \$1,256 | \$0 |
| Total, All Funds | \$18,674,853 | \$21,108,525 | \$2,433,672 |
| Caseloads | | | |
| State Operated Services | 302 | 302 | 0 |
| Regional Centers | 489,254 | 526,848 | 37,594 |
| Departmental Positions | | | |
| State Operated Services | 1,753.7 | 1,715.1 | (38.6) |
| Headquarters | 810.0 | 824.0 | 14.0 |

¹⁴ LAO, “The 2026-27 Budget: Department of Developmental Services,” March 13, 2026.

Service Provider Rate Reform Implementation. In 2016, the Legislature required a rate study to address the sustainability, quality, and transparency of community-based services for individuals with I/DD. Beginning in the 2021 Budget Act, the Governor and Legislature initiated a multi-year plan to phase in rate reform, with an annual cost of \$1.8 billion (\$1.1 billion General Fund) at full implementation. The final phase of rate reform was implemented on January 1, 2025. See Issue #8 for an update on rate reform and the Quality Incentive Program.

Update on Direct Support Professional (DSP) workforce initiatives. In addition to initiating service provider rate reform, the 2021 and 2022 Budget Acts included various programs designed to address challenges in recruiting and retaining regional center service coordinators and direct support professionals (DSPs). This includes the DSP University program, a training and certification program tied to wage differentials, and bilingual pay differentials. Both of these programs are tied to wage differentials, with the goals of stabilizing service access and diversifying and professionalizing the DSP workforce. The DSP University program launched on March 30, 2026. For the bilingual pay differential, DDS anticipates a launch in late summer across all 21 regional centers.

SB 138: Legislative Equity and Oversight Measures. SB 138 (Committee on Budget and Fiscal Review), Chapter 192, Statutes of 2023, included several changes to improve consistency, equity, and oversight in the regional center system. These changes were in response to longstanding issues raised by stakeholders and families regarding inequities in access to services across geographic, ethnic, and language lines. Key components of SB 138 included a standardized process for several important processes including IPP development, respite assessments, vendorization, and regional center intake. SB 138 also required DDS to define and develop options to improve the coordination of generic services, recommend ways to address inconsistent service availability across the state, and to standardize and improve various data reporting, especially around intake.

Update on SB 138 Implementation. DDS has made progress implementing many of the SB 138 requirements, and continues to work towards the various milestones outlined in SB 138:

- *Standard IPP Template:* DDS worked with stakeholders to establish a standardized IPP template and procedures by June 30, 2024, which Regional Centers phased in January 1, 2025. The new IPP template has also been integrated within DDS's current case management system.
- *Generic services:* DDS is working with other departments and stakeholders to better understand how various generic services are funded and delivered and to identify options to improve access to those services.
- *Standard Respite Assessment:* DDS developed a new tool for assessing individual needs for respite services and recently conducted a testing period for that tool (testing ended April 30). DDS will then analyze the data and preliminary feedback.
- *Standard Intake Process:* DDS is behind the January 2025 milestone to establish a standard intake process, given the complexity and variation in existing intake processes across regional centers. DDS is meeting regularly with regional center intake staff and clinicians to understand current intake processes and is working on improving data quality on intake timelines.

- *Standard Vendorization*: DDS is phasing in a standard vendorization process with new service providers who enroll in the Provider Directory.

2025 Budget Act. The 2025 Budget Act included reductions to DDS in order to address the deficit, and made other various changes, including the following:

- **Quality Incentive Program Eligibility.** The 2025 Budget Act included a reduction of \$221.7 million General Fund in 2026-27 and ongoing as a result of expanded requirements developmental services providers must meet in order to qualify for the Quality Incentive Program, which comprises up to 10 percent of a provider's full rate. These requirements are compliance with Electronic Visit Verification, Home and Community-Based Services rules, and independent audit and fiscal reviews.
- **Service Provider Rate Reform Hold Harmless.** The 2025 Budget Act included a reduction of \$75 million General Fund in 2025-26 and corresponding trailer bill language to end the DDS service provider rate reform hold harmless policy as of February 28, 2026 instead of June 30, 2026.
- **Self-Determination Program.** The 2025 Budget Act included a reduction of \$22.5 million General Fund in 2025-26 and \$45.5 million General Fund ongoing to the DDS Self-Determination Program, corresponding to a number of program changes in trailer bill language. Trailer bill language requires DDS to reduce barriers to participation and improve equity in enrollment by establishing, with community input, no later than March 1, 2027, statewide standardized processes and procedures for the Self-Determination Program. Trailer bill language additionally established parameters around individual budgets in the program, the certification of participant spending plans, and other program components.
- **Life Outcomes Improvement System (LOIS).** The 2025 Budget Act included an increase of \$13.3 million (\$5.1 million General Fund) for the extension of 17 limited-term positions at DDS, regional center resources, and consulting services to continue the planning phase of the LOIS project, which will modernize the department's fiscal and case management systems into a single integrated solution.
- **Porterville Developmental Center.** The 2025 Budget Act included a reduction of \$25 million General Fund in 2025-26 and \$16 million General Fund in 2026-27 and ongoing to align the budget to recent expenditure trends at Porterville Developmental Center.
- **Public Records Act (AB 1147).** The 2025 Budget Act included \$10.7 million (\$7.6 million General Fund) in 2025-26 and \$14.3 million (\$10.2 million General Fund) in 2026-27 and ongoing for four permanent headquarters positions and regional center resources (approximately four positions per regional center) to address the new workload associated with AB 1147 (Addis), Chapter 902, Statutes of 2024.

H.R. 1 impacts and considerations for the DDS caseload. Federal Medicaid funding for home-and community-based services (HCBS) provided to individuals enrolled in Medi-Cal is a primary component of how DDS services are funded. According to the LAO, federal HCBS funding has historically supported

about 35 to 45 percent of total costs in DDS.¹⁵ Many individuals with I/DD also rely on Medi-Cal for health coverage outside of regional center HCBS services. DDS estimates that about 15,000 adults with I/DD in the regional center system are part of the Affordable Care Act expansion population that are newly subject to the new H.R. 1 Medi-Cal requirements: (1) the 80-hour per month work verification requirement and (2) the requirement to renew eligibility every six months. The Administration has stated that individuals in the DDS system will qualify for a disability-related exemption to these requirements, and that DDS is working with the Department of Health Care Services and CDSS to streamline automatic exemptions for these 15,000 individuals and their family caregivers by using existing data sources. However, as the LAO notes, the degree to which these exemptions are seamlessly granted without excessive paperwork burdens depends on the Administration's approach and the success of data matching efforts.¹⁶

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide a brief overview of the department's proposed 2026-27 budget and caseload.
2. Please provide a brief update on the department's progress and work ahead to implement equity and consistency changes included in the 2023 Budget Act under SB 138, including the standard respite assessment, standard intake procedures, and improving coordination of generic services.
3. Please provide an update on the department's efforts together with the Department of Health Care Services and CDSS to maximize exemptions allowable under H.R. 1 for CalFresh and Medi-Cal enrollees with I/DD to maintain access to food and health care benefits.

¹⁵ LAO.

¹⁶ LAO.

Issue 4: Regional Center Oversight

Panel Discussion. The Subcommittee has invited the following individuals to participate in a panel discussion on this issue:

- Pete Cervinka, Director, Department of Developmental Services
- Judy Mark, President, Disability Voices United
- Amy Westling, Executive Director, Association of Regional Center Agencies
- Omar Sanchez, Finance Budget Analyst, Department of Finance
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst’s Office

Trailer Bill Language – Governor’s Budget. The Governor’s Budget proposes trailer bill language that would make several changes to regional center governance, performance measures, and vendor requirements. There are four primary components to this proposal:

1. Regional center board governance: changes governing board composition and professional and other standards that regional center boards are required to meet.
2. Fiscal allocation letter authority: streamlines the ways in which DDS adjusts contracts with regional centers.
3. Regional center performance: consolidates various performance measures and contracts between regional centers and the state and modifies accountability measures.
4. Vendor requirements: adds flexibilities for vendors by eliminating courtesy vendorization and removing physical location requirements.

Background.

Regional center board governance. DDS is responsible for contracting with and overseeing 21 non-profit regional centers. Each regional center has a board of directors, responsible for complying with the contract, overseeing the regional center and hiring its executive director, and other governance obligations pursuant to state and federal law. Many regional centers are responsible for serving their local communities with annual budgets approaching or exceeding \$1 billion and employ hundreds of employees.

Existing law requires the membership of the governing board of a regional center to include persons with legal, management or board governance, financial, and developmental disability program expertise. Existing law also requires that a minimum of 50 percent of the members of the governing board be people with I/DD or their parents or legal guardians, with at least half of this proportion being individuals with I/DD. Existing law allows, but does not require, regional center boards to appoint a consumers’ advisory committee composed of individuals with developmental disabilities. Regional center boards are required to review and approve any regional center contract of \$250,000 or more.

Fiscal allocations to regional centers. At the start of each fiscal year, DDS issues an initial contract to each regional center to provide essential funding allocations and advance funds, along with operational and programmatic terms and conditions. These contracts are approved by the Department of General Services (DGS). Funding allocations for regional center operations and services are issued periodically through contract amendments, based on factors such as actual and projected expenditures, caseload

changes, and increases in costs or service rates. These amendments currently require approval by DGS, execution by DDS, and formal action by each regional center’s board of directors.

Regional center performance. In addition to the initial contract between DDS and each regional center that is approved by DGS, existing law requires a separate regional center performance contract, developed with public input and other specific requirements. Separately, existing law establishes Regional Center Performance Measures, which include standard performance improvement indicators and benchmarks for regional centers, developed by specified stakeholders. DDS notes significant overlap across these three requirements.

Vendor requirements. SB 138 (Committee on Budget and Fiscal Review), Chapter 192, Statutes of 2023 required the establishment of a standardized vendorization process for service providers to become approved to deliver services. The standardized vendorization process was launched in December 2025 through the Provider Directory and is required to be used for almost all services starting March 1, 2026.

While current practice permits a vendor to use their vendor number across any of the 21 regional centers, some regional centers may require the vendor to have a physical office location within each regional center as a condition of approval to offer services. Some regional centers use a process known as “courtesy vendorization” to allow a service provider who is vendorized by a different regional center to provide services to individuals in their service area.

Proposed trailer bill language. The Governor’s Budget proposes trailer bill language that would make the following changes across each area:

Regional center board governance. Requires regional center boards to conform to the following criteria by July 1, 2027:

- Requires regional center boards to be composed of 10-15 members.
- Recasts the requirements for the board as a whole to possess expertise across the following domains:
 - Legal, evidenced by at least two years experience in the practice of law.
 - Management, evidenced by at least two years experience in managing supervisors.
 - Board governance, evidenced by at least one year of experience serving on a non-regional center entity.
 - Fiscal or financial, evidenced by at least two years of work experience in fiscal or financial subjects.
 - Developmental disability programs, evidenced by at least one year of paid or unpaid policy advocacy work or at least three years of service or program administration, beyond personal or family lived experience with a developmental disability.
- Requires the governing board to reflect the “disability” characteristics of the area, in addition to the geographic and ethnic characteristics.
- Strikes the requirement that at least 50 percent of board members be individuals with I/DD or their parents/guardians, and instead requires the board to encourage persons with intellectual or developmental disabilities and their parents, legal guardians, or family members to become members of the governing board and its committees.

- Requires all members of the governing board, prior to assuming their role and annually thereafter, to complete trainings provided by DDS. Requires these training topics to include a variety of specified topics on board management and operations, such as fiduciary responsibilities, conflicts of interest, and legal requirements.
- Makes it mandatory for all regional center governing boards to appoint a consumers' advisory committee, and requires the committee to designate two of its members to serve on the governing board as full voting members.
- Specifies the metrics by which the governing board must review the performance of the regional center executive director. Metrics include, but are not limited to, compliance with contract objectives, compliance with required audits, and clean annual independent fiscal audits.
- Increases the dollar threshold for contracts that the governing board must review from \$250,000 to \$350,000 until July 1, 2030, and then increases the amount to \$450,000 and allows for increases in \$50,000 increments every five years.
- Requires each regional center governing board to retain an attorney and prohibits this attorney from being an employee of the regional center.

According to DDS, these changes will professionalize and support regional center governing boards in their oversight of operations and funding.

Fiscal allocations to regional centers. Allows DDS to issue and adjust funding allocations to regional centers, at the department's discretion, by letter, contract, or contract amendment, consistent with funding appropriated in the annual Budget Act. Exempts allocations and adjustments made in this manner from public contracting requirements and the DGS approval process.

According to DDS, providing timely allocations based upon appropriations would increase efficiency, improve fiscal estimation and uncertainty, and improve flexibility to meet emerging needs.

Regional center performance. Requires DDS-approved performance measures and benchmarks developed via the existing Regional Center Performance Measures requirement to be incorporated into regional center contracts, with the goal of standardizing outcomes measures and benchmarks that incentivize high-quality regional center operations. Requires DDS to consider the availability of regional center operations funding when establishing these measures. Additionally, in the case that a regional center is on probationary status and a corrective action includes mandated consultation with a contractor, removes the requirement that the contractor be designated by DDS. In the case that a regional center contract is terminated, modifies the requirement that DDS directly operate the regional center in any interim period to also allow DDS to operate the regional center through a contract.

Vendor requirements. Effective January 1, 2027, states that a vendor shall not be required to maintain a physical location within a regional center's service area unless a physical location is required for the delivery of services, including but not limited to a licensed residential facility. No later than March 1, 2028, requires DDS to end the practice and processes known as "courtesy vendorization." Thereafter, service providers seeking to provide services through authorizations from more than one regional center would not be required to seek vendorization from regional center beyond their initially vendorizing regional center. Requires service providers to give preference to providing services to individuals served by the initially vendorizing regional center.

According to DDS, with the vendorization process now standardized and digitized through the Provider Directory, there is consistency across regional centers for all new vendorizations. Regional centers can access vendor information and provider documents from other regional centers, eliminating the need for redundant approvals. Additionally, many services can be delivered without a physical office location, which can be a costly barrier for service providers looking to start or expand services.

Stakeholder opposition. Several organizations have expressed opposition to some components of this proposed trailer bill. Disability Voices United, Disability Rights California, the Arc California, the Association of Regional Center Agencies (ARCA), and Integrated Community Collaborative oppose the removal of the requirement that at least 50 percent of regional center governing boards be individuals with I/DD and their parents/guardians. These organizations point out that the involvement and direction of individuals with disabilities and their family members in the regional center system is a foundational element of the Lanterman Act.

Other areas of concern expressed by stakeholders about the regional center governance provisions of this proposal include the 10-15 person limit on regional center governing boards and overly stringent professional requirements. Stakeholders including Disability Voices United and Disability Rights California also have suggestions around training requirements and support for members of the governing boards to ensure all members are able to meaningfully participate in board meetings.

ARCA also has suggestions around the requirement to end courtesy vendorization, noting that regional centers' responsibility to provide quality assurance and oversight of vendors should be contemplated as the state moves to provide this type of flexibility for service providers.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.
2. How does this proposal balance the need for increased professionalization of regional center governing boards with the foundational element of the Lanterman Act that regional center boards consist largely of individuals with developmental disabilities and their family members?
3. As DDS moves to standardize and streamline vendorization by removing the courtesy vendorization process and the requirement that a service provider have a physical location in the service area, how will the department ensure that regional center responsibilities around the vetting, approval, and quality assurance and oversight of vendors are clearly defined and maintained?

Issue 5: Federal Access Rule

Panel Discussion. The Subcommittee has invited the following individuals to participate in a panel discussion on this issue:

- Michael McNulty, Branch Chief & Katie Hornberger Deputy Director, DDS
- Fernando Antonio Gomez, Parent Advocate & Founder, Integrated Community Collaborative
- Will Liener, Managing Attorney, Disability Rights California
- Omar Sanchez, Finance Budget Analyst, Department of Finance
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst's Office

Budget Change Proposal and Trailer Bill Language – Governor's Budget. The Governor's budget proposes \$2.4 million (\$2.1 million General Fund) and nine permanent positions in 2026-27 and ongoing to support the increased workload related to compliance with the new federal Home and Community-Based Services (HCBS) Access Rule requirements. This request is to make permanent the temporary resources that were approved in 2025-26. This issue includes corresponding trailer bill language to create a new grievance process to comply with the new HCBS Access Rule. The proposed trailer bill language will create a new federally compliant grievance process that also incorporates existing state requirements and processes around individual rights and complaints.

Background – HCBS Access Rule. In April 2024, the federal Centers for Medicare and Medicaid Services released the HCBS Access Rule to advance access to care, quality of care, and improve health outcomes for Medicaid, including HCBS programs. The Access Rule requires states to establish a new grievance process for individuals who believe their IPP was not developed in a person-centered way, that their services are not delivered in a person-centered way, or that their residential setting is not compliant with the Access Rule.

The Access Rule mandates that states oversee a 90-day resolution process and provide a second-level review of a regional center's grievance resolution upon request of an affected individual. DDS currently has multiple complaint processes, but none of them meet the requirements necessary to comply with the new Access Rule.

Background – existing regional center complaint processes. Currently, Individual Rights complaints are submitted directly to regional centers or DDS State-Operated Facilities. Regional centers and state-operated facilities must respond to complaints within 20 working days. If a complainant is dissatisfied with the response, they can appeal to DDS within 15 working days. DDS then reviews the complaint and issues a response within 45 calendar days. Common topics of Individual Rights complaints include, but are not limited to:

- IPP development and implementation
- Service coordination
- Service providers
- Individual rights violations under the Lanterman Act
- Incorrect noticing
- Regional center compliance with response timelines

Approximately 20 percent of total complaints are appealed to DDS. According to DDS, insights into systemic issues are limited because DDS only has visibility into this 20 percent of complaints that are appealed. DDS also notes that the resolution to these complaints are often a commitment to train staff or take other actions that do not necessarily solve the specific individual problem that led to the complaint.

| Complaint Type | FY 22/23 | FY 23/24 | FY 24/25 |
|---|----------|----------|----------|
| Total Individual Rights Complaints filed with RC/SOFs | 346 | 437 | 485 |
| Total Individual Rights Appeals filed with the Department | 67 | 76 | 98 |

In addition to the existing Individual Rights complaint process, state law also includes a Citizen Complaint process which allows members of the general public to submit issues of concern to DDS. When DDS receives this type of complaint, the complaint is either referred to the regional center or addressed directly by DDS. There are no timeline or outcome requirements for these Citizen Complaints.

| Complaint Type | FY 22/23 | FY 23/24 | FY 24/25 |
|----------------------------|----------|----------|----------|
| Total Citizen's Complaints | 12 | 11 | 91* |

** 70 of these 91 complaints were from families supported by a single vendor that ceased services.*

There is a formal fair hearing process that relates to dissatisfaction with a determination of eligibility for regional center services under the Lanterman Act or the services that are authorized as a part of a person's IPP. That process was significantly overhauled as part of the 2022 Budget Act and is not subject to the changes included in this proposal.

Proposed trailer bill language. The proposed trailer bill creates a new grievance process that is federally compliant with the new federal HCBS Access Rule, and also subsumes the two existing DDS complaint processes into a single process. For reporting purposes and to maintain oversight of regional centers, the trailer bill proposes that grievances be filed with DDS and then transmitted to regional centers. Regional centers must address the grievances and record resolutions in a DDS database. DDS will monitor compliance, provide second-level review of resolutions, and use the database to identify the need for technical assistance or corrective action. Specifically, the proposed trailer bill:

- Beginning July 1, 2026, requires DDS to post specified information regarding provider compliance with the HCBS Final Rule on its website, and to update this information at least every six months.
- Sunsets the existing Individual Rights complaint process (also known as 4731 complaints) effective July 1, 2026.
- Creates a new single complaint resolution process that applies to grievances filed after July, 1 2026, described below.
- Allows a person who desires to file a grievance to submit the grievance to DDS online, orally, or in writing.
- Requires all consumers to be notified in writing of the right to submit a grievance.
- Requires DDS and regional centers to assist consumers with reasonable assistance in the procedural steps to file a grievance with DDS.

- Requires DDS to refer grievances to the associated regional center or state-operated facility.
- Requires the grievance to be reviewed within five days, with priority for review if there is an indication of serious harm.
- Prohibits retaliatory action against a person filing a grievance.
- Requires the regional center (or state-operated facility), to review the grievance and provide reasonable opportunity for the person to present evidence and arguments about the grievance.
- Provides that the person filing the grievance has a right to relevant information in their case file.
- Requires the regional center to review the grievance and send a resolution plan to the person, DDS, and a service provider, if applicable, within 60 days of the grievance being filed.
- Includes examples of a resolution, such as:
 - Convening the IPP team
 - Communication with the regional center
 - Completion of identified steps in the resolution plan
 - A statement of alleged noncompliance with HCBS settings rules
- Allows for an extension of the 60 days by up to 14 days at the request of the person or regional center, as specified.
- Allows a person who is not satisfied with the regional center's resolution plan to request a review by DDS within seven days of receiving the resolution plan. Allows this seven days to be extended based on good cause.
- Requires DDS to review the resolution plan within 21 days and notify the relevant parties of its determination.
- Requires DDS to annually review a sample of resolution plans for each regional center and state-operated facility.
- Requires DDS to annually post deidentified results of reviewed grievances and statewide data on grievances filed.
- Requires DDS to use the review process to identify operational or systemic problems within a regional center and address those problems.
- Requires DDS to convene stakeholders by August 1, 2027 regarding implementation of the new grievance process.
- Requires DDS to report to the Legislature on implementation of the new grievance process by December 1, 2027.

According to DDS, the proposal provides the department with an opportunity to enhance accessibility, oversight, transparency, and accountability over Individual Rights and Citizen complaints by incorporating them into the new federally mandated Access Rule grievance process. This integration will enable DDS to review all complaints, establish standardized timelines for these processes, and promote person-centered outcomes.

Resource Request. To implement the new federally compliant grievance process, DDS requests \$2.4 million (\$2.1 million General Fund) and nine permanent positions. This would make permanent temporary positions that were approved in the 2025 Budget Act.

DDS states that California will need to demonstrate compliance with the federal HCBS Access Rule regarding the handling of grievances. The state will also be subject to additional federal reporting requirements for certain quality measures, meet new website transparency requirements, and update

processes for the management of critical incidents. Between 2028 and 2030, DDS will need to begin reporting on the percentage of rates for specified services that are paid to direct service providers and ultimately demonstrate that direct service providers receive a minimum of 80 percent of the rate the state pays for specified services. In 2032, the state will be expected to be monitoring and reporting on all the quality measures required by the Centers for Medicare and Medicaid Services.

The 2025 Budget Act included one-year limited-term resources to begin to address the new federal grievance process requirements. This budget change proposal requests these resources be made permanent. DDS is using these positions and associated funding to plan for implementation of the new grievance process, including user-friendly automation of the filing process and reporting capabilities.

DDS will maximize federal financial participation that may be available for system development. DDS notes that compliance with the federal HCBS Access Rule is necessary to maintain federal matching funds through the Medicaid program, and that timely due process is a legal requirement for recipients of Medi-Cal services.

Federal government has since delayed enforcement of the access rule. In a February informational bulletin to states, the federal Centers for Medicare and Medicaid Services (CMS) announced a decision to “exercise enforcement discretion to provide additional time for states to come into compliance with...grievance system requirements.” This action does not delay the effective date that states are required to comply with the federal regulations, but states that CMS does not anticipate taking enforcement against states until December 31, 2027. This effectively provides states with more time to fully come into compliance.

Stakeholder concerns. Some stakeholders including the Integrated Community Collaborative and Disability Rights California have expressed concerns about this proposal. The stakeholders note that the existing 4731 grievance process does not function well, but express concern that the current proposal as drafted could fall short of achieving the meaningful resolutions and outcomes for consumers that the current process lacks.

Disability Rights California recommends several changes to the proposed trailer bill, including clarifying DDS’s front door responsibilities; strengthening notice, access to information, and anti-retaliation protections; requiring resolution plans to include an investigation summary; requiring consideration of compensatory services in some cases; making DDS review enforceable; and adjusting the timelines of 60 days for a regional center to issue a resolution plan and seven days for a person to request review.

Lastly, the Association of Regional Center Agencies (ARCA) states that they would support this proposal if the implementation date were extended to February 1, 2027 to allow greater time for regional center staff and community training, and if fiscal resources needed to carry out regional centers’ new responsibilities are included in the budget.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.

2. How will this proposed process ensure that resolutions of grievances are more actionable and specific relative to the typical outcomes of the current 4731 process? Please provide examples of how a grievance would be resolved differently under this proposal compared to the current process.

Issue 6: Remote Services

Panel Discussion. The Subcommittee has invited the following individuals to participate in a panel discussion on this issue:

- Ernie Cruz, Deputy Director, DDS
- Emmalynn Chaubard, Government Affairs Director, California Disability Services Association
- Aaron Carruthers, Executive Director, State Council on Developmental Disabilities
- Omar Sanchez, Finance Budget Analyst, Department of Finance
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst’s Office

Trailer Bill Language – Governor’s Budget. The Governor’s budget proposes trailer bill language to authorize the continued use of remote services as an option for specified services for individuals with I/DD served by regional centers. The proposal would codify the ability of individuals and families to select remote services when appropriate.

Background. During the COVID-19 Pandemic, DDS authorized certain services to be delivered remotely, including day programs, look-alike day programs, independent living services, behavior services, and clinical assessment services. Most recently, this authorization was extended via DDS guidance in through December 31, 2026.¹⁷ That guidance noted that “the department establishes this [December 31, 2026] deadline, and does not intent to further extend it, with the expectation that data and information (to be determined by the community including individuals and families, advocates, service providers, and regional centers) will be collected and shared to inform the establishment of statutory authorization for remote services, if any should continue, by the end of the current two-year legislative session.

DDS is currently working on a way to collect data relating to the volume, types, and reasons that individuals select remote services, and will be able to collect this type of data in the coming months through the provider billing process. Currently no data is available that speaks to the extent of services that are delivered remotely.

Proposed trailer bill language. The proposed trailer bill language establishes permanent authorization for developmental services to be delivered remotely, if the individual choses this option. Specifically, the proposed trailer bill:

- Allows individuals and families to choose to receive any of the below services remotely, if receiving those services or supports remotely would effectively meet the needs identified through the planning team process:
 - Day programs
 - Look-alike day programs
 - Independent living programs
 - Behavioral therapy services
 - Clinical assessment activities for Lanterman Act eligibility

¹⁷ DDS, [D-2025-Community Services Division-003, Remote Services – Day Programs and Independent Living Services](#), March 6, 2025.

- Any other services that could, as determined by DDS, appropriately address a need of a consumer identified in an individual program plan.
- Requires providers to document the number of remote services each individual receives on a monthly basis.
- Allows DDS to implement this policy through written directives until regulations are adopted, by October 31, 2029.

Stakeholder concerns. The State Council on Developmental Disabilities, along with many stakeholders, note that continuing some flexibilities learned during the pandemic are welcome. However, the State Council is concerned that “the proposed language widely opens the possibility of remote services for those that are better delivered in person. For example, there may be creative options for remote day program activities, however socialization is lost. Behavioral therapy and independent living programs would be fundamentally altered if solely virtual...we can imagine a scenario where in-person services are phase out, leaving no true option for individuals served and families.”

Subcommittee Staff Comment and Recommendation – Hold Open. The right of individuals with I/DD to have maximal choices over their services and their daily life is a foundational component of the Lanterman Act. Allowing individuals the option to receive services remotely was essential during the public health crisis and certainly has benefits beyond protecting populations from a pandemic. Remote services may be useful in improving individuals’ personal freedom and choice as well as addressing other health and safety risks, for example if a person is temporarily sick or injured or otherwise unable to leave their home safely.

However, the permanent and broad authorization for remote service delivery proposed in this trailer bill raises several questions. For example, what are best practices for high-quality, person-centered service delivery across the various types of services? Is remote delivery for clinical services, such as behavior therapy or clinical assessments to assess an individual’s disability status, in the best interest of individuals? Are there circumstances in which remote delivery could be ineffective or inappropriate? Should service providers be paid the same rate for remote services as for services that are delivered in-person? What long-term impacts could the availability of remote services have on access to in-person services? These are difficult questions to answer without statewide data on the current use of remote services.

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

1. Please provide an overview of this proposal.
2. What data does DDS plan to collect on the use of remote services and how will this data be used?
3. How would DDS maintain standards of quality and accountability with the delivery of remote services?

Issue 7: Regional Center Supported Living Services 40-Hour Work Week

Trailer Bill Language – Governor’s Budget. The Governor’s budget proposes trailer bill language to codify federal overtime requirements for hourly workers providing supported living services. This codifies the right to overtime compensation for all hours worked over 40 hours per workweek, and creates parity with similar language enacted in last year’s budget to codify overtime protections for IHSS workers.

Background. Federal regulations under the Fair Labor Standards Act (FLSA) establish that home care workers are subject to overtime compensation of 1.5 times an employee’s pay rate for hours worked over 40 hours per workweek. In July 2025, the U.S. Department of Labor issued a proposed rule change to the FLSA to roll back these regulations, allowing third-party agencies to exempt home care workers from overtime.

To protect overtime rights under current federal law, the 2025 Budget Act codified overtime requirements for IHSS workers in SB 156 (Committee on Budget and Fiscal Review), Chapter 110, Statutes of 2025. This proposed trailer bill would extend the same protections to hourly workers who provide supported living services. Many supported living services providers employ and coordinate the work of people who receive payment through both IHSS and supported living services.

Proposed trailer bill language. The proposed trailer bill language establishes that hourly workers who provide supported living services to individuals served by regional centers and who are employed by a vendor shall be compensated for overtime at the rate of 1.5 times the employee’s regular rate of pay for all hours worked over 40 hours per workweek.

According to DDS, if the proposed federal overtime regulation is overturned, caregiver wages would decline and turnover would increase, ultimately reducing the quality and consistency of care. Safeguarding labor standards for caregivers would provide stability, retain experienced caregivers, and protect the health, safety, and independence of individuals with I/DD. It would also ease payroll calculations for supported living services providers who employ people who receive payment through both IHSS and supported living.

Stakeholders propose minor amendment. The California Community Living Network (CCLN), which represents supported living services providers, supports the proposed trailer bill and recommends a minor amendment to clarify that this change does not alter the personal attendant exceptions granted to workers who provide supported living services under California’s Industrial Welfare Commission Wage Order No. 15. According to CCLN, “the absence of clear statutory alignment with Wage Order No. 15 creates a greater risk of inconsistent interpretation and unnecessary litigation. For that reason, we believe the clarification is both reasonable and necessary to ensure stability, consistency, and true parity.”

Subcommittee Staff Comment and Recommendation - Hold Open.

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

1. Please provide an overview of this proposal.

Issue 8: Rate Reform and Quality Incentive Program Contract Exemption

Trailer Bill Language – Governor’s Budget. The Governor’s Budget proposes trailer bill language to extend the contract exemption authorized in the annual Budget Act for rate reform and the Quality Incentive Program to December 31, 2030 and to extend the timeline to finalize rate reform regulations from June 30, 2028 to December 31, 2030.

Background. The 2021 Budget Act authorized a multi-year implementation of DDS service provider rate reform. Given the complexity of rates for developmental services and the timeline to implement adjustments, recent budget acts provided a contracting exemption through provisional language authorizing DDS to execute service contracts related to implementation, with the Budget Act of 2025 providing this exemption through June 30, 2026.

Full implementation of rate reform took effect January 1, 2025. Additionally, AB 2423 (Mathis), Chapter 904, Statutes of 2024 requires DDS to review and update the rate models posted on its website every two years beginning July 1, 2025. These updates are identify accurate, cost-based payment structures for service providers. This requires a detailed cost analysis of each service code’s rate model – work that has been supported by the expertise and technical capacity of a contractor. DDS states that updating rate models and a vast number of regulations for a variety of services requires the continued but ultimately temporary ability to secure and maintain specialized expertise.

Proposed trailer bill language. The proposed trailer bill contains two provisions:

- Exempts contracts related to rate reform and the Quality Incentive Program from public contracting requirements through December 31, 2030.
- Extends the date that DDS must complete regulations to implement rate reform from June 30, 2028 to December 31, 2030.

DDS states that changing contractors at this time would cause delays and inefficiencies as well as the loss of the current contractor’s specialized expertise and history with the rate models. DDS states that retaining the current contractor through 2030 for rate model updates and regulations will also facilitate ongoing rate model knowledge transfer to DDS staff.

DDS also states that the substantial technical revisions to Title 17 regulations, the complexity of the rate models across hundreds of service codes, and the need for stakeholder engagement, require more time for the regulatory process to formalize rate reform and requests a two-year extension to 2030.

Update on rate reform and the Quality Incentive Program. Beginning in the 2021 Budget Act, the Governor and Legislature initiated a multi-year plan to phase in DDS service provider rate reform, with an annual cost of \$1.8 billion (\$1.1 billion General Fund) at full implementation. Rate reform is intended to address an outdated DDS rate structure that lacked transparency, was overly complex, not tied to person-centered outcomes, and varied across providers who provided the same service in the same region. The final phase (50 percent) of rate reform implementation took effect on January 1, 2025. DDS has been working to consolidate and clarify service codes and categories under the now fully funded rate model. The 2021 Budget Act required that at full implementation, fully funded models be implemented using two payment components: (1) a base rate equaling 90 percent of the rate model, and (2) a quality incentive

payment, equaling up to 10 percent of the rate model, implemented via a new Quality Incentive Program. The quality incentive component of rate reform responds to the prevailing need within the developmental services system of moving from a compliance-based system to an outcomes-based system rooted in meeting individual needs.

DDS has gradually phased in the 10 percent Quality Incentive Program component of rate reform, first by creating a Provider Directory – a centralized mechanism to store statewide provider information. For the years 2024-25 and 2025-26, providers were able to earn the 10 percent quality incentive component by registering and validating information in the Provider Directory. By building the Provider Directory and focusing on the collection of baseline data in the initial years of the Quality Incentive Program, DDS will be able to phase in more specific quality and outcome measures in future years.

The 2025 Budget Act included a reduction of \$221.7 million General Fund in 2026-27 and ongoing as a result of expanded requirements developmental services providers must meet in order to qualify for the Quality Incentive Program, which comprises up to 10 percent of a provider’s full rate. These requirements include: compliance with Electronic Visit Verification, Home and Community-Based Services rules, and independent audit and fiscal reviews. This effectively means that a provider must demonstrate compliance with these three criteria prior to becoming eligible to earn the 10 percent quality incentive component of their rate in any given year. For example, in 2026-27, providers are able to earn the 10 percent quality incentive component of their rate first by demonstrating compliance with the three pre-conditions described above, and secondly by completing the quality incentive requirement of submitting a survey about workforce capacity and service delivery. As of April 2026, DDS estimates that about 83 percent of providers have completed all requirements for 2026-27 to earn the 10 percent quality incentive.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.
2. Please provide an update on the status of current rate reform efforts underway, including implementation of the Quality Incentive Program changes enacted under the 2025 Budget Act, and efforts to address issues with certain service codes such as transportation, residential, Early Start, and certain unique services that are currently exempt from the rate model.

Issue 9: Life Outcomes Improvement System (LOIS) Project

Budget Change Proposal and Trailer Bill Language – Governor’s Budget. The Governor’s budget proposes \$14.6 million (\$5.7 million General Fund) for one-year limited-term resources to continue the planning phase of the Life Outcomes Improvement System (LOIS) project. This includes resources equivalent to 20 positions, contract costs, and resources for regional center positions related to data analysis, migration, and governance workload. This includes trailer bill language to codify requirements for regional centers to transition from existing information technology systems to LOIS upon implementation.

Background: LOIS Project. LOIS is a modernization initiative designed to replace the current case management and financial systems used by DDS and regional centers. LOIS will replace and consolidate the existing decentralized systems that were built in the 1980s with a single unified case management and fiscal system.

DDS and regional centers currently rely on a variety of decentralized technology platforms developed in the 1980s spread across several functions: fiscal and billing, case management, federal billing, and clinical record systems for state-operated services. In addition, because of the limitations of the current case management system, several regional centers also have independent case management systems that have been developed over the last 40 years. These disparate systems are outdated and have many limitations. For example, the case management system lacks interfaces for individuals, families, and service providers to access or update their own information. Disparate and non-standard systems have led to inaccurate data, delayed reporting, limited insight into authorized services and trends, delayed enrollment in the federal waiver, delayed federal reimbursements, and a high reliance on manual business practices.

Resource request. DDS requests one-year limited-term resources equivalent to 20 positions and additional resources which will allow the department to continue the Project Approval Lifecycle (PAL) activities, prepare the solicitation, and plan for implementation of the solution provided by the awarded systems integrator. The requested resources include positions that understand case management and fiscal requirements and can develop detailed requirements/user stories, support Organizational Change Management (OCM), and conduct the procurement, design, development, testing, training, and implementation.

| LOIS | Count | Classifications (or equivalents) | Division |
|------------------------------|-------------|----------------------------------|----------|
| Project Director | 1.0 | ITM I | ITD |
| Project Manager | 3.0 | ITS II | ITD |
| Business Analyst | 3.0 | ITS II | ITD |
| Technical Architect | 3.0 | ITS II | ITD |
| Contract Manager | 1.0 | ITS I | ITD |
| Project Support | 1.0 | ITS I | ITD |
| Software Engineer | 1.0 | ITS I | ITD |
| ServiceNow Support | 1.0 | ITS I | ITD |
| Product Owner | 1.0 | RDS III | CAYAS |
| Program Support | 1.0 | Supervisor I | CAYAS |
| Program Support | 1.0 | CPS III | WARD |
| Program Support | 2.0 | CPS III | CSD |
| Program Manager | 1.0 | Supervisor II | DCAR |
| Total State Positions | 20.0 | | |

This request also includes \$3.2 million to continue consulting services to assist with the PAL process, OCM, and Data Management services. These consulting services originally were procured in 2023 utilizing American Rescue Plan Act of 2021 funding. The Project Manager and Business Analysis services develop the documentation and approvals for the PAL. OCM is needed for managing change with department staff, regional centers, vendors, and individuals. Data Management services are required to evaluate the quality of data from the regional centers and determine and execute the data cleanup strategy.

Additionally, DDS requests resources dedicated at each regional center to support the project as follows:

- Two Research Data Specialists for each regional center to lead the effort of end-to-end data analysis, data profiling/cleansing and validation services, data migration/conversion planning and activities, and data governance framework establishment for the project.
- \$200,000 annually per regional center for subject matter experts during planning.

| | | | |
|---|--------------|--|--|
| Regional Center | | | |
| Data Analysis and Regional Center Staff Resources, incl SMEs | \$ 7,255,000 | | |
| Consulting Service | | | |
| Project Management (PM)_& Business Analyst (BA) Services (\$2AA, \$3SD, \$4PRA) | \$ 1,300,000 | | |
| Organizational Change Management | \$290,000 | | |
| Data Management Services | \$507,000 | | |
| Legacy Systems Analyst | \$175,000 | | |
| CMS PAPD & IAPD Manager (CMS Support) | \$250,000 | | |
| California Department of Technology (CDT) & STP Services | \$ 660,000 | | |

Project funding. The LOIS project (previously referred to as the UFS/CERMS project) began with \$6 million in federal funds from the 2021 Home and Community-Based Services Spending Plan. The 2023 Budget Act included \$12.7 million (\$12.2 million General Fund) for continued planning, and also required supplemental report language requiring quarterly updates to the Legislature on project status. The 2024 Budget Act included \$1 million General Fund and up to \$5 million in provisional authority for continued planning. The 2025 Budget Act included \$13.3 million (\$5.1 million General Fund) for the extension of 17 limited-term positions at DDS, regional center resources, and consulting services to continue the planning phase.

DDS has requested funding from the Centers for Medicare and Medicaid Services for the planning, development, and implementation of this project. The project plan was approved by the Centers for Medicare and Medicaid Services in August 2025. The project may receive federal funding for approximately 90 percent of the planning effort’s eligible costs and 75 percent of eligible implementation costs.

Project planning and progress. DDS has completed the first two stages of the California Department of Technology (CDT) PAL process. In addition, the department focused on additional stakeholder engagement in 2025 with department and regional center staff, providers, and individuals and families.¹⁸ As a result of feedback, the department has identified seven themes to guide the project moving forward:

- Improving communication and collaboration.
- Supporting transparency and accountability.
- Centralizing information and education.
- Enhancing authorization and payment processes.
- Supporting person centered planning and outcomes.
- Improving system accountability and usability.
- Advancing consistency across regional centers.

The LAO notes that it is reasonable to continue planning for LOIS, but that legislative oversight of the project is warranted: “the completed planning documents, including the cost estimate and projected time line to finish the project, will provide the Legislature with the information necessary to evaluate the merits of the proposed project. Given the fiscal constraints facing the state, legislative oversight of the LOIS project’s costs and progress will be particularly important.”¹⁹

Proposed trailer bill language. DDS proposes corresponding trailer bill language to codify the LOIS project and identify steps for regional centers to prepare for phasing out old systems and transitioning to LOIS. Specifically, the proposed trailer bill language:

- Establishes the intent of the Legislature to modernize DDS’s financial and case management information technology systems through the development and implementation of LOIS.
- Makes various findings and declarations about the purposes and vision of LOIS, including to provide a consistent statewide experience for individuals, families, and services providers; to

¹⁸ Legislative Analyst’s Office (LAO), [The 2026-27 Budget: Department of Developmental Services](#), March 13, 2026.

¹⁹ LAO.

simplify the complexity of current systems and eliminate costly duplications and redundancies; and to improve transparency, data collection, oversight, and policymaking.

- Beginning July 1, 2026, requires regional centers to do the following to assist in the transition to LOIS:
 - Notify DDS regarding any actions permitting third-party applications or systems to access specified data.
 - Notify DDS of any plans to use any new systems that contain, replicate, or replace the data or functionality of existing systems.
 - Prohibit the transition of any existing case management system to solutions other than LOIS without approval.
 - Prioritize data cleanup and other transitional activities as directed by DDS.
- Requires regional centers to discontinue the use of all other case management and financial technology systems upon the implementation of LOIS, in a way that minimizes disruptions for individuals and families and regional center operations.

According to DDS, codifying the requirement to use one system will provide clear expectations to regional centers about the future and allow for a higher level of transparency in program monitoring and administration during the modernization process. It will also focus efforts on developing and maintaining one system rather than supporting multiple interfaces across several systems.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal and the current status of the LOIS project.

Issue 10: Self-Determination Program Administrative Costs

Trailer Bill Language – Governor’s Budget. The Governor’s budget includes trailer bill language to clarify that administrative costs associated with the Self-Determination Program (SDP) be the first priority for use of savings generated by matching federal funds for prior SDP pilot participants.

Background. The SDP is a voluntary program for Californians receiving Lanterman Act services. In the Self-Determination program, the individual with I/DD and their planning team create a spending plan that allows them to purchase services and supports from organizations or individuals of their choosing, instead of receiving services only through vendors contracted with the regional center, under certain conditions. As of December 2025, over 8,000 individuals are enrolled in the SDP.

Existing law specifies authorized uses of \$4 million in federal funds generated by former participants of the Self-Determination Pilot Projects, when this program was in pilot status. Current law prioritizes the use of these funds for criminal background checks and other administrative costs associated with program administration. Additionally, after consultation with stakeholders, any remaining funds could be used to address participants’ needs, increase service access and equity, and reduce disparities. Funds for this second category are generally used at the direction of local volunteer advisory committees (LVACs) for activities such as independent facilitators and trainings about the SDP.

DDS estimates that approximately \$4 million General Fund annually became available when the program began to access federal matching funds through the SDP waiver. Over the past five years, DDS has allocated these funds as follows:

- \$1.8 million General Fund annually to regional centers for program administration.
- \$2 million General Fund annually for LVACs to address participant needs and promote access and equity.
- \$215,000 to the State Council on Developmental Disabilities for implementation of the SDP orientation.

Proposed trailer bill language. The proposed trailer bill language recasts existing law outlining the use of the \$4 million in federal funds generated by the former SDP pilot participants. The proposed language retains the requirement that the first priority of these funds be used to offset the cost of criminal background checks and other administrative costs incurred to implement the SDP, and removes existing language around the use of any remaining funds for other purposes.

According to DDS, this has the effect of redirecting the \$2 million currently allocated to LVACs to instead cover DDS administrative costs. (The \$215,000 to the State Council on Developmental Disabilities for orientation would remain unchanged). While LVACs would no longer have a dedicated funding source to fund programming or activities at their discretion, the LVACs themselves would continue to exist in their advisory capacity to make recommendations to regional centers about the SDP program.

Stakeholder opposition. Members of local LVACs have written in opposition to this proposal, noting that the \$2 million in funds that has been directed to LVACs have supported activities such as participant coaching, independent facilitator training, peer support groups, and accessible training materials about the SDP that have benefited underserved communities. Disability Voices United and the Integrated Community Collaborative have also written in opposition to this proposal.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.
2. How will this proposal improve the administration of the SDP and the experience of SDP participants? How will DDS fill any gaps that may be created in the area of SDP facilitation, training, and peer support if these funds are redirected away from LVACs?

Issue 11: Employment Access Alignment

Trailer Bill Language – Governor’s Budget. The Governor’s budget proposes trailer bill language on behalf of both DDS and the Department of Rehabilitation (DOR) that would give both departments authority to establish a dual provider system for individuals with I/DD seeking competitive integrated employment. This proposal would also align vendorization requirements across DDS and DOR and remove barriers that prevent individuals from accessing employment. This includes removing the requirement that employment service providers be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Background. State law requires individuals pursuing employment services to exhaust “generic services” and or maximize utilization of “comparable services” before receiving regional center-funded services. For employment services, DOR often is the generic service, placing the burden on individuals to navigate between DDS-funded and DOR-funded services.

Some community service providers are dually approved by both departments. However, the departmental processes remain largely independent of each other. Individuals with I/DD seeking employment supports have experienced challenges related to transitioning between employment service providers when redirected between DOR and DDS, impacting and destabilizing successful employment opportunities.

Additionally, current law requires all employment service providers to be accredited by CARF. Historically, regional center-funded programs, such as day programs, provided employment-related services under different service codes that do not require accreditation. As part of DDS service provider rate reform, these programs are required to transition to service codes that match the services they provide. Transitioning to an employment service code requires pursuing CARF accreditation, which is a costly barrier to becoming an employment vendor.

Proposed trailer bill language. The proposed trailer bill language includes the following changes:

- Removes statutory requirements that employment services be CARF-accredited.
- Replaces the CARF accreditation requirement with a requirement that employment services providers comply with service standards established by DDS. Requires DDS to consult with regional centers, providers, and other stakeholders to establish those service standards by September 1, 2027.
- Requires DDS and DOR to develop an interagency agreement for employment services and vocational rehabilitation programs to create an integrated employment system between DOR and regional centers, with the goals of uninterrupted services, minimized handoffs, and fewer barriers, and to increase timely access to competitive integrated employment.
- Requires that the integrated system include the following:
 - A dual provider process for employment providers between DOR and regional centers.
 - Clear funding paths between DDS, DOR, and regional centers to enable timely access to services.
 - A process for seamless services regardless of which department an individual is receiving services through.
- Requires DDS and DOR to develop the interagency agreement by August 1, 2027.
- Requires DDS and DOR to develop the integrated employment system with input from the community no later than March 1, 2029 and specifies groups that must be consulted.

- Requires, beginning December 1, 2026, DDS to semiannually report milestones online until the integrated system is developed.

According to DDS, a new framework between regional centers and vocational rehabilitation offices aims to streamline navigating program processes for individuals. Improving access to employment services will reduce barriers to employment for individuals with I/DD. Further, removing the CARF accreditation requirement would encourage more vendors to provide supported employment services. Feedback from the provider community notes the costly nature (upwards of \$11,000) and time-intensive process of CARF accreditation as a major reason potential providers do not pursue vendorization for employment services. Furthermore, employment service providers are already subject to other regular oversight and monitoring activities from DDS, regional centers, DOR, and Home and Community-Based Services monitoring.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.
2. What type of services standards does the department anticipate will be developed in place of CARF accreditation?

Issue 12: Early Start Oversight

Trailer Bill Language – Governor’s Budget. The Governor’s budget proposes trailer bill language that reflects the discontinuation of an interagency agreement between DDS and the California Department of Education (CDE). This includes three-year authority for DDS to issue directives to local education agencies (LEAs) and regional centers operating early intervention programs.

Background. Part C of the Individuals with Disabilities Education Act provides federal funding for states to develop and implement early intervention programs for children from birth up to age three with developmental delays, disabilities, or conditions that place them at a high risk for disabilities. California’s Early Intervention Services Act designates DDS as California’s lead agency for implementing Part C, also known as Early Start, while assigning CDE responsibility for early intervention services to a specified population of eligible infants under Government Code 95007(j).

DDS receives approximately \$55 million in federal funds annually for Early Start. Historically, about \$14.2 million has been allocated to CDE through an interagency agreement to support LEAs in providing direct services to infants and toddlers with low incidence disabilities (vision, orthopedic, or hearing impairments). As of June 30, 2025, the Department and CDE mutually discontinued the agreement after a three-month extension to facilitate the transfer of CDE’s oversight responsibilities to DDS.

Proposed trailer bill language. The proposed trailer bill language includes the following changes:

- Allows DDS to issue directives to LEAs and regional centers operating Early Start Part C until regulations are adopted, no later than June 30, 2029.
- Recasts existing requirements to clarify CDE, DDS, regional center, and LEA responsibilities about transitioning from Part C to Part B of the Individuals with Disabilities Education Act, as follows:
 - Requires CDE to enter into an interagency agreement with DDS to facilitate a seamless transition between services in Part C and Part B.
 - Requires this agreement to include the joint development and dissemination of educational materials about transitioning from Part C to Part B, and requires each regional center and LEA to designate a main point of contact for coordinating and completing the transition (a requirement under existing law).
 - Requires that the lead agency provide information to families regarding:
 - The difference between Part B and Part C services.
 - Information about local Part B programs and other services.
 - Options for families after their child reaches three years old.
 - Process and timelines for a child’s transition at three years old.
 - Establishes the regional center’s responsibility to assess a toddler who qualifies for early intervention services and refer a toddler transitioning out of Part C services to a California State Preschool Program.

According to DDS, the proposed amendments would facilitate a seamless transfer of oversight responsibilities for LEAs receiving federal grant Part C, as California’s early intervention service delivery models can vary significantly between regional centers and LEAs. This change will offer an opportunity to unify and strengthen consistent practices statewide. Further, in alignment with federal guidelines, DDS

aims to extend the record review process currently used with regional centers when monitoring the compliance of LEA Part C programs.

CDE has expressed concerns with this proposal, noting that effective 2025-26, CDE no longer receives Part C funds and has completed the transition of all Part C management responsibilities through an interagency agreement. CDE states that mandating CDE's participation in unfunded activities may create potential legal and fiscal risks.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal, including a description of the specific activities involved in monitoring LEA compliance of Early Start Part C.
2. How would this transfer of oversight responsibilities change the experience for families whose children receive Early Start services?

ISSUES FOR NON-PRESENTATION

Issue 13: Stakeholder Proposals for Investment

Proposals for Investment. The Subcommittee has received the following proposals for investment:

1. **Minimizing Harm from IHSS Community First Choice Option (CFCO) Penalties.** CWDA proposes \$16 million General Fund ongoing and corresponding trailer bill language to maintain the 50 percent state/county cost share of federal CFCO penalties levied by the federal government for late reassessments of certain IHSS cases. The 2025 Budget Act created a 50 percent state/county cost share for 2025-26 and then shifted 100 percent of costs to counties beginning in 2026-27.

According to CWDA, “Counties are facing growing financial penalties for untimely reassessments under the IHSS CFCO program, despite chronic underfunding of IHSS social workers and historically high caseloads. Beginning in 2025–26, the state shifted half of the CFCO penalty cost to counties and is scheduled to shift the full cost starting July 1, 2026, exposing counties to significant fiscal risk. To avoid these penalties, counties are prioritizing CFCO reassessments, which has delayed processing of new IHSS applications and reassessments for non-CFCO recipients, placing vulnerable individuals at risk of unmet or worsening needs...The CFCO policy had led to the intended prioritization of CFCO reassessments, but with the severe, unintended consequence of delayed processing of new IHSS applications (intakes) and reassessments of current IHSS recipients not in the CFCO program. This is due in large part to the chronic underfunding of the IHSS social workers by the State, resulting in high caseloads of 400-600 cases per social worker, thus forcing county staff to shift workload and resulting in lower compliance with required intakes and assessments...Absent sustainable workforce funding for the growing IHSS Program, social workers must shift caseload priorities.”

2. **Promise Neighborhoods Emergency Funding Request.** A coalition of organizations including the Mission Promise Neighborhood, Hayward Promise Neighborhood, and Chula Vista Promise Neighborhood proposes \$6 million General Fund one-time to provide gap funding for three Promise Neighborhoods that were previously supported with state funding that sunset in 2025.

According to this coalition, “The \$1 million annual allocation each year for two years will allow for critical operations to continue for these backbone agencies and their partners, providing coordinated services to families in low-income communities ranging from academic support to housing, food, public benefits, jobs, financial education, early learning and more. This support will give neighborhoods the stability to apply for additional local, state, federal and private funding to ensure their longevity...Each community serves low-income primarily students and families of color and immigrant students and families. Communities are facing high rates of poverty, chronic absenteeism, food insecurity, homelessness and housing instability among other challenges. Local infrastructure has been built in each community that serves as an emergency response network for the state’s most vulnerable families. Given the breadth of current and expected future cuts to social services, benefits and the safety net, this investment can ensure that these distressed communities navigate the ongoing impacts.”