INADEQUATE RATES FOR SERVICE PROVISION IN CALIFORNIA

Prepared by the

Association of Regional Center Agencies

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SERVICE PROVISION IN CALIFORNIA
EXECUTIVE SUMMARY

The Association of Regional Center Agencies (ARCA) represents the 21 regional centers in supporting and advancing the intent and mandate of the Lanterman Developmental Disabilities Services Act (the Lanterman Act). ARCA advocates on behalf of the 265,000 individuals served by the regional centers statewide, and works in cooperation with other entities to promote services for persons with developmental disabilities.

Regional center budgets are divided into two parts: Purchase of Service (POS) which provides funding to pay more than 45,000 direct service providers in the community, and Operations (OPS), which provides funding to support the regional center's role in service coordination, resource development, and quality assurance.

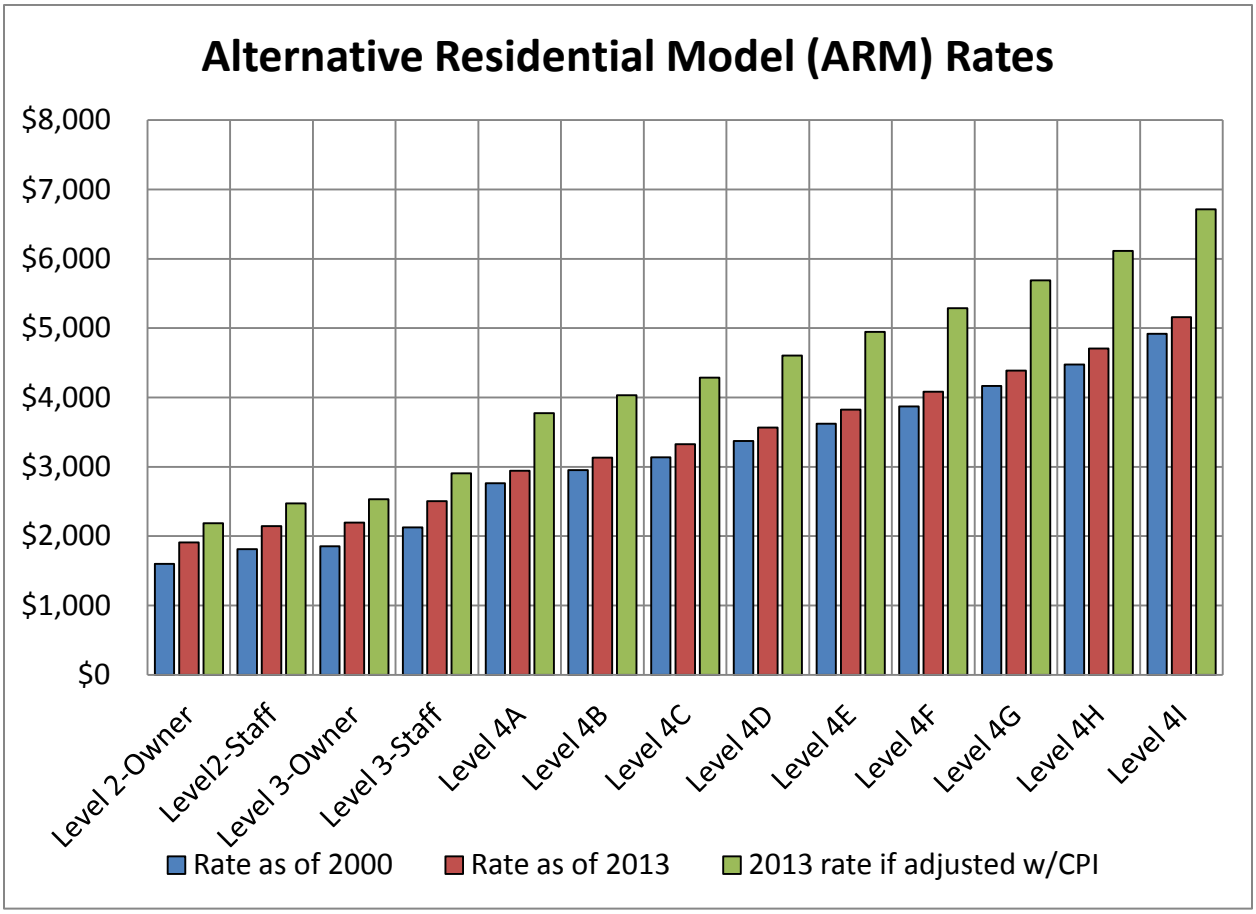
Issues impacting the OPS budget are addressed in ARCA's publication *Funding the Work of California's Regional Centers.* This paper focuses on the POS budget and the problems caused by stagnant rates for the provision of services, which in turn impacts the clients regional centers are charged to serve. There are five major areas covered in this paper in order to illustrate the issue of underfunding for services.

1. Overview of Rate-Setting Processes in California

There are six primary mechanisms to establish rates for service providers: Alternative Residential Model (ARM), Non-Negotiated Rate Community Based Programs, Supported Employment, Negotiated Rates, Usual and Customary, and Schedule of Maximum Allowances (SMA). As the regional centers are not involved in the rate-setting for SMA or Usual and Customary, this paper addresses the first four rate types.

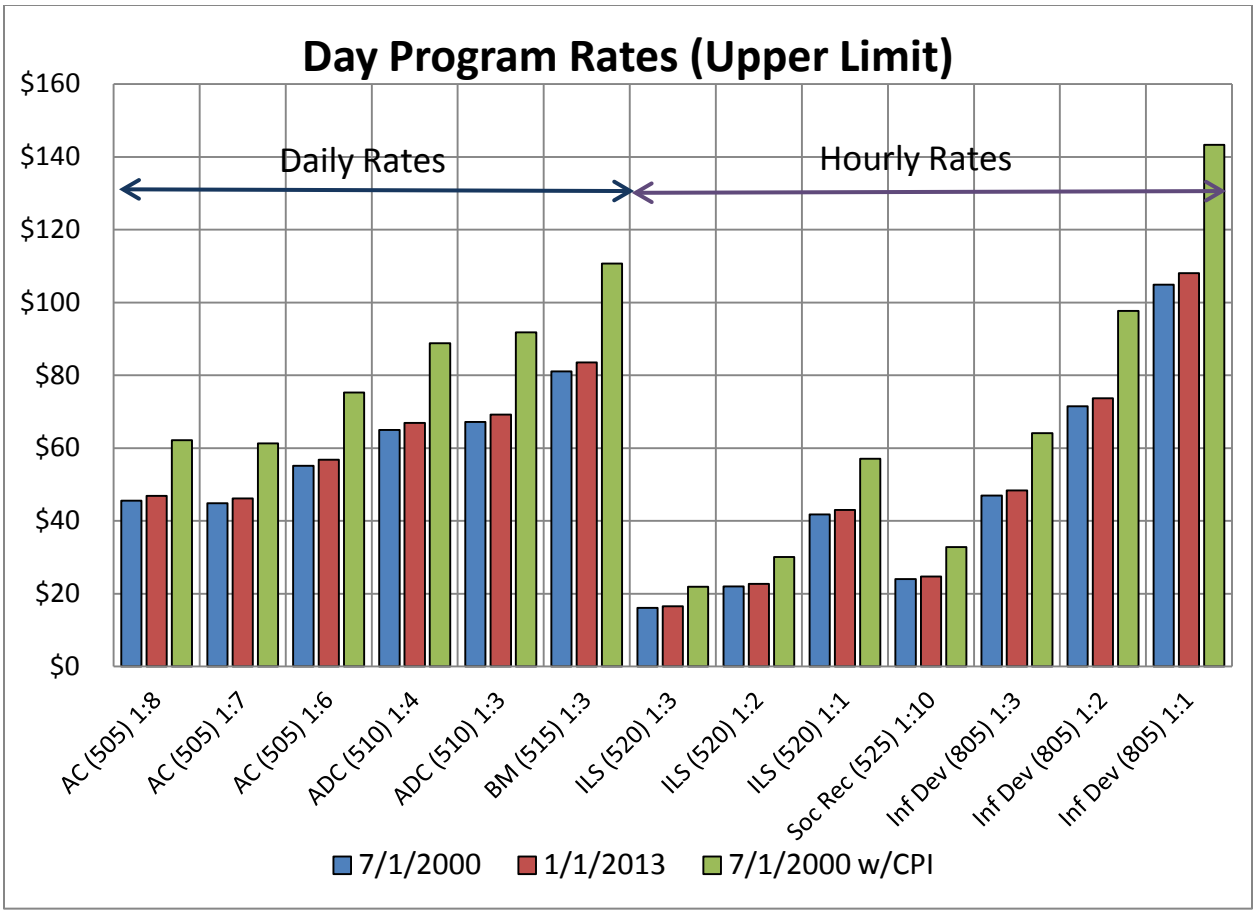
2. Rate-Setting Processes

The ARM rates and the community-based day program rates are set by DDS. The chart below illustrates the ARM rates as of July 1, 2000, the current ARM rates, and what the ARM rates would be if they had kept pace with inflation.



Source: DDS Rates Lists.

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The chart below compares the day program upper limit rates as of July 1, 2000, the current upper limit rates, and what the upper limit rates would be if the day program rates had kept pace with inflation.



Source: DDS Rates Lists.

Negotiated rates became subject to legislation that imposed a freeze and a maximum allowable rate (the median), regardless of the provider's actual costs. These two measures have created extreme difficulties for regional centers in their attempts to develop new and specialized services. Supported employment is the only service with rates that are set statutorily. They have been unchanged since 2008. In order for individuals with developmental disabilities to achieve full participation in the community, they must have integrated living and employment options, as well as the necessary supports to achieve those. This has become increasingly difficult to provide.

3. California Budget Crises And Their Effects

Since 2000, the budget crises in California have caused rate increases to be infrequent and minimal. There has been legislation that resulted in payment reductions, as well as

freezes that have kept the reimbursement rate stationary. For over a decade service rates have been subjected to this holding pattern, while actual costs have continued to increase. All new service providers were subject to the median rate, which was frozen once it was established. Finally, there was additional legislation which established: 1) a uniform holiday schedule with 14 non-service and non-paid days per year; 2) requirements for provider reviews and audits at a cost of $4000-15,000; 3) a cap on administrative costs impacts providers when costs increase to absorb changes in health care and workers' compensation; and 4) restriction on the use of POS funds to start up new programs, which can impact the development of needed services. These actions have impacted services in many different ways, but ultimately they put at risk the fiscal viability of the services for individuals with developmental disabilities.

4. Changing Needs For A Changing Population

Over the years the services necessary to support individuals with developmental disabilities have evolved. Most individuals live in the community as intended by the Lanterman Act, but this integration requires new and different services to assist in the achievement of independence, self-sufficiency, and quality of life. The demographics of the individuals served by Regional Centers has changed. There are more individuals with autism. There is a significant number of children who will be exiting the public education system and entering adult services provided through regional centers. Over the next twelve years there will be over 70,000 young adults exiting the school system, and of these, 24,000 will need services in the next three years. Advanced medical interventions let people served by regional centers live longer. Parents who have supported their adult children in their homes are aging as well. Statistics indicate there are over 5,400 persons between the ages of 52 and 62 and older with disabilities still living with their parents. Regional centers will need to develop community services for these individuals. Over the next ten to twelve years all of these variables will add significant stress to the system via a need for services that are difficult to develop and sustain at current inadequate funding levels.

5. Reports And Studies

The serious concerns about the effect of low reimbursement rates on services have been long-standing. A number of studies and reports have drawn the same conclusion; the rate system is inadequate and does not effectively support services as they were intended. Although some changes to the system have been attempted, there needs to be a long-term solution through overall rate adjustment to reflect the realities of the costs. The client population has changed over time and the service delivery system has evolved, but the rate system has not kept pace with those changes.

SUMMARY

From a policy perspective, California's developmental services system is poised to promote better service outcomes for the over 265,000 individuals with developmental disabilities. Services can be more individualized and lead to greater levels of community participation, employment, and independence. Unfortunately, long-standing underfunding of the service system not only undermines this potential forward progress, but also the adequacy of the community-based provider network.

The concepts in this paper are not new. Studies dating back many years all draw the same conclusion; quality services and achievement of outcomes is directly related to staff qualifications, retention and continuity of care. But this goal is unachievable within the limitations of the current rates. Acknowledging the problem with a passive response does not help the over 265,000 individuals served to move forward. The task before us seems insurmountable because it has been ignored for so long.

Forty-five years ago, California made a promise to the state's most vulnerable residents. The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge…." Without a definitive response to the

problem presented, the state risks the health and well-being of clients and their families for whom the state has accepted responsibility.

PREFACE

The Association of Regional Center Agencies (ARCA) represents the 21 regional centers in supporting and advancing the intent and mandate of the Lanterman Developmental Disabilities Services Act. ARCA advocates on behalf of the over 265,000 individuals served by the regional centers statewide, and works in cooperation with other entities to promote services for persons with developmental disabilities.

Since the 1990s, the regional center system has experienced extensive budget reductions. The state budget crises have resulted in provider rate freezes, inadequate median rates, and limited start-up funding. The quality and effectiveness of purchased services and supports for individuals with developmental disabilities has suffered, and many individuals and families are facing barriers to receiving the services and supports they need.

ARCA considers the preservation of services for individuals with developmental disabilities as one of its highest priorities. Towards that end, ARCA has made a commitment to pursue rate reform in order to maintain needed services for persons with developmental disabilities. ARCA's Strategic Plan includes rate reform for the developmental services system as a primary area of focus.

INTRODUCTION

Californians with developmental disabilities receive direct services from approximately 45,000 service provider agencies throughout the state. Those service providers deliver needed community-based supports and services as an alternative to institutional care. These services include residential care, day programs, independent and supported living services, respite services, transportation, behavioral services, and many others. Regional centers assist individuals with developmental disabilities in understanding the services that are available to them in order to live in the community. These services are designed to meet the unique needs and choices of the individuals. The developmental services system is focused on ensuring minor children can remain in their family homes, and seeing adults achieve the greatest level of independence possible. There are more than 150 service category types (service codes) that define each specific service available. Eighty-seven and one-half percent of the regional center budget, called "Purchase of Services" (POS) funding, funds those service providers. For fiscal year 2014-15, it is estimated that approximately $3.9 billion will be spent on these services.

> "…Regional centers are mandated to access generic and other services for consumers and families before expending regional center funds. There are both fiscal and philosophical reasons for this mandate. The backdrop precipitating the Lanterman Act was the devaluation of people with developmental disabilities, with the attending discrimination and segregation, which limited their access to services commonly available to others…
> Despite heavy reliance on accessing alternative resources, the special service and support needs of people with developmental disabilities are such that the needs cannot always be met through generic resources. In such cases, the regional centers are required to develop and fund needed services and supports. Thus, regional center consumers receive services from a broad array of public and private providers or vendors…"[i]

Although the expenditures for developmental services are significant, it is important to look at California's expenditures from a national perspective. Data in the publication *The State of the States in Developmental Disabilities* illustrates California's spending compared to other states. Calculation of a state's fiscal effort is the measure used in this report to compare and rank states. Based on the most recent data, California's fiscal effort for community and institutional services is ranked 34th among all states, or 16% below the national average. California

has consistently fallen in the bottom half in fiscal effort for many years. For example, California ranked 37th in 1997, then ranked 39th in 2002, and is currently ranked at 34th.

The funding the state invests in services is linked to the quality of the services. In order to provide quality services, it is important for providers to be able to hire, train, and retain qualified staff for consistency and continuity of care. Lack of adequate revenue affects the ability of providers to:

- Compete with other types of employers in the recruitment of experienced and educated staff due to lower staff wages
- Retain staff due to lower wages and the inability to offer benefits comparable to other employers

These constraints, as a result of an inadequate rate system and outdated rates, are a serious impediment to the provision of the specialized services necessary to meet the needs of persons served. Individuals with autism, challenging behaviors, or complex medical needs require providers to hire more experienced and educated staff to provide services that produce the intended outcomes. Over the past 20 years, laws, regulations, and best practices have changed, placing increased expectations on providers.

> *"Although little data is available on direct-support workers, the last available survey of community-care facilities documented average wages of $10.24 per hour in 2001 after wage pass-through legislation—a rate augmentation earmarked to increase compensation by almost 20% in order to retain direct-support workers. In the five years since then, reimbursement rates have been frozen. This wage is lower than a single worker with no dependents would have needed for basic self-sufficiency in California in 2005. Data on access to health insurance is even more limited.*
>
> *Low wages are the main cause of very high turnover rates in community settings. In Wyoming, for example, when total compensation rose from $9.08 in 2001 to*

$13.19 by 2004, turnover dropped from 52% per year to 32%. California does not collect data on turnover, but small surveys reported turnover rates ranging from 24% to over 50%. High turnover forces providers to struggle to find qualified workers, undermines training, continually disturbs relationships between workers and clients, and ultimately undermines quality of care." [ii]

The serious concerns about the effect of low reimbursement rates on the quality of services have been long-standing. A number of studies and reports show the rate system is inadequate. Some changes to the system have been attempted, but there needs to be a long-term solution through overall rate improvement. The needs of people served have changed over time, and the service delivery system has evolved, but the rate system has not kept pace with those changes. It no longer supports the services to meet the needs of the individuals regional centers serve. Years of underfunding, paired with increased statutory and regulatory requirements, have pushed the system to its breaking point, causing shortages in services and supports needed now and in the future.

OVERVIEW OF RATE SETTING PROCESSES IN CALIFORNIA

In order to understand the costs for the provision of services, and thus see their underfunding, it is important to know how rates are established. There are six primary mechanisms to establish rates for service providers. None of those rates, once set, can be adjusted without (funded) legislative action.

1. *Alternative Rate Model (ARM)* – Community Care Facilities (CCFs), which make up the bulk of residential care providers, are paid a rate according to the ARM. The rate depends on the program design for the facility. The program design shows services and level of care, which is the basis for the number of direct care hours (staff-to-client interaction) provided to the clients in the facility.

2. *Non-Negotiated Rate Community-Based Programs* – Day programs, independent living services, in-home respite agencies, and some other services had their rates set by the Department of Developmental Services (DDS) based on a cost statement the provider completed and submitted to the regional center. The cost statement reflected the anticipated costs of operating the business. Initially, a temporary rate was set, based on aggregate projections. After six months, a permanent rate was set based upon actual costs.

3. Statutorily Set – Supported employment rates are the only statutorily established rates in the developmental services system. The rate for all providers is the same, regardless of actual service costs. Neither DDS nor the regional centers have the authority to modify the rate.

4. *Negotiated Rates* – Some service providers are paid a rate negotiated with the regional center, based on cost data submitted to the regional center. The ability of regional centers to negotiate rates has been almost completely eliminated by the establishment of the median rate, which sets an upper limit that cannot be exceeded, regardless of the provider's cost of operation.

5. *Usual and Customary* – Some categories of service providers are paid their "usual and customary" rate, which is what they charge the general public for their services, such as counseling. This option is available only when at least 30% of their customers are not regional center clients.

6. *Schedule of Maximum Allowances (SMA)* – Service providers who provide services that are reimbursable under the Medi-Cal program, such as nurses, are paid the SMA rates. These rates are established by the Department of Health Services (DHS).

Since usual and customary rates are the current market rates, and DHS sets the SMA rates, these rates will not be addressed in this paper. This paper will address the first four types of rates, various changes that have affected them, the implications for

individuals with developmental disabilities and service providers, and providers' ability to provide ongoing quality services.

RATE SETTING PROCESSES

Alternative Rate Model (ARM)

History and Foundation of Rate-Setting Procedure

Community Care Facilities (CCFs) are defined in Title 17 regulations. They serve children, adults, and the elderly. Payment rates are set by DDS in accordance with the ARM, which was developed in the late 1980s. The ARM rates were introduced in a pilot program conducted from 1985 to 1987. By January 1, 1991, all CCFs were converted to the ARM rates.

The ARM system set rates based on the level of support provided by the CCF. Those levels range from 1 to 4, with level 4 being subdivided from 4a through 4i. Level 1 CCF residents require the least intensive supports, while Level 4i CCFs serve clients with the most complex needs. The current ARM rates range from $993 (Level 1) to $5,159 per month per resident (Level 4i) (see Appendix B: Community Care Facility Rates for more information). As the facility levels (and resident needs) increase, so do the mandated levels of staffing hours, staff training, and outside consultation in areas such as medical and behavioral supports. Generally, regional center clients do not live in Level 1 facilities, as they require more support to meet their needs. Some individuals' needs can be met with basic supervision, while others require staff who have specialized training in medical or behavioral management, and lower staff-to-client ratios. The ultimate aim of the ARM model was to base reimbursement for service providers on the intensity of the support needs of the individuals within the facility.

Rate Adjustments, Reductions, and Freezes

Since July 1, 2000, the ARM rates have been increased three times:

1. In FY 2001-02 the ARM rates were increased for the Supplemental Security Income-State Supplementary Payment (SSI/SSP) pass-through of 1.5%.

2. In FY 2002-03 the ARM rates were again adjusted for the SSI/SSP pass-through of 1%.

3. In FY 2006-07 all service providers whose rates are set by DDS were granted a 3% rate increase. Some CCFs (Levels 2 and 3) also received a 3.7% increase due to the minimum wage increase. Other CCFs, which provide increased levels of service, did not receive the 3.7% increase, even though many of them had employees qualifying for the minimum wage increase. Those levels of service are classified as 4a through 4i.

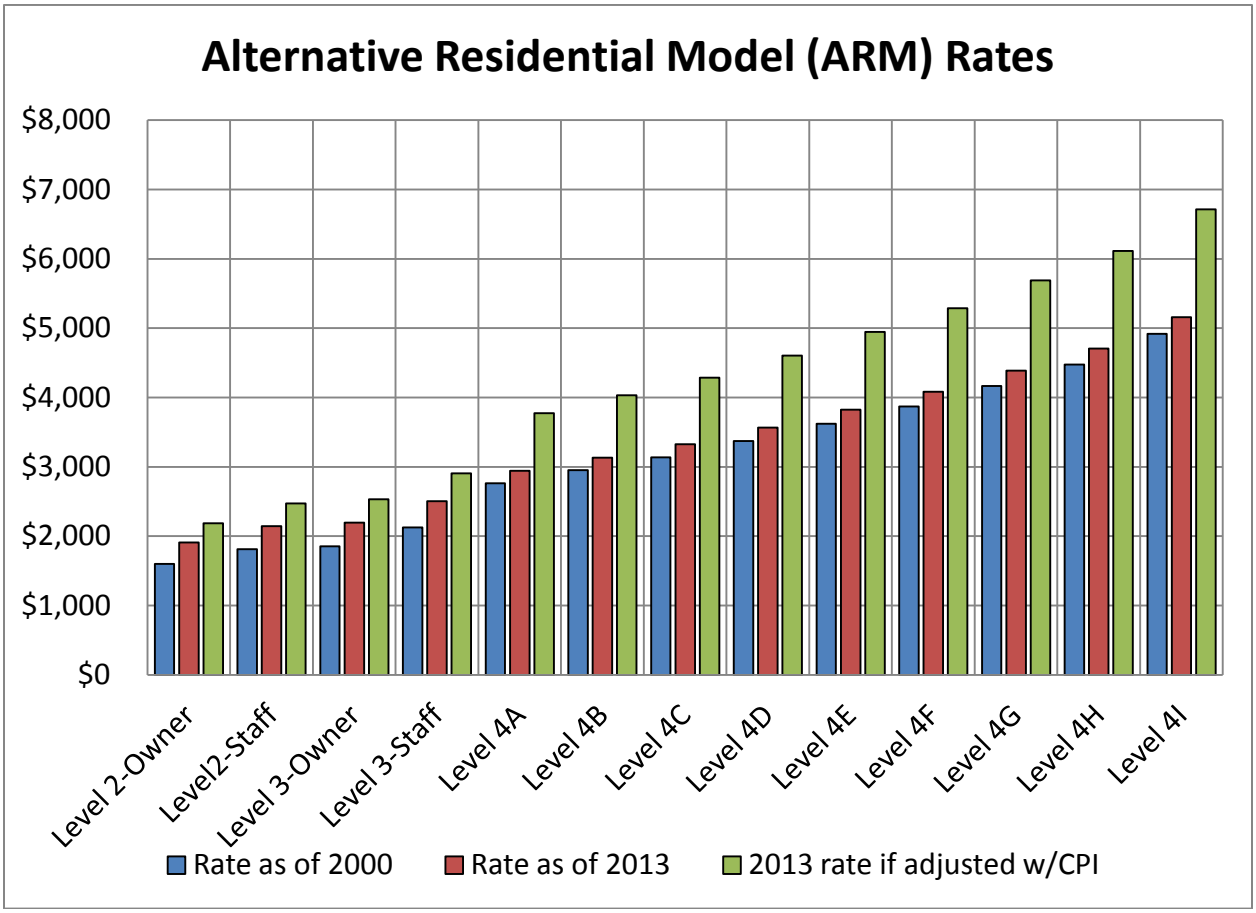
From February 1, 2009 to June 30, 2010, CCFs were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total of 4.25% reduction. On July 1, 2012, the 3% payment reduction ended but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

Although the ARM rates were initially established to reflect residents' level of need, statute froze CCF rates on June 30, 2008. That statute states "…no regional center may approve any service level for a residential service provider, as defined in Section 56005 of Title 17 of the California Code of Regulations, if the approval would result in an increase in rate to be paid to the provider…."[viii] Many individuals become long-term (and, often, life-long) residents in these facilities. As residents age, their needs increase, requiring more support. Regional centers are forbidden, with a few exceptions, from increasing a facility's reimbursement to match the changing needs of the residents. Therefore, as residents' needs increase, either the facility can try to provide more services for the same rate to maintain these individuals in a facility that they consider home, or the resident will have to move.

Rates and Inflationary Growth

In comparing the current ARM rates to those in effect on July 1, 2000, the rates for Level 2 homes have increased by 19.3%, whereas the rates for Level 4i homes (meeting the most complex needs), have increased by only 4.9%. Since July 2000, the Consumer Price Index (CPI) for California has increased 36.6%. Although the CPI is an important indicator in the stagnation of rates, it still does not reflect all of the additional costs of doing business that have occurred.

The chart below illustrates the ARM rates as of July 1, 2000, the current ARM rates, and what the ARM rates would be if they had kept pace with inflation.



Source: DDS Rates Lists.

New Philosophy, Old Rates

In recent years, regional centers have moved towards providing clients with more home-like living arrangements. To achieve this type of living environment, regional centers have requested providers to develop homes with four beds or fewer. This philosophy is driven by the guidelines issued by the Centers for Medicaid and Medicare Services (CMS) for establishing home-like environments that qualify for the home and community-based waiver. The ARM rates were established using a six-bed model that spread the fixed costs over the first five residents, with the sixth resident providing a profit margin. Consequently, care providers find it difficult to develop these smaller homes with the current ARM rates, as fixed costs make it more expensive to operate a facility with fewer residents. This is beginning to result in an inadequate supply of this resource.

Non-Negotiated Rate Community-Based Programs

Day Service Categories, Service Codes, and Client-Staff Ratios

Activity Centers	Adult Development Centers	Behavior Managment Programs
•Service Code 505 •Ratios - 1:8, 1:7, 1:6	•Service Code 510 •Ratios - 1:4, 1:3	•Service Code 515 •Ratios - Variable

Independent Living Programs	Social Recreational Programs	Infant Development Programs
•Service Code 520 •Ratios - 1:3, 1:2, 1:1	•Service Code 525 •Ratios - Variable	•Service Code 805 •Ratios - 1:3, 1:2, 1:1

Ratios are defined in Regulations and/or within the program design

Source: Title 17 Regulations.

History and Foundation of Rate-Setting Procedure

Five types of day programs are defined in Title 17 regulations, with a sixth, for infants and their families, defined in Welfare and Institutions Code § 4693. In 1984, per Welfare

and Institutions Code § 4691, DDS established program standards, and developed a rate-setting procedure delineated in the 'Rate Procedure Manual.' But in 1987, the California Association of Rehabilitation Facilities (CALARF) and others took legal action seeking to compel DDS to make regulations establishing a new set of standards and rate-setting procedures. A settlement of the case, along with additional legislation (AB 877, Chapter 1396, Statutes of 1989), eventually resulted in the adoption of rate-setting regulations for community-based day programs that are in use today. [ix]

DDS set day program providers' rates based on their cost statements. The cost statement calculated a rate of reimbursement for the program, and DDS set the rate depending on where that rate fell within the schedule of "Allowable Range of Rates." That schedule was established by averaging the costs for all the types of like programs throughout the State. Based upon the prescribed calculations in regulations, a lower and upper limit was set, and the average became the temporary rate. New programs received the temporary rate for six months, and then they submitted a cost statement documenting their actual costs for assignment of a permanent rate. If a program's calculated rate was between the upper and lower limits of the "Allowable Range of Rates", then DDS set the provider's rate at their calculated rate. But even if the program's calculated rate was above the upper limit of the "Allowable Range of Rates", DDS would only set the rate at the upper limit. Providers whose calculated rate fell below the lower limit were compensated at the lower limit of the range. In the past, programs would submit cost statements every two years to DDS, which would update the "Allowable Range of Rates" based on the new data. The biannual cost statements would be the driving force for adjustment to the range of rates, which ensured the rate range realistically reflected contemporary costs.

Closely related to day programs are work activity programs, which are defined in Welfare and Institutions Code § 4850.2 (g). Work activity programs assist individuals with increasing their time in paid work, productivity rate, attendance level, and work-appropriate behavior, with the aim of developing the skills necessary for competitive

employment. Similar to day programs, temporary rates are assigned by DDS, but in the case of work activity programs, the permanent rate is set after there are at least three months of cost data.

Rate Adjustments, Reductions, and Freezes

A California Bureau of State Audits report, released in October 1999, stated "if the State had increased funding, providers would have received a rate adjustment every two years; however, there were no rate increases between fiscal years 1992-93 and 1997-98. [In] September 1998 the State granted $33 million in additional funding. Although the increase allowed these providers to receive adjustments, it was only enough to fund rates based on their fiscal year 1995-96 costs… Furthermore, their rates will remain at this level until the department revises its current rate-setting process or receives additional state funding." [x]

The "Allowable Range of Rates" was last updated in FY 1998-99, when that report was written, which means the rates were already substantially outdated and stagnant even prior to the 2003 rate freeze, under AB 1762.

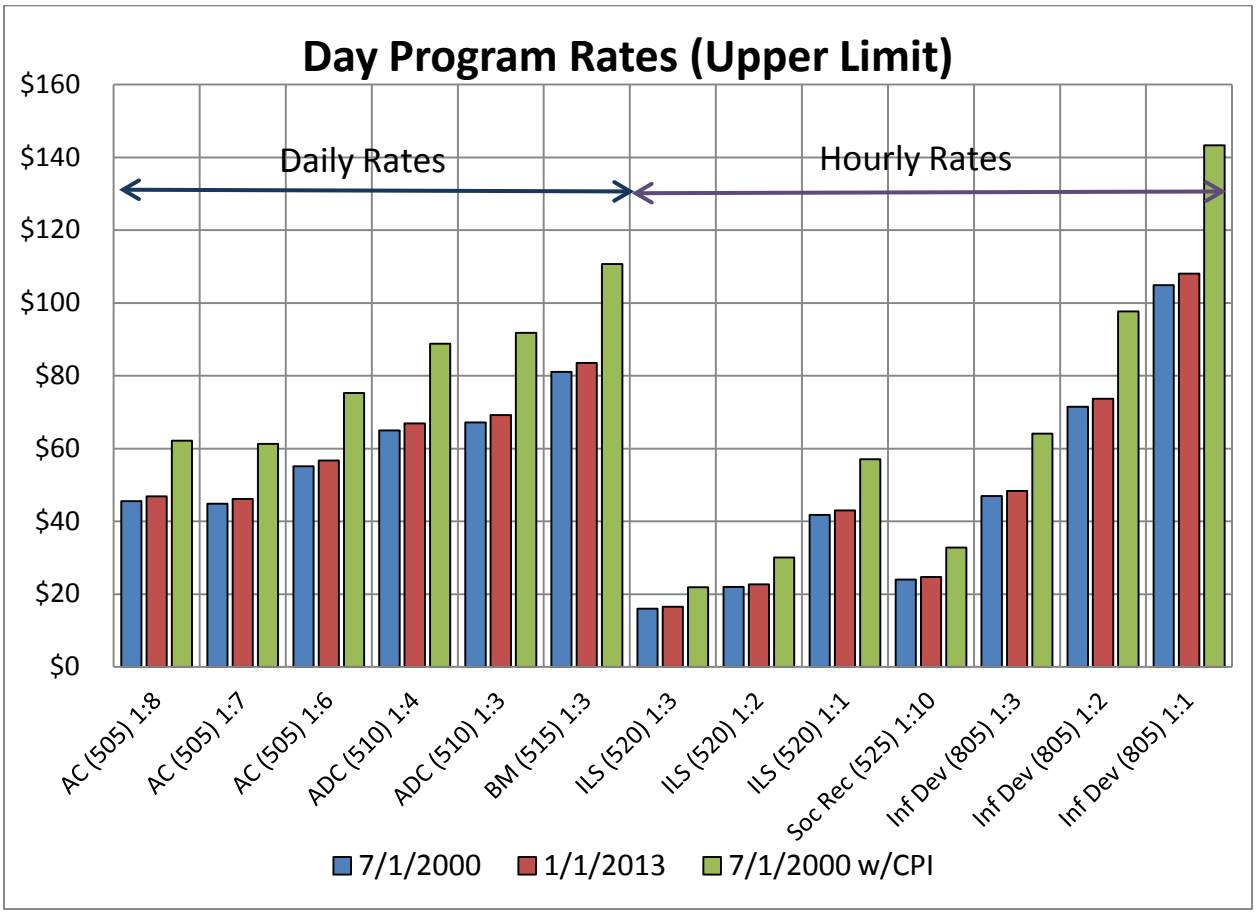
It is important to note that regional centers and providers report that DDS currently sets the rate at the temporary rate, and they remain frozen at this rate indefinitely. Cost statements are not being required and rates are not being considered based upon actual provider costs, which is resulting in underfunding of these programs.

Since FY 2000-01, day program rates were increased in FY 2006-07 by 3%, and then again via an adjustment for the raise of the minimum wage in that same year.

From February 1, 2009 to June 30, 2010, day programs were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total reduction of 4.25%. On July 1, 2012, the 3% payment reduction ended, but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

Rates and Inflationary Growth

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The chart below compares the upper limit rates as of July 1, 2000, the current upper limit rates, and what the upper limit rates would be if the rates had kept pace with inflation.



Source: DDS Rates Lists.

New Philosophy, Old Rates

Day programs have evolved and expanded the scope of their services. Day programs now include behavioral skills training. People moving out of the developmental centers, as well as those in the community with challenging needs, create demands that day programs have to address. Day programs are also being limited to 30 to 45 participants, rather than the larger traditional model, in order to provide more innovative,

individualized, and outcome-driven services. The new smaller model, while preferred, does not work financially for providers given the current rates.

Many programs now place a strong emphasis on pre-vocational skills - helping an individual prepare for the workplace. Some of the needed skills include dexterity, attention span, time management, compliance, and attention to detail. To assist in their success, regional centers work with providers to supply individual or group supports in their place of employment through supported employment.

Supported Employment

History and Foundation of Rate-Setting Procedure

Supported employment provides individuals with the opportunity to work in the community in integrated settings, either in individual or group job placements. Support services are provided to enable individuals to learn job skills needed in order to maintain employment. The services were originally vendorized and authorized by regional centers, but the program later became the responsibility of the Department of Rehabilitation. During this period, the rates were statutorily established, with an aim of balancing overall costs with program outcomes and demand. In 2004, responsibility for the program transitioned back to the regional centers, but the statutory determination of rates continued. This is the only service category which has statutorily-defined rates.

Rate Adjustments, Reductions, and Freezes

Rates for supported employment have risen and fallen with more volatility than rates that are established by DDS. In 1998, the rate for both group and individual supported employment job coaching hours was set at $27.50 per hour (AB 2779). In 2000 it was increased to $28.33 (AB 2876) and reduced in 2003 to $27.62 (AB 1752). In 2004 the rate was again increased to $28.33 when the program was returned to the purview of the regional centers (SBX1 24). In 2006, as a result of too few individuals securing employment, the rate was increased to $34.24 (AB 1807), only to be reduced two years later to $30.82 (AB 1781), a rate that remains in effect today.

Supported Employment Reductions				
Hourly rate for individual Reduced from $34.24 to $30.82	Hourly rate for group services Reduced from $34.42 to $30.82	Intake fees Reduced from $400 to $360	Job Placement Reduced from $800 to $720	90-dayRetention fee Reduced from $800 to $720

Source: AB 1183 (2008)

Rates and Inflationary Growth

From July, 2000, to January, 2013, the CPI for California has increased 36.6%. The rate for supported employment services has increased only 8.8% in that same timeframe.

New Philosophy, Old Rates

Supported employment provides the most integrated work option for individuals served by regional centers. In spite of the increased focus on this outcome, the service has not expanded to meet the needs of a population increasingly interested in it. Consistent with national trends and the passage of recent legislation (AB 1041), the movement of individuals from day programs or directly from school into employment settings is expected to increase. Regional centers work with providers to supply individual or group supports in the person's place of employment through supported employment.

Negotiated Rates

History and Foundation of Negotiated Rates

Negotiated rates, per Section 57300 of Title 17 of the California Code of Regulations, were paid for many services, based on negotiations between a service provider and the regional center (see Appendix D: Service Codes for more information). Regional centers can negotiate rates for services that meet individuals' unique needs.

Title 17 regulations prescribe the service categories that allow for negotiation in order to meet these needs. But "…there [was] little regulatory guidance on how these negotiations [were] to be conducted and few parameters governing how the rates [were] set and adjusted. In an effort to better understand and control costs in areas where

rates are negotiated, DDS embarked on a multi-year project. The first step in this project involved developing and distributing three rate surveys to the regional centers." [xi] The surveys, conducted during FY 2007-08, reviewed the negotiated rates paid by regional centers and the vendors who qualify for negotiated rates.

Rate Adjustments, Reductions, and Freezes

As a result of the review, negotiated rate services were changed to a median rate system – which had the effect of simultaneously being an adjustment, a reduction, and a rate freeze.

A median is determined by arranging data set in numeric order. The middle of the array has an equal number of points above and below it – even if some points are the same. This middle value is called a median. The "median rate" is determined by finding the median among all the rates paid to providers of a particular service code.

Examples:

$2,400	$2,500	$2,800	$3,000	$4,900	$5,000	$5,600

The median rate in the example above is $3,000

$10.75	$10.75	$11.38	$11.38	$12.99	$18.78	$33.95

The median rate is $11.38 (although the mathematical average, or "mean," is $15.71, and there are several duplicate rates. The middle remains the middle.)

After the study was completed, DDS set the median rates based on the 2007 data in the regional centers' rate tables. Those rates included the median rates at both the regional center and state level. The former reflected the median paid for each service within each regional center's catchment area. The latter was the median of each service's rates across the state. 77 service code categories were impacted by the introduction of the median rates. Commencing July 1, 2008, with few exceptions, existing negotiated rates were frozen at the rate in effect as of June 30, 2008.

Median rates for all new negotiated rate services/providers, inclusive of specialized residential facilities and supported living services, were established. Once the rates were set, they were frozen (AB 5, Welfare and Institutions Code § 4691.9). Median rates require the vendoring regional center to use either their median rate or the statewide median rate, whichever is lower (AB 5 and AB 1183, Welfare and Institutions Code § 4681.6 and § 4689.8). In many cases, the statewide median is much lower than the regional center's median and is inconsistent with other similar programs vendored by that regional center. This creates a wide disparity in rates between existing and new providers, and creates difficulty in obtaining new providers. Service providers in regions with particularly high costs of doing business are immediately short-changed by this methodology. Some statewide median rates are lower than the current minimum wage. In 2011, median rates were reviewed and recalculated based on updated data from regional centers, resulting in some median rates being decreased.

From February 1, 2009 to June 30, 2010, negotiated rate services were subject to a 3% payment reduction. On July 1, 2011, an additional 1.25% payment reduction was added, resulting in a total reduction of 4.25%. On July 1, 2012, the 3% payment reduction ended, but the providers were still subject to the remaining 1.25% reduction. On July 1, 2013, the remaining 1.25% payment reduction ended.

When median rates were established by DDS, regional centers and service providers raised a number of concerns. Two of them, explained below, illuminate the severe constraints the median rate places on the service system.

Some service codes, called "miscellaneous service codes," can be used by a regional center for multiple types of services. For example, socialization training is used for social skills training provided by a licensed therapist, which requires a higher rate based on a therapist's expertise and training. This rate was also used for various after-school socialization opportunities or activities receiving much lower rates. Therefore, this particular service code could have varying hourly rates of $10.00, $12.50, $28.75, $70.00, or $95.00, resulting in a median rate set at $28.75. Individuals with the

diagnosis of autism frequently require this type of service. Yet with this low rate, the opportunity to expand the availability of new, licensed and skill-intensive providers has been extremely difficult, if not impossible.

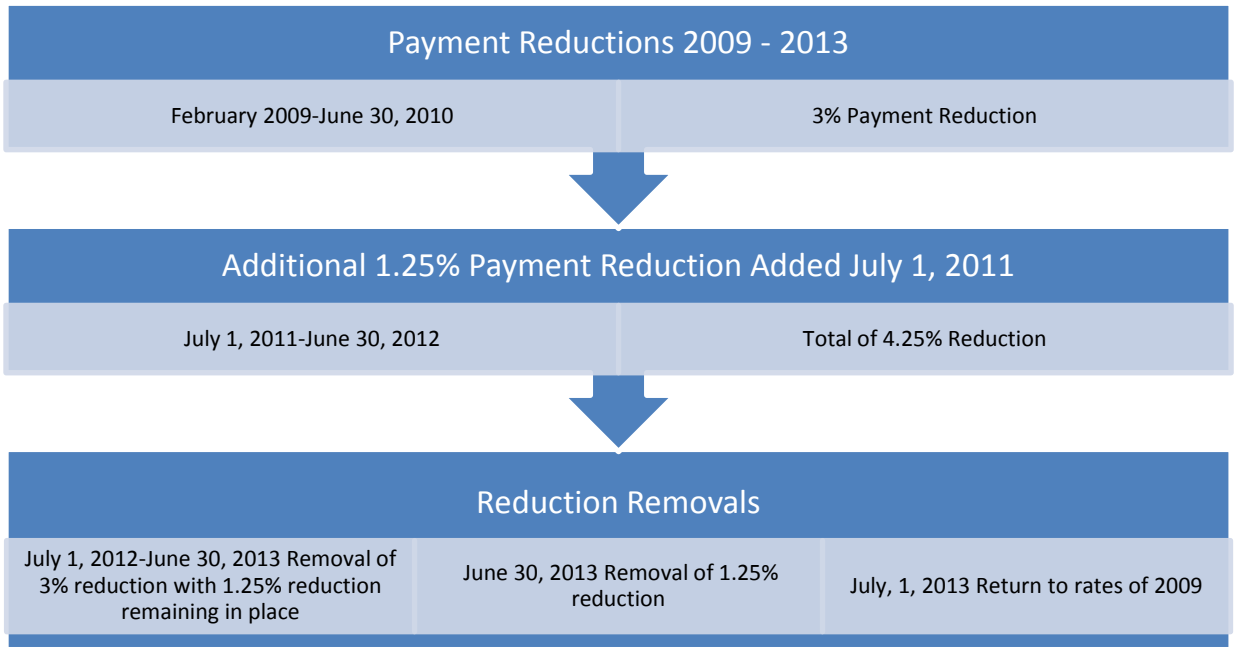
Another important issue is the start-up of new facilities. A vendor with a long track record of excellent work may wish to expand their services to meet regional needs. If they provide those services at a facility (a "site-based" program) and decide to open a new site, they would be subject to the median rate at the new site. They would not be paid their existing rate for the **same service.** Regardless of the service – and vendor – being identical, since it is being provided at a new site, it is considered a new service. If a vendor does not have a site, because their services are offered within the community (*e.g.*, services helping an individual actively participate in the community), then they can expand their services to more individuals through their existing vendorized business. Without a new vendorization, they retain their current rate, and are not subject to the median rate. This creates an inequity between vendors. It also makes it difficult for those providers who are subject to the median rate to expand services to other geographic locations where their services may be needed.

CALIFORNIA BUDGET CRISES AND THEIR EFFECTS ON SERVICE PROVIDERS

Since 2000, there have been recurring budget crises impacting the rates of services for persons with developmental disabilities. In response to these crises, and in attempts to contain costs, over several years various legislation was passed that eroded services. In 2003, many service rates were frozen at their already inadequate rates, and these rates remain frozen. Also in 2003, there was a restriction placed on regional centers preventing the use of POS funds to start up new programs. Service providers were subject to payment reductions from 1.25% to 4.25% from 2009 to 2013. Other factors affecting services were the implementation of an ongoing uniform holiday schedule (FY 2009-2010), a requirement for independent reviews and audits, and an administrative cap of 15% for providers (2011).

Payment Reductions and Freezes

From 2009 through 2013, regional centers were required to implement payment reductions for most services (Sec. 10 of Chapter 13 of the third Extraordinary Session of the Statutes of 2009, as amended by Section 16 of Chapter 9 of the Statutes of 2011). Two separate reductions, of 3% and 1.25%, were put in place.



Although on July 1, 2013, those reductions were ended, rates still remain low and far behind where they should be, due to lack of adjustments and rate freezes. The additional effect of this payment reduction, although time-limited, took its toll on many of the providers.

Aside from small rate increases and an adjustment for the minimum wage to three of the service categories (residential levels 2 and 3, day programs, and in-home respite) in FY 2006-07, rates have remained stagnant, while inflationary pressures have increased (*i.e.*, fuel costs and worker's compensation).

In 2003, many service rates were frozen, and continue to remain so by virtue of an annual renewal of this freeze (initially set forth by AB 1762, Chapter 230, Statutes of 2003. Welfare and Institutions Code §§ 4648.4, 4691.6, and 4681.5). The services in the table below were initially subject to the rate freeze, but additional services' rates were frozen by subsequent legislation, to be discussed later in this paper (see Appendix A: Glossary for more information).

Supported Living Services	Transportation, including travel reimbursement
Socialization Programs	Community Integration Programs
Mobile Day Programs	Behavior Intervention Programs
Creative Arts Programs	Supplemental Day Service Program Supports
Adaptive Skills Trainers	Independent Living Specialists
Community Care Facilities	Day Programs
Respite Agencies	

Source: AB 1762, Chapter 230, Statutes of 2003.

Decrease in Available Service Days

During FY 2009-2010, Trailer Bill language (ABX4 9, Chapter 9, Statutes of 2009) added § 4692 to the Welfare and Institutions Code. Called the "uniform holiday schedule," it imposed fourteen total unpaid/non-service (furlough) days each year on work activity programs, activity centers, behavior management programs, social recreation programs, and infant development programs. In addition to day and work programs, it also impacted a number of other services: adaptive skills trainers; socialization training programs; client/parent support behavior intervention programs; community integration training programs; community activities support services; program support groups (day service); and creative arts programs. It was effectively a 1.6% reduction in funding for these programs. It also placed burdens on family members and residential providers who had to provide care on these additional

holidays. The uniform holiday schedule was implemented August 1, 2009 and remains in place today.

Independent Reviews and Audits

On March 24, 2011, Welfare and Institutions Code § 4652.5 required an independent review of vendors who receive regional center funding in excess of $250,000, and an independent audit of vendors who receive regional center funding in excess of $500,000. Vendors are reporting that the cost of these reviews and audits can run between $4,000-$15,000. The threshold for these reviews and audits is low; many small providers meet this threshold. For example, the owner of a single Level 4i home with five of their six beds filled could be funded at over $300,000 annually, requiring an independent review. As previously indicated, the ARM rate was based on the fixed costs spread over five beds, with the sixth bed as a profit margin. Given this scenario, the residential provider may barely cover their fixed costs, yet is responsible for the additional expense of an independent review. These reviews/audits do not yield useful information for the regional centers from a quality assurance (QA) perspective. The focus is fiscal, not programmatic, and does not examine utilization of funds as intended within their program design. The audits do not provide the regional centers with information relevant to determining if the provider is using the money appropriately for direct services to the individuals served. This requirement places an additional financial burden on many providers, and negatively impacts the ability to provide direct services to the individuals they serve.

Administrative Cap of 15%

Trailer Bill Language (SB 74, effective March 24, 2011) added § 4629.7 to the Welfare and Institutions Code, requiring all regional center contracts or agreements with service providers to expressly require that not more than 15% of regional center funds be spent on administrative costs. Direct service expenditures are those costs immediately associated with the services provided to clients. Administrative costs include, but are not limited to, any of the following:

- Salaries, wages, and employee benefits for managerial personnel whose primary purpose is the administrative management of the entity, including, but not limited to, directors and chief executive officers
- Salaries, wages, and benefits of employees who perform administrative functions, including, but not limited to, payroll management, personnel functions, accounting, budgeting, and facility management
- Facility and occupancy costs, directly associated with administrative functions
- Maintenance and repair
- Data processing and computer support services
- Contract and procurement activities, except those provided by a direct service employee
- Training directly associated with administrative functions
- Travel directly associated with administrative functions
- Licenses directly associated with administrative functions
- Taxes
- Interest
- Property insurance [xiii]

Some providers report that California has a tremendous amount of employment and tax regulations that require expertise that they do not have as a clinician, for example. The providers must hire or contract for payroll, human resource department or staff (HR), data and computer services, and office staff for scheduling. These employed/contracted individuals stay apprised of employment laws, workers' comp issues, taxes, disciplinary issues, quality assurance, and finance.

Providers now must also participate in E-billing requiring data entry to submit billings to regional centers. They have to have the expertise and manpower for billing insurance companies and regional centers for services and co-pays. In an attempt for providers to become more productive and responsive in case reporting to regional centers, they are becoming more automated, allowing staff to do electronic scheduling and online report

writing, etc. Automation results in requiring Information Technology (IT) assistance for protection of information as related to the Health Insurance Portability and Accountability Act (HIPAA).

The cost of insurance and workers' compensation is increasing dramatically. Providers who work with the more challenging individuals state that their workers compensation increases with injuries occurring during the course of doing business.

Providers are also reporting that they will be affected by the Affordable Care Act (ACA), but the state currently does not allow for adjustments to rates in response to legislative changes/mandates.

Restriction on Start-up Funding

Initially set forth by AB 1762 (Stats. 2003, Ch. 230), Welfare and Institutions Code §§ 4781.5 & 4781.6 restricted regional centers from using POS funds to start new programs. Before this, regional centers could use POS funds to help start programs to serve unmet needs. But AB 1762 limited start-up funding to just two circumstances – the protection of client health and safety, or "extraordinary circumstances." The regional center must receive prior written approval from DDS in either case.

There are a number of different reasons start-up funding is helpful in establishing services within a given geographic area (as indicated by a needs assessment). The ability to establish services closer to where individuals live improves access to services in their own communities, and can be more cost-effective by decreasing the need for an extensive transportation network and its related costs.

Separately, regional centers have the ability to utilize Community Placement Plan (CPP) budgets to offer start-up funds for specialized services for individuals moving from the developmental centers, and for those at risk of placement in a developmental center. These factors limit the ability of regional centers to offer specialized services and maintain long-term viability within the community.

Changing Needs For a Changing Population

The Center for Health Policy Studies reports that *"today's complex, community-based service delivery is comprised of thousands of different providers… Requirements for providers have also grown in sophistication as federal and state laws have changed. Expectations of the community service delivery system have also become more rigorous as knowledge and information about best practices are more readily shared through conferences, resource libraries, internet webpages and listservs…*

To a large extent, our sense of successful service provision has been focused on the quantity of services provided….The reports of workgroups recognize the importance of requiring and gathering information on the quantity of services provided and compliance with law and needed regulations. However, they recommend an additional focus that asks: Is anyone better off? ...In the past ten years, there has been a nationwide movement toward outcome-based service delivery that links quality assurance processes for providers to the achievement of consumer and family outcomes." [xiv]

Changing Demographics' Effect on Service Needs

A 2004 study by Braddock and Hemp found a quartet of factors driving demand for services. Youth aging out of special education programs, increased longevity (coupled with aging caregivers), and a general trend out of institutional, and into community, settings. [xv]

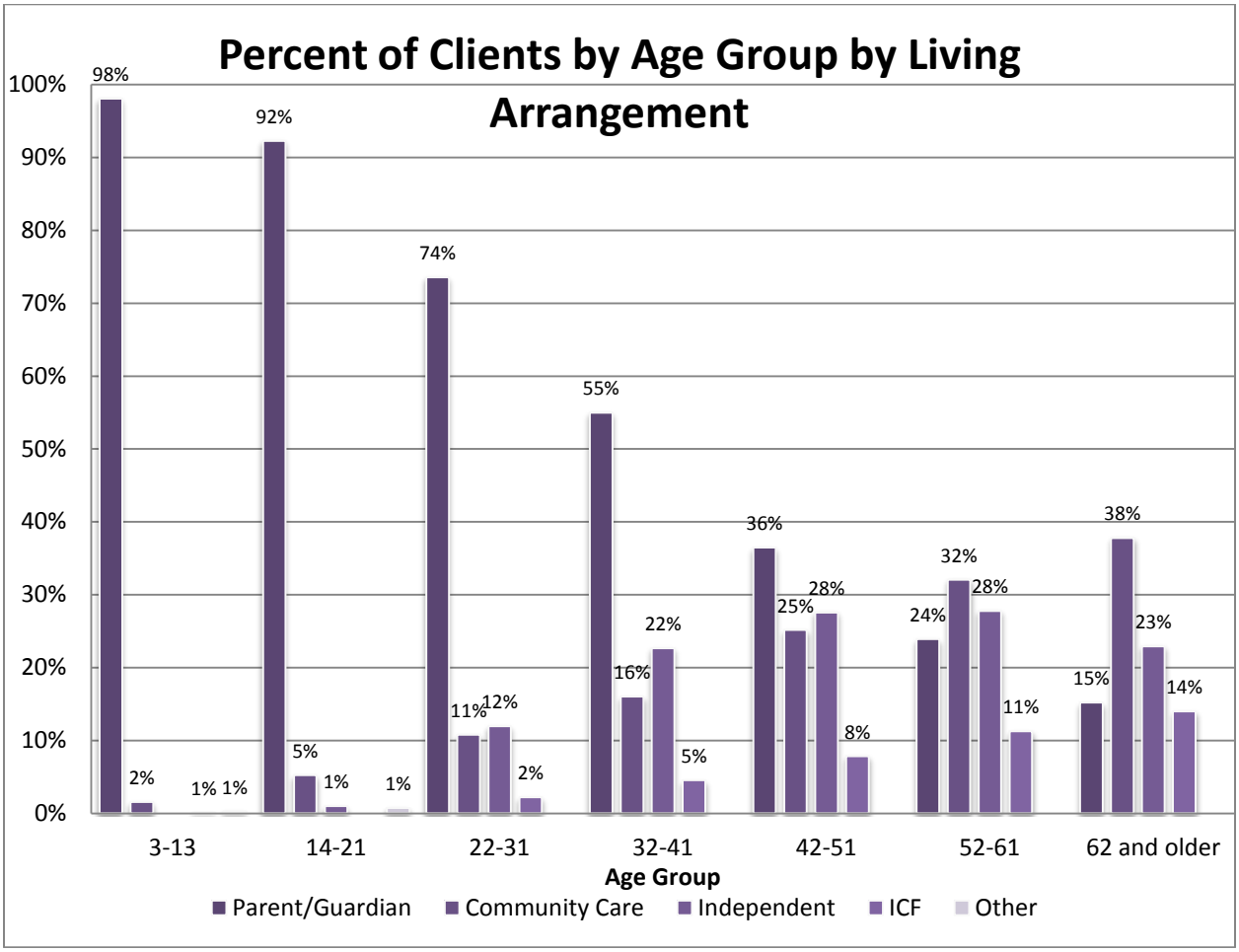
In 2011, a report from University of California, Los Angeles (UCLA) reiterated those concerns and found that improvements in modern medicine have increased the life expectancy of persons with developmental disabilities. In a lifetime-service system, this translates to more years of service needs and needs that grow more intense as individuals age. As they age, the caregiving provided by aging parents must often be

supplemented or replaced by more formal services. And “when a caregiver dies, a DDS consumer likely requires an alternative residential setting at a high cost.” [xvi]

Current data bears out the timeless truth and growing relevance of the core findings of those two studies.

Living Arrangements

As indicated in the chart below, individuals 21 years and younger primarily live with their parent or guardian, but this begins to shift significantly from the age of 22 on.



Source: DDS Quarterly Report – September 30, 2013.

It is projected that individuals served by the regional center system, ages 42-62 and older, who are currently living with their parent(s) or guardian(s) will require residential and day/work services in the coming years to support them in the community.

Aging Caregivers

"An aging caregiver may require an increased level of services and supports to maintain their family member in the home. When these caregivers die, or are no longer able to support their loved ones, alternative living arrangements must be developed or located. Almost all forms of out-of-home care are more costly than supporting a person in their own home. The Department's data clearly shows that the percentage of consumers living out-of-home increases as they age." [xvii]

Individual choice and needs change over time

The data indicate that almost 90% of 18-21 year-olds still live with their parent(s) or guardian(s). Among 22 to 31-year-olds, roughly 74% have such living arrangements. In short, as with the population as a whole, as the adult child ages, they move from the parent/guardian's home to another living arrangement. There are different reasons for this movement, such as the choice to live in another setting as an assertion of independence or an aging parent being unable to continue to care for them. The new living arrangement is not always a community care facility, but there will still be a need for services and supports, such as independent living skills, to help them to maintain that new situation.

With increasing age, individuals' needs expand to require community care facilities, supported living, personal assistance, transportation, medical services, or medical equipment. With individuals' increased needs, it can be projected that those in independent living may require personal assistance, medical assistance, community care, or ICF or SNF placement, dependent upon their age and/or health-related variables.

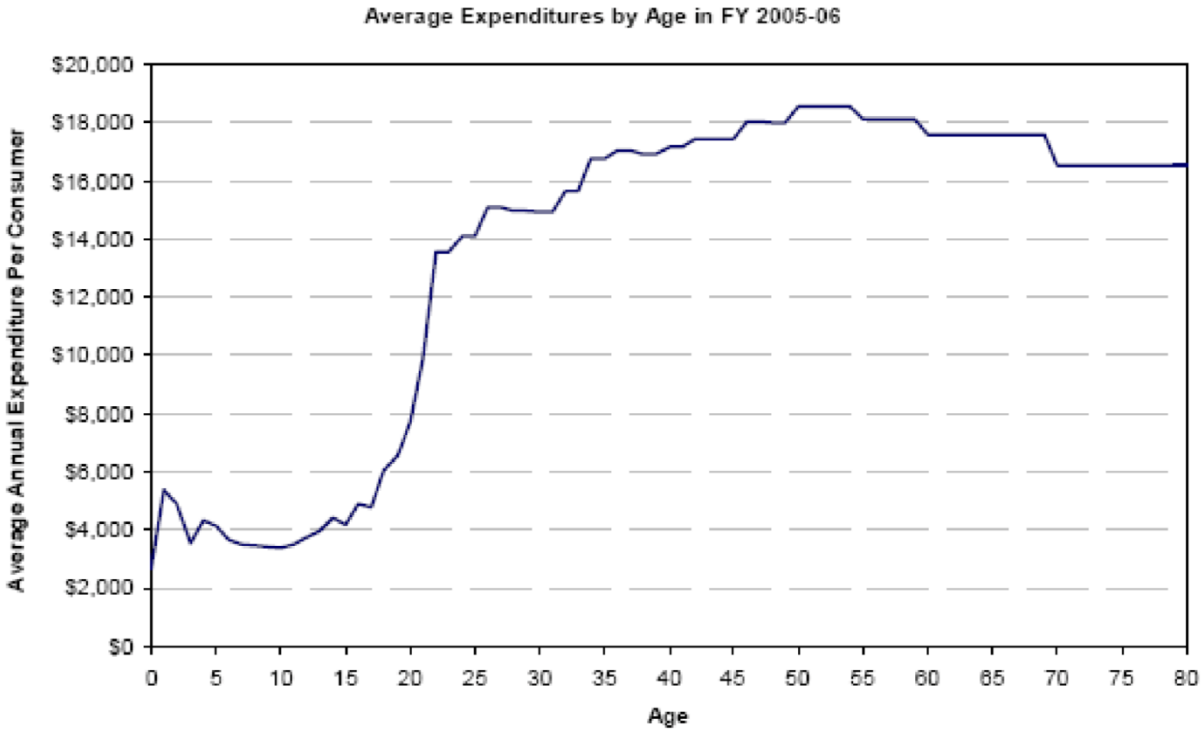
Given the need for these additional services and supports, the system needs to be prepared to have an array of alternative living arrangements and other support services available. This requires an assessment of need and the proactive development of resources. To facilitate this, an adequate rate structure needs to be in place to encourage providers to expand their services to address the growing need.

As of September 2013, there are 5,427 individuals 52-62 years and older still living with their parents, 2,096 who are 62 years and older living independently, and 1,422 individuals still residing in the developmental centers. Regional centers will have to develop community services for up to 8,945 individuals in the next five to ten years.

Individuals Aging Out of the Public School System

The number of young adults who will be transitioning out of the public education system in the next decade is significant. There is an increase in regional center costs when this happens because those individuals require day or work programs, independent living skills training, residential services, or other supports to assist them to work and live as independently as possible. Additionally, young adults with autism typically need a higher intensity and number of services. This issue has been compounded in recent years by the sharp decrease in funding for adult education programs which once funded services to many adults without cost to the regional centers. This shift in funding from a generic resource to the regional centers creates additional pressures for development and sustainability.

Per-client expenditures by age



Source: "Controlling Regional Center Costs." [xix]

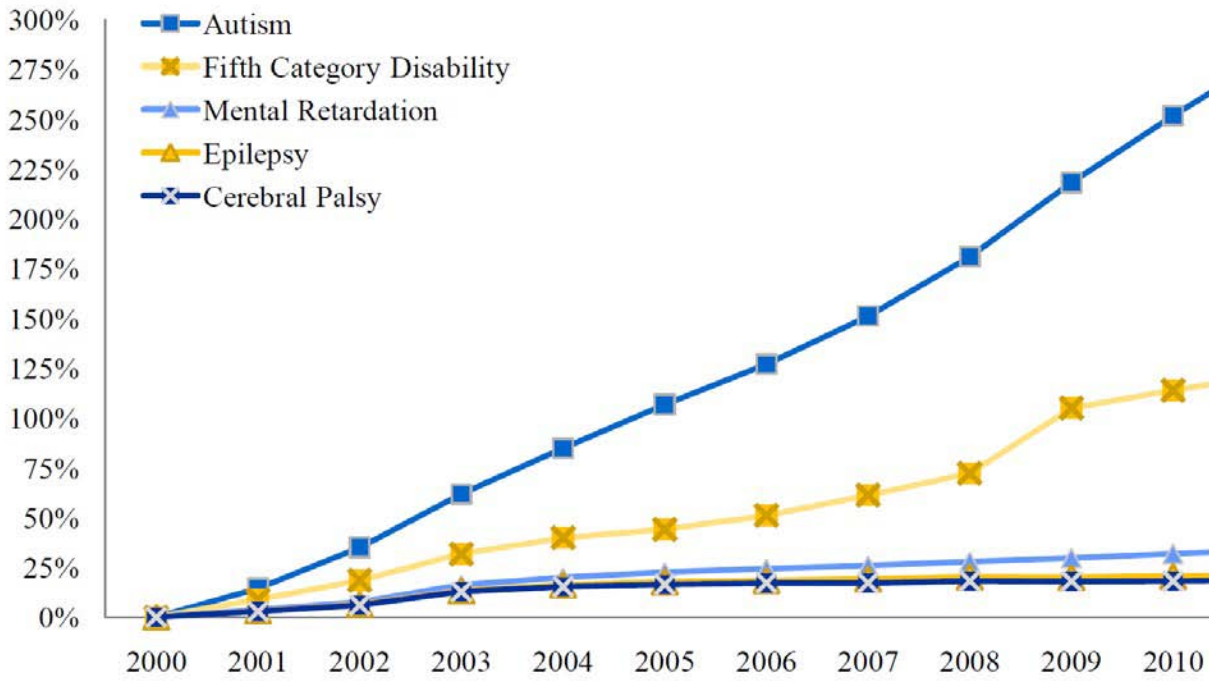
The DDS quarterly report of September 2013 indicates that the number of children with an eligible developmental disability between the ages of 10-21 years (regardless of diagnosis) are:

- 10-13 years - 24,758
- 14-17 years - 22,452
- 18-21 years - 23,924

From the statistics in the report, it can be projected that community-based services will need to be developed to meet the needs of 71,134 young adults in the next twelve years, and of them, almost 24,000 will need services in the next three years alone.

The majority of children with developmental disabilities aging out of the school system have autism. As indicated in the chart below, the growth has exceeded the number of persons with other developmental disabilities.

Growth in California population with autism versus three other major developmental disabilities and the "fifth category," 2000–2010



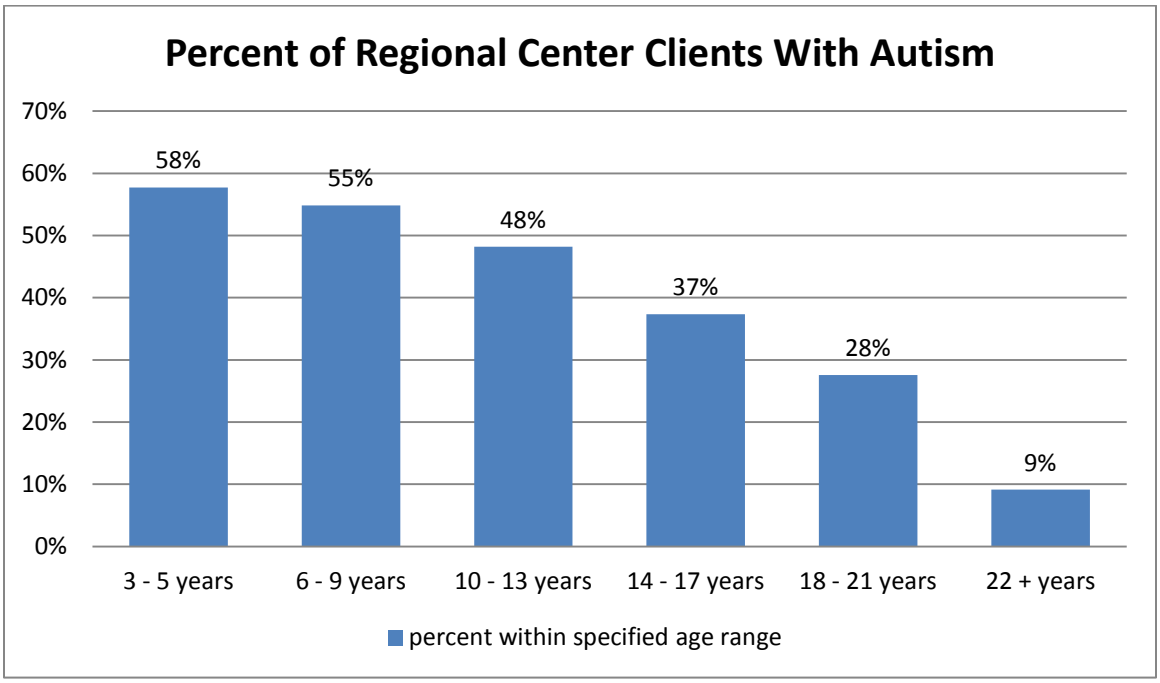
Notes: Developmental disability groups are not mutually exclusive, due to potential duplication of individuals across diagnostic categories. The "fifth category" refers to disability conditions found to be closely related to mental retardation or to require similar treatment (Welf. & Inst. Code §4512).

Source: Authors' analysis of data provided by Department of Developmental Services Data Extraction Unit; 2011.

Source: "Challenges to Sustaining California's Developmental Disability Services System." [xviii]

Most persons with autism are in the younger age ranges. There are many services offered to younger children with autism, but the cost of services is usually shared with schools and private insurance. Also illustrated in the chart below, only 9% of adults older than the age of 22 served by regional centers have a diagnosis of autism. In spite

of this low percentage, the development of services to meet their needs associated with aging is a significant challenge as well.



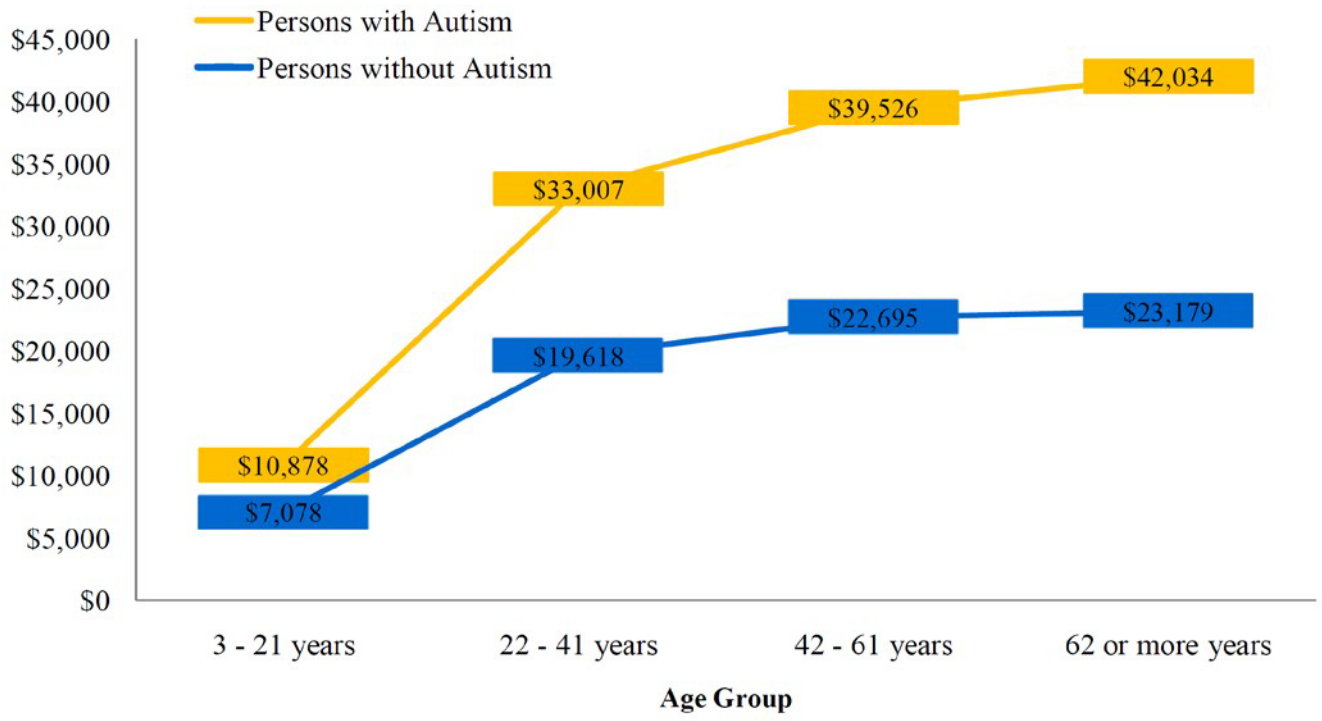
Source: DDS Quarterly Report – September 30, 2013.

The DDS quarterly report as of September 2013, indicates:

- Individuals ages 10-13 years (11,926) have a diagnosis of autism
- Individuals ages 14-17 years (8,382) have a diagnosis of autism
- Individuals ages 18-21 years (6,599) have a diagnosis of autism

Community-based services and supports to meet the specialized needs of almost 27,000 young adults with autism will need to be developed over the next 12 years. Those services and supports are generally more expensive than for persons with other diagnoses. The challenge the median rate creates for regional centers is an inability to negotiate adequate rates, not only for the establishment and expansion of the needed services, but also to sustain these services.

Average annual expenditure per Regional Center client by age group for those with autism and those without (FY 2006-07)



Source: Department of Developmental Services, *Factbook, 11th Edition*, 2008, State of California, Department of Developmental Services.

Source: "Challenges to Sustaining California's Developmental Disability Services System." [xx]

Individuals with Challenging Needs

Many negotiated rate services address severely challenging needs, whether medical, psychiatric, forensic, or a combination thereof. Supporting individuals with complex needs requires staff with extensive training and experience in the individual's particular area of need. Staff-to-client ratios, as well as staff skills, are the primary drivers of service cost for this population. The table below illustrates the number of individuals served in forensic or psychiatric facilities and out-of-state placements.

In 2012, Trailer Bill language (AB 1472), created Welfare and Institutions Code § 4648(a)(9)(B) and (C), which prohibits regional centers from purchasing residential services from facilities that are not eligible for federal funding. The law went into effect

July 1, 2012. All residents are to be moved out of those facilities by June 30, 2014. To develop appropriate community settings to meet those individuals' unique and intensive needs it is commonly acknowledged as taking up to three years. Only two years were provided in law and regional centers were expected to begin transition almost immediately without sufficient resources. More fundamentally, the services required are subject to the median rate, making it extraordinarily difficult to find service providers to meet those needs.

Type of Facility	Number of Individuals (Statewide)
Criminal Justice System	208
Facilities Ineligible for FFP	149
Out-Of-State	24
Total: 381	

Source: Department of Developmental Services, Individuals with Challenging Needs, November 2013.

There are hundreds of individuals who need specialized services to meet their medical, psychiatric, and forensic needs who are not currently in these facilities. These individuals remain in the community accessing a patchwork of available services. This patchwork frequently costs more than if a specialized, holistic service with an adequate rate structure was able to be developed.

The Health and Human Services Agency convened a Task Force on the Future of the State's Developmental Centers. Its report, released at the end of 2013, identified 445 individuals with complex medical needs, 315 of whom will require specialized medical homes in the community. The Task Force also identified 227 residents with complex and challenging behaviors and approximately 200 other residents with involvement in the criminal justice system. All of these individuals will most likely require more

specialized negotiated-rate living arrangements and day programs to meet their needs in the community.

REPORTS AND STUDIES

1997: Department of Developmental Services (DDS) Report to the Legislature

As part of the 1996 Budget Act, DDS was required to review existing methodologies in use, survey other possibilities, and gather stakeholder input. In November 1996, DDS met with stakeholders to review current, and recommend new, rate-setting practices. In summary, DDS said "retaining the existing system would involve no disruptions of current practices and trends, and allows continued use and evaluation of the several alternatives, and particularly the AB 637 proposal process discussed…that are designed to increase the flexibility and creativity of regional centers in meeting local needs. It is undesirable to alter the system before the efficacy of present and anticipated practices can be assessed." [iii]

Reports and Studies

1997
Department of Developmental Services Report to the Legislature

1999
Bureau of State Audits Report

2000
DDS May Revise

2001
Center for Health Study Policies report in response to SB 1038

2007
DDS Report to the Legislature on Controlling Costs

2011
UCLA Study on Challenges to the System

1998: Senate Bill 1038

Welfare and Institutions Code § 4681.1, enacted by SB 1038, states that the department shall adopt regulations that specify rates for community care facilities. As a result, DDS contracted with the Center for Health Policy Studies to examine the rate system and identify a methodology for payment to providers that would support the achievement of the desired outcomes for clients and family.

1999: Bureau of State Audit Report

The BSA found "the State's system was designed to provide optimal service to adult consumers, yet insufficient funding hampers providers' and regional centers' ability to appropriately supply services and retain staff. Inadequate state funding often forces centers to pay providers rates that do not reflect current economic conditions, which increases the chance that consumers will receive fewer or inferior services and increases the difficulty providers have in retaining staff." [iv]

2000: May Revise to the Governor's Budget:

In comments submitted with its request for rate increases for several services, DDS stressed the importance of adequate funding. "Without funding sufficient to recruit, train, and retain a skilled labor force, the Department puts at significant risk the health, safety, and well-being of consumers. Specialized knowledge results from a long-term relationship with consumers, families, and the surrounding community. Turnover issues are amplified in the lives of consumers and families when the knowledge, skills, and abilities of the experienced direct support professional gains over time is lost. The transfer of knowledge to newly hired workers is incomplete, and results in a reduction in service quality. Without sufficient funding, we jeopardize the long-term investment value of a skilled workforce." [v]

2001: Center for Health Policy Studies

As a result of 1998 legislation, DDS contracted with the Center for Health Policy Studies (CHPS) to develop a cost-modeled rate system. The two-phase contract ran from February 1, 2000, through July 31, 2001. The first phase was to develop a residential rates model. The second phase was to apply the model to other services. The model developed was built around client outcomes. From that baseline, it allowed for the incorporation of different variables, such as current economic trends, changes in law (*i.e.*, minimum wage), and other elements to be accounted for, thereby making rate adjustments fair and equitable among providers. The conclusion was that cost-modeled systems, if funded adequately, and if developed for all service types, would promote consistency and fairness among providers. [xiv]

2007: DDS Report to the Legislature

DDS completed a report in response to "legislation chaptered on August 24, 2007, [that] required the Department of Developmental services to 'develop a plan of options for consideration by the Administration and the Legislature to better control regional center costs of operating and providing state-supported services." This report contains an extensive review of the developmental services system. The report concludes by stating "there are no simple solutions for reducing regional center expenditures. However, it is critical that discussions about cost containment are informed by an understanding of the existing system so that fiscally responsible decisions can be made while ensuring quality services for [clients] and their families." [vi]

2011: UCLA Study

A UCLA report, published almost ten years after the 2001 CHPS study, reiterated CHPS' conclusion: *"Establishing a fee schedule that is informed by thorough cost-based analysis and that incorporates adjustments for the increasing cost of service provision would allow vendors to sustainably maintain operations by limiting undue fiscal strain. A cost-based analysis recognizes the inherent variability in consumer needs -- where more severe conditions require more intense and expensive services -- and it also engages stakeholders in the rate-setting process.*

Furthermore, the cost statements required for rate setting should reflect the true costs of providing efficient and high-quality services, as required by the California Welfare and Institutions Code § 4690. This would allow for the consideration of any mechanisms that have been employed by vendors to reduce costs in a rate-restricted environment in order to maintain solvency. The inclusion of an explicit adjustment for input price inflation, such as the Consumer Price Index (CPI), would mitigate threats to access by recognizing the ongoing cost increases faced by vendors." [vii]

SUMMARY

From a policy perspective, California's developmental services system is poised to promote better service outcomes for more than 265,000 individuals with developmental disabilities. Services will be more individualized and will lead to greater levels of community participation, employment, and independence. Unfortunately, long-standing underfunding of the service system undermines this potential forward progress and the adequacy of the community-based provider network.

The concepts in this paper are not new. Studies dating back many years speak to the same point, but it bears repeating now. Even though client outcomes are directly tied to the quality and availability of services, the rate structure inhibits their quality – or makes it impossible to provide them. Acknowledging the problem with a passive response does not help the people we serve to progress. The challenge before us looms large only because it has been ignored for so long.

The provision of services has changed dramatically in recent years, owing to the shift in client population and advances in knowledge and methods of intervention. Accompanying these changes has been an evolution of services and service categories, as existing models were not flexible enough to meet emerging needs. The ability to negotiate rates for more innovative or individualized service models makes them viable. It is critical that all service codes be considered for rate-setting review. As the philosophy of the developmental services system evolves, and better outcomes are expected, there needs to be a renewed commitment to develop and sustain service models to meet the needs of individuals both today and in the future.

Over fifty years ago, California made a promise to the state's most vulnerable residents. The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to the people with developmental disabilities as follows: "The State of California accepts a responsibility for persons with developmental disabilities and an

obligation to them which it must discharge…" Absent effective intervention, the health and well-being of clients and their families, for whom the state has accepted responsibility, are at risk. [xxi]

ENDNOTES

[i] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 14.

[ii] "Supporting Californians with Developmental Disabilities," CPRC/CPAC Briefing Paper, California Policy Research Center, University of California, Berkley, 2006, p. 4-5.

[iii] "Rate Setting Alternatives for Community-Based Day and Residential Services," Report to the Legislature, Department of Developmental Services, Community Services Division, February 27, 1997, p. 19.

[iv] "Department of Developmental Services: Without Sufficient Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults," Bureau of State Audits, California State Auditor, October 1999, p. 14.

[v] "Rate Increase for Day, Infant, and Respite Programs," State of California May Revision Proposal, Fiscal Year 2000-2001, Department of Developmental Services, April 2000, p. 4.

[vi] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 98.

[vii] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 7.

[viii] Welfare and Institutions Code § 4681.5 (*Amended by Stats. 2008, 3rd Ex. Sess., Ch. 3, Sec. 6. Effective February 16, 2008.*)

[ix] "Department of Developmental Services Detail of Proposed Changes," 2001 May Revise to the Governor's Budget.

[x] "Department of Developmental Services: Without Sufficient Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults," Bureau of State Audits, California State Auditor, October 1999, p. 15.

[xi] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 52.

[xii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 12.

[xiii] "Additional Clarification on Implementation of Statutory Requirements in SB 74, Chapter 9, Statutes of 2011," Department of Developmental Services, Letter of Regional Center Executive Directors, September 16, 2011, p.4.

[xiv] Draft Report to the Service Delivery Reform Committee, Center for Health Policy Studies, May 15, 2001.

[xv] "Analysis of California's Commitment to Developmental Disabilities Services," David Braddock, Ph.D. and Richard Hemp, M.A., January 23, 2004, p. 8.

[xvi] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 4.

[xvii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 23.

[xviii] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 3.

[xix] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 26.

[xx] "Challenges to Sustaining California's Developmental Disability Services System," UCLA Center for Health Policy Research, March 2011, p. 4.

[xxi] WIC § 4501