

October 9, 2014

Senator Jim Beall, Chairperson
Senate Human Services Committee
State Capitol, Room 2068
Sacramento, CA 95814

RE: Association of Regional Center Agencies' Testimony for *The Lanterman Act: Promises and Challenges Hearing*

Honorable Senator Beall:

The Association of Regional Center Agencies (ARCA) represents the network of 21 non-profit regional centers that coordinate services for, and advocate on behalf of, Californians with developmental disabilities.

In 1969, in response to the grassroots advocacy of parents of individuals with developmental disabilities, the Lanterman Act was signed into law and established that "[the] State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge." With the passage of the Lanterman Act, the state designated regional centers as its agents to act as a single point-of-entry into the service system and to carry out the state's responsibilities to individuals with developmental disabilities and their families throughout California. At its core, the goal of the developmental services system is to provide local support to persons with developmental disabilities, that they may lead independent, productive lives in the community.

Regional centers, as independent non-profit organizations, contract with the Department of Developmental Services (DDS). Regional centers are governed by boards of directors, legally required to be primarily comprised of persons with developmental disabilities and family members of individuals with developmental disabilities. Regional centers serve nearly 275,000 persons with epilepsy, autism, cerebral palsy, as well as intellectual disabilities and similar conditions.

Regional centers use person-centered planning to identify the services and supports needed by individuals and their families to implement each person's individual program plan (IPP), or for children under the age of three, their individualized family service plan (IFSP). These IPPs and IFSPs are developed by a planning team that includes the individual, the individual's parents (for a minor), his or her regional center service coordinator, service providers, and others as appropriate or as invited by the individual. The plan describes the supports and services the individual needs, and identifies who will provide and pay for those services. This process is time-consuming, but allows for the greatest customization of each individual's services to best meet his or her needs, while taking into account his or her preferences, culture, and lifestyle. This type of individualized needs-based determination has been the standard in California for decades and is consistent with recent federal guidance that requires a separation between service planning and service provision functions.

The Community Services budget of DDS is divided into two parts that work in tandem to both meet individuals' needs and fulfill state and federal mandates. The Purchase of Service (POS) budget allows centers to secure services for individuals from community service providers. The Operations (OPS) budget provides funding for assessment, service coordination, clinical services, quality assurance, programmatic functions, and administrative responsibilities, all of which are required to fulfill federal and state mandates. Years – and in some cases decades – of stagnant and reduced funding levels for service provider rates and regional center operations have left regional centers and their community partners all trying to do significantly more with far less. And individuals with developmental disabilities are the ones who suffer the most from this.

Today, California operates the nation's largest developmental services system, funded by \$2.6 billion in state funds, and nearly \$2 billion in federal financial support that is contingent upon meeting various requirements. During the recent recession, California's developmental services system endured over \$1 billion in total funding reductions. These cuts destabilized the developmental services system and have significantly compromised its ability to meet all of its obligations to individuals served, their families, and the federal government. These short-sighted cuts also led to the limitation of choice and funding flexibility in the planning team process as well as the availability of family support services. Service provider rates and regional center operations funding suffer from chronic underfunding that threatens service quality, federal funding, and most importantly, the health and safety of the nearly 275,000 individuals served by the system today. In order to carry out California's commitment to individuals with developmental disabilities, a significant ongoing investment must now be made in the service system. State law intends that these services "maximize opportunities and choices for living, working, learning, and recreating in the community." However, regional centers cannot always offer the most appropriate service for the individual's needs, only what is available given the current environment. In an effort to document the chronic underfunding of the developmental services system ARCA authored two reports, *Inadequate Rates for Service Provision in California* [tinyurl.com/POS-rates] and *Funding the Work of California's Regional Centers* [tinyurl.com/RC-OPS-report].

Inadequate Rates for Service Provision in California

There are over 45,000 direct service providers that contract with regional centers to support individuals in community settings. Community service providers are the "boots on the ground" in the provision of services to individuals with developmental disabilities and their families. For young children, this may include the therapists who help a toddler learn to speak or an infant learn to crawl. For others, it may be the behaviorist who helps a family shape their child's behaviors and assist the child to be more integrated in their community. For adults, it may be the residential facility, job coach, or supported living provider who helps the individual to live, work, and develop greater independence within their community. Services are selected based on the specific needs and goals identified by the individual's planning team.

Funding of community service providers (POS) is 87.6% of the total Community Services budget, up from 71% in 1988. Service provider rates are set using a variety of mechanisms that were once based on the actual or presumed cost of providing services. For example:

- Many residential homes are reimbursed under the "alternative residential model" (ARM) rate, established in the late 1980s with varying levels of reimbursement based upon the level of support individuals required. A basic premise of this model was that, while rates are meant to

cover the variable costs of each resident, after housing five residents, all fixed costs would be covered. Only by adding a sixth and final resident would the provider be able to realize a profit.

- Day and vocational services are the largest part of an individual's day, and are critical to increasing their skills and independence. Originally, most day and vocational service rates were based on the submission of a cost statement, a calculation of all the costs for the provider.
- Specialized programs serving individuals with complex behavioral, psychiatric, and/or medical needs negotiate their rates with regional centers. These rates were originally set based on a cost statement submitted to the regional center, followed by review and negotiation.
- Rates for supported employment services, which help individuals secure and maintain integrated community employment, are statutorily determined.

Between 2009 and 2013, most service provider rates were cut twice to a cumulative 4.25% reduction. Those rates were eventually returned to their pre-2009 cut levels, but the process exacerbated an already-unstable structure. Even prior to those four years, provider rates had been previously frozen (in some cases for years) at inadequate levels. As a result of California and other states taking similar action during the recent economic recession, CMS has clarified in its HCBS Final Rule that such reductions will no longer be permitted without CMS approval. Each of the service types described above has also seen particular cuts or direct operational challenges. Respectively:

- ARM rates for residential settings have been adjusted incrementally over time, but those serving individuals with the most significant needs have seen the smallest increases. Additionally, federal reimbursement is based on guidelines requiring more homelike environments - smaller facilities with fewer beds and the option of private rooms. This makes it almost impossible for six-bed providers to maintain these homes as a viable option given the unchanging and increasingly inadequate rate of reimbursement. This not only results in fewer providers, but fewer options for individuals who desire this type of setting.
- Current rates for most vocational and day services are no longer based on a cost statement, but must fall within a range set by DDS, called the Allowable Range of Rates, which is based on 1995-1996 costs. Since that time, there has only been a 3% enhancement, and some minor adjustments to account for increases in minimum wage. Regulations require programs to have certain staff-to-client ratios. Without adequate funding, service providers are limited in whom they can hire, given the requirements and reimbursement rates – this directly impacts the quality of the services.
- Negotiated rates for specialized programs for individuals with complex needs were limited in 2008. New rules set a ceiling of the lesser of either the regional center or statewide median rate for that service category. This cap was not based on the projected actual costs or geographical differences, among other variables, but instead was the median rate at that point in time for services provided statewide. Sometimes this resulted in significantly lower rates for new or expanded programs for existing providers. Median rates also made it difficult to attract new providers. In general, the median rate is a disincentive for program creation. Many rates were again reduced in 2011, meaning that the actual allowable rates for many services for people with the most complex needs have actually decreased in recent years.

- Supported employment rates were cut by 10% in 2008. Despite repeated efforts, they have not yet been restored to previous levels. Many multi-service providers report this rate is actually 25% below their cost to provide the service, so they must limit the number of individuals they provide this (now internally subsidized) service to, despite the fact that it remains in demand. Between the 2006-2007 and 2010-2011 fiscal years, the number of consumers served in individual supported employment settings dropped by nearly 6%.

Aside from cuts, inflation has also taken its toll. One of the leading indicators of economic changes over time is the Consumer Price Index (CPI). From July 2000 through January 2013 the CPI for California rose by 36.6%, meaning that service provider rates would have needed to rise by that same percentage to keep pace with inflation. This has not been the case. For example:

- During that time, though the CPI increased by 36.6%, rates for some residential homes increased by only 4.9%. The underfunding of these homes is so severe that many providers, mainly small business owners, can no longer afford to keep their doors open. This has led to an overall scarcity of homes, harming all individuals. But this dynamic has the greatest impact on homes serving individuals with the most significant health and behavioral concerns, leaving them with even fewer options for community living.
- Day and vocational service rates have fallen more than 20% behind what they would have been if they had been adjusted in tandem with the CPI. These programs, in jeopardy of survival, occupy the majority of the individual's day and provide him or her with the necessary skills for continued independence or a pathway to employment. Without these programs, individuals would lack sufficient support for integrated community living, further isolating them and placing stressors on families attempting to provide care for them.

Exacerbating this problem are certain costs that are much more volatile than the CPI, and oftentimes rise at an accelerated rate, including:

- Health insurance benefit costs, which have increased for many years and in some cases have increased dramatically in response to the implementation of the Affordable Care Act;
- Worker's Compensation Insurance premiums, which can increase significantly in response to isolated incidents, particularly for providers serving individuals with complex needs. California has among the nation's highest worker's compensation rates and direct care service providers report having some of the highest rates in California;
- A tremendous variance in costs across the state, including commercial and residential rents, local minimum wages, and other costs of living. Both employers and employees face these highly varied costs. Living and working is fundamentally different in places such as San Francisco or Fresno. However, no regional rate differentials are provided; and
- Transportation, a key to mobility, particularly in California. Rates for providers of transportation have been frozen since 2003. But in that time, the state-wide average prices of gasoline and diesel have more than tripled.

Service providers continue to work diligently to serve individuals with developmental disabilities, despite an inadequate rate structure and diverse other pressures. Though service providers are essentially contractors being paid to do a job, they are paid so little that many resort to fundraising to fill in gaps in funding, among other creative strategies. Many find themselves operating at a loss, or looking for strategies to remain in operation. For some, inadequate funding has made it impossible for them to meet mandatory standards. In any event, the end result is the same – an ever-increasing number of providers closing the doors on an unsustainable business model. One regional center alone has seen the loss of over 100 residential beds funded at ARM rates since July 2013, with the expectation that nearly 100 more will be lost in the short-term. This not only leads to accelerated cost pressures, as new placements are almost always more expensive, but it also means those individuals are forced to move from their homes or day programs, oftentimes leaving friends and stable, familiar staff members behind.

Funding the Work of California's Regional Centers

There are 21 regional centers in California. The catchment areas served by the centers vary in size from one to 10 counties; however, owing to population density, Los Angeles County is subdivided into seven regional center catchments, based on health district lines.

Funding of regional center operations (OPS) is 12.4% of the total Community Services budget, down from 29% in 1988. Individuals with developmental disabilities and their families receive a number of direct regional center services related to their specific needs and challenges, including:

- Intake and assessment to determine eligibility for services, clinical diagnoses, and challenges that any diagnosed conditions pose;
- Service coordination to both identify individual and family needs related to the developmental disability and to develop and coordinate a service plan that drives supports to meet those needs;
- Advocacy with community agencies, such as school districts, the Social Security Administration, and the Department of Rehabilitation to ensure individuals receive the services they are entitled to; and
- Clinical services, such as specialized medical and pharmaceutical reviews that augment the expertise available in the local medical community, related to the individual's developmental disability.

Additional services regional centers provide address community services for individuals generally, such as:

- The initial development of resources that will ultimately serve individuals with developmental disabilities (*e.g.*, residential facilities, vocational programs, behavior intervention, etc.);
- Monitoring the quality of established programs and the provision of technical assistance to service providers to promote quality improvement; and,

- Investigations of individual special incidents and the evaluation of any emerging trends to develop new training for regional center staff and service providers.

The bulk of the OPS budget is determined using a calculation known as the “core staffing formula.” In it, some positions are set based on the number of individuals served by each center (*e.g.*, service coordinator), while others are done on a “per-center” basis (*e.g.*, executive director). The core staffing formula was developed in 1978 and implemented in 1980. It was based on then-current assumptions about the number of staff positions required to operate a regional center, and the state salaries for comparable positions. Today, the core staffing formula no longer reflects the actual cost of operating a regional center. As noted in the 1999 Citygate Associates study of the core staffing formula:

“The Core Staffing Formula has outlived its usefulness. The Lanterman Act (the primary mandate for DDS and RC services) has undergone major changes in the past seven years. The local catchment areas have all had varying levels of growth and change. When originally defined, each of the 21 RCs was intended to serve approximately the same number of consumers. In 1991-98, workload in RCs varied from 2,000 to 13,500 consumers, averaging 6,700. Information systems and automation were unknown in 1978. The Core Staffing Formula budgets for a different operating environment than exists today.”

Ever-increasing caseload ratios are a key concern for regional centers. The most significant factor in their increase has been the salary budgeted for each service coordinator. Service coordinators make up approximately 54% of the regional center workforce, and the core staffing formula sets the position’s salary at \$34,032. By way of comparison, the current state equivalent salary is \$50,340. But regional centers must compete with local counties for skilled case management staff. In Contra Costa County the salary for similar positions is \$62,841; in Kern County it is \$61,071. Had the budgeted annual salary for the service coordinator position kept pace with inflation, it would now be in excess of \$61,000 per year.

This reality leaves regional centers no choice but to pay more than budgeted salaries (the average real salary is \$46,121) by hiring fewer service coordinators and other critical employees, using that money for more realistic salary levels. Those coordinators who are hired must therefore carry a larger caseload. This is a problem that continues to grow, demonstrated by the fact that in 2011 regional centers employed only 88% of the service coordinators they were statutorily required to have; by 2014 the percentage dropped to 84%, with centers employing 661 fewer service coordinators statewide than they need to meet required caseload ratios. And as other key regional center positions go unfilled in order to allow centers to pay service coordinators more than is budgeted by the state, service coordinators must also fulfill more functions, leaving them even less time to spend directly working with each individual.

In order to maximize the federal funding that supports California’s developmental services system, regional centers must perform a number of tasks related to certifying each individual’s disability and provide quality documentation regarding interactions with each individual, his or her needs, and the services provided. This certification requires detailed reviews of the records for over a hundred thousand individuals each and every year for compliance with federal standards, in addition to needed in-person contact.

Since 1999 there have been even more changes to both the Lanterman Act and the demands placed on regional center staff. The largest regional center now serves over 27,000 clients. Additionally, other

factors have contributed to the erosion of the regional centers' ability to effectively meet the many mandates required of them. For instance:

- Initially, when state salaries were adjusted, the core staffing formula was, too. But this practice was halted in 1991 in response to a state fiscal crisis and never resumed. The last major adjustment to the formula, in 1998, was to service coordinator salaries, due to federal and public pressure.
- The fringe benefit rates to cover expenses such as health insurance premiums and retirement were frozen at that same time at 23.7%. The fringe benefit rate for state workers has continued to increase to its current benefit rate, at about 48%.
- Over the years various ongoing unallocated reductions were imposed, resulting in an annual funding reduction of \$44 million system-wide, which equated to a 7.6% reduction in the core staffing formula during the 2013-2014 fiscal year.
- Leases, particularly long-term commercial leases that regional centers must enter into, oftentimes contain escalator clauses that force annual rents upwards regardless of the rate of inflation during any given year, further straining regional centers' operations budgets.
- As was the case with most service provider rates, from February 1, 2009, through June 30, 2010, regional center operations budgets were decreased by 3%. From July 1, 2010, through June 30, 2012, this reduction was increased to 4.25%. Though eventually reversed, these cuts forced regional centers to use some combination of layoffs, furloughs, and hiring freezes, further stressing each center's capacity to meet the needs of its community.
- The number of various types of services, the development of new services, the expectations for service outcomes, and the monitoring and oversight for quality improvement and assurance have all increased dramatically through the years. But the core staffing formula does not account for the additional staff positions needed to perform this work. Community services are meant to ensure the needs of individuals and their families are met. If these services cannot be developed or sustained, the results can include health and safety issues for the individuals, excessive strains on families, and any number of other concerns.

Changing Populations

Ten years ago a study conducted by Braddock and Hemp concluded that major cost-drivers in California's developmental services system include increased longevity of individuals, aging caregivers, the transition of services from institutional to community settings, and youth aging-out of the school system. These fundamental service needs, in conjunction with increasing rates of autism, must inform today's rate and service development policies. For instance:

- As individuals and their family members age, support needs intensify as self-care, mobility, and the availability of family supports diminish.
- As family members age, they are no longer able to care for their son or daughter in their home, resulting in the individual being placed outside the home. Increasingly, individuals and their

families are interested in this transition being into an independent or supported living arrangement rather than a residential facility.

- Individuals once served in developmental centers are being successfully supported in community settings at a cost lower than the average for developmental centers, but still higher than the average support cost for an individual in the community. California Health and Human Services Secretary Diana Dooley convened a task force last year to address this transition; the group noted the need to stabilize and increase the capacity of the community services system to adequately support all individuals with complex needs.
- With the assistance of individualized services and clinical support, individuals with intensive psychiatric and behavioral support needs are increasingly being served in community-based settings. To come to fruition, these services require not only the development or modification of services to address those specialized concerns, but take a great deal of collaboration and cross-training with generic agencies. Additionally, service providers' ability to succeed often hinges on being able to spend time working with families to help them understand and support their family members.
- A number of individuals with developmental disabilities find themselves involved in the criminal justice system. These individuals can have co-occurring diagnoses, such as substance addiction, mental illness, or both. Serving these individuals necessitates significant resource development. But it also requires coordination with criminal justice agencies, other treatment and care systems, and regional center service providers to support these individuals to remain within, or return to, the community.
- The cost to support individuals rises sharply as they exit school settings. In the next three years, over 24,000 individuals statewide will leave the educational system, requiring regional centers to provide services previously obtained there.
- Individuals with autism oftentimes require customized supports to be successful, which frequently cost more than standard available services. While only 9% of individuals over age 22 served by regional centers are diagnosed with autism, this number jumps to 28% for individuals age 18-21, who will be exiting the school system soon.

Innovative models to serve each of these populations are costly to develop and require rates above the artificially-set limits. Until 2003 regional centers were permitted to use purchase of service money to help providers start programs that addressed an unmet need in their catchment areas through the request for proposal (RFP) process. Now, no money is available up front to develop programs for anyone except the small number of individuals either leaving, or being deflected from entry into, developmental centers. For reasons described earlier, providers do not have the cash reserves or borrowing ability to meet those initial costs. In the exceedingly rare cases when they do, they work with the understanding that in many instances the reimbursement rate for the service will not cover their operating expenses, largely as a result of the median rate structure. Consequently, new and innovative programs are difficult to develop. Many times regional centers issue RFPs for needed services and are unable to locate or interest qualified applicants to meet identified needs. California prides itself on not having waiting lists for services. Yet individuals and their families have identified needs, with inadequate or no services available to meet them. People are, essentially, waiting for something that is either in short supply or non-existent.

As California's population continues to diversify, the system must serve more individuals in ways that are responsive to and respectful of their language, ethnicity, geography, or family economic situation. Developing new, or augmenting traditional, service models to meet these various needs is essential in order to ensure that individuals of diverse backgrounds can be well-served. Community service providers and regional centers strive to provide services in a variety of languages and settings to accommodate this growing need, but there is no additional funding earmarked to offset the costs associated with customizing service delivery. As with other service developments and expansions, identifying providers to serve specific populations is difficult given the existing rate structures.

Changing Expectations, Unchanging Compensation

Service providers and regional centers are being subjected to a number of changes in expectations from federal, state, and even local authorities. Yet in that change, the only constant is a lack of new funding. At its inception, California's community-based service system for individuals with developmental disabilities was almost entirely state-funded. In 1982 the state was approved for its first federal Medicaid Waiver to offset the cost of these services. Receipt of the federal money, however, came with new federal requirements for assessments, service planning, documentation, and service monitoring. All of these requirements put pressures on regional centers to modify their operations to come into compliance, oftentimes at significant expense.

Then, beginning with the United States Supreme Court Olmstead decision in 1999, there has been increased pressure to provide services in non-segregated community-based settings. Regional centers have encouraged service providers to develop services that serve fewer individuals in more integrated, individualized settings. While service providers have been largely receptive, it is challenging at best to make these changes while keeping a program financially viable. As discussed earlier, the residential ARM rate is based on an assumption of a six bed home with fixed costs spread over the first five beds. Under this funding model, it is difficult for a provider to open and maintain a home for fewer individuals that provides them with private bedrooms and services designed to meet each individual's unique needs.

In 2012 AB 1472 was passed, placing limitations on regional centers' ability to access certain facilities for the care and treatment of individuals with developmental disabilities and challenging needs. This was intended to reduce the reliance on developmental centers and residential settings that were not eligible for federal funding, such as mental health rehabilitation centers (MHRCs), institutes for mental disease (IMDs), and out-of-state placements. This legislation also established the DDS Statewide Specialized Resource Service (SSRS) to assist in the identification of resource options. Regional centers were required to move these individuals without existing resources to serve them. Thus, clients and their families faced the stress and uncertainty of a move without knowing exactly what would be available. Rates made the few interested service providers often unable to meet the individuals' needs. And regional center workloads (including transition plans and comprehensive assessments to identify the need for services within the community) were not considered.

The successful transition of individuals from developmental centers and these other facilities, as well as the support of those at risk of institutionalization, was and continues to be dependent on the availability of appropriate resources. The Developmental Center Task Force reiterated the need to build capacity within the community, but given the current rate structure, many individuals remain in these facilities, or are only able to access an inadequate patchwork of services while waiting for the development of needed resources.

Sufficient dedicated funding is needed to expand specialized models, such as mobile crisis teams, specialized residential programs, and specialized day programs. This year's Budget bill addresses only a portion of the problems for these individuals who so drastically need unique, tailored care for their complex and challenging needs.

Additional cost pressures on both service providers and regional centers are on the horizon. In January 2014 the Centers for Medicare and Medicaid Services (CMS) issued guidance that establishes new expectations for the continued receipt of federal funding for services. This includes the requirement that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting. The determination of which services comply with this standard, and the appropriate response to those that do not, will require a tremendous effort on the part of both service providers and regional centers. The ultimate success of California's ability to ensure initial and ongoing compliance with these federal expectations, directly related to federal reimbursement, will be heavily dependent on service provider rates and regional center operations funding for monitoring and technical assistance. Many providers will have to undertake the costly proposition of modifying their settings, staffing, and program designs in order to meet the new expectations. Regional centers will have to assess the services and oversee the transition of services to meet the new rules of CMS.

There are other unfunded mandates for service providers and regional centers in the form of legal requirements stemming from state or federal legislation, such as requirements around the payment of overtime or an employer's responsibility to fund sick time or health benefits. Local and state mandates also control the minimum wage that must be paid to an employee.

Many of these changes are positive, improving the service environment for individuals with developmental disabilities, and ensuring better compensation for those who directly serve them. But the costs associated with these changes are not accounted for, leaving regional centers and providers struggling to meet new expectations with few, if any, additional dollars to do so.

Risks to Ongoing Federal Financial Participation

In 1997 the Health Care Financing Administration (now CMS) reviewed California's developmental services system and found significant deficiencies. In response, it froze the number of individuals whose services qualified for offsets of federal financial participation. This sanction was not lifted for six years and ultimately cost the state \$933 million in lost federal funds. One of the deficiencies identified at that time was the exceedingly high caseload ratios of regional center service coordinators. The most significant problems arising from this were an inability to ensure individuals' health and safety or to provide them with the level of expert case management services they require. In response to the federal audit, the state set a statutory limit on caseload ratios and provided additional regional center operations funding to allow for compliance with this expectation. However, the previously-described factors quickly eroded regional centers' ability to maintain compliance. During the 2014-15 Budget hearings, DDS indicated that not a single regional center is meeting all mandated caseload ratios.

2008 guidance from CMS instructing states on completing their Waiver applications indicates that "[w]aiver payment rates may be determined in a variety of ways and frequently the methods that are employed vary by the type of service." It cautions, however, that whatever methodology is employed by states must ensure that "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers." As noted earlier, rates for some services are now so low that there are not enough providers to satisfy the demand for services. While in some cases substitute

services are provided, in other instances, no appropriate alternative exists and individuals do without until appropriate services become available.

In order to continue receiving federal funding for the system, California makes assurances that caseload ratios are being met and that sufficient services are in place to support the number of individuals being served. Yet the reality of those situations poses a significant risk to the ongoing receipt of federal dollars for the developmental services system. The risk is greater now than ever, as the system relies on nearly \$2 billion annually in federal funds.

Priorities for Advancing the System

California's developmental services system is severely underfunded as a result of years of neglecting to make needed investments to sustain it. Steps need to be taken to put the system back on track and ensure the health and safety of the persons served. Three areas that need to be of immediate focus are:

- **Stabilize System Funding** - The service delivery system, including service provider agencies and regional centers, is currently unable to provide services and supports needed to protect the health and safety of individuals and support their integration into the mainstream life of the community. The Lanterman Coalition, of which ARCA is a member, agrees that service provider rates and regional center operations should receive an immediate 10% increase, and 5% annual increases to provide a measure of system stability until sustainable rates and core staffing formula levels can be established, to ensure that needed supports continue to be available to Californians with developmental disabilities for years to come.
- **Commit to Fully Funding New Mandates** - The system must be nimble in its response to changing expectations arising from a variety of sources, including shifting service populations and evolving federal, state, and local mandates. State and local changes to minimum wage, AB 1522's mandate of sick time benefits, as well as new service requirements stemming from federal regulations, lead to considerable new costs. In order to meet increased expectations, there must be an explicit commitment to fully fund the impact of these changes for service providers and regional centers alike.
- **Reverse Failed Policies** - In response to state budget shortfalls in the past few years, DDS had to identify strategies to achieve targeted savings amounts. Several of the approaches identified have not achieved the anticipated savings levels and have actually increased fiscal pressures on service providers and regional centers. These failed policies should be reversed, including:
 - **Annual Family Program Fee** – This program requires families of children not on Medi-Cal to pay an annual fee to DDS. The cost of administering the program likely exceeds the proceeds that it generates. Described by some advocates as a “disability tax,” the program acts as a significant artificial barrier between children and needed services.
 - **Provider audits** – Providers receiving over \$500,000 in regional center funding must have a financial audit completed, often at a cost of \$10,000 or more. These audits do not save money and do not help to evaluate the quality of programs. Providers must divert scarce financial resources away from direct services to individuals in order to fund these audits.

- Family support services – Regional centers are prohibited from purchasing services that support families to stay together, such as camp and social recreation services, and are limited in the amount of respite hours that can be provided. Those services support families who choose to maintain an individual with developmental disabilities in the family home – respecting personal choice and avoiding the need for a more expensive residential facility placement. These reductions have put tremendous additional strain on families who strive to maintain loved ones at home, rather than doing the right thing by supporting them to make a decision that best reflects their personal or cultural preferences, all while saving the state money.

Additional information about the challenges facing service providers can be found in the ARCA publication *Inadequate Rates for Service Provision in California* [tinyurl.com/POS-rates]. A similar ARCA publication titled *Funding the Work of California's Regional Centers* [tinyurl.com/RC-OPS-report] provides comparable information about the challenges facing the regional center operations budget. Service provider rates and regional center operations funding suffer from chronic underfunding that threatens service quality, federal funding, and most importantly, the health and safety of the nearly 275,000 individuals served by the system today. In order to carry out California's ongoing commitment to individuals with developmental disabilities, significant ongoing investment must be made in the service system now.

Sincerely,
/s/Eileen Richey
Executive Director

Cc: Members, Senate Human Services Committee
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