SDTA

SELF-DETERMINATION TECH ALLIANCE

What the Community Said: The Comments

Companion volume: all 584 attendee comments from the Department of Developmental Services webinars on the proposed definition of "cost-effective," organized by category

Sessions of June 29 and June 30, 2026 · Prepared by the Self-Determination Tech Alliance · July 2026

About this volume

This is the companion to the summary titled "What the Community Said." It contains every attendee comment from the chat records of the two sessions, sorted into the same fourteen categories used in the summary. Each comment is assigned one primary category; many touched several. Comments appear in chronological order within each category.

Part One holds the 489 attendee comments from the June 29, 2026 session for individuals, families, self-advocates, and advocates. Part Two holds the 95 attendee comments from the June 30, 2026 session for service providers, sorted by SDTA into the same categories. Staff replies (24 on June 29 and 67 on June 30, most reading "Thank you for your feedback") are not reproduced here.

Comments appear exactly as written, including original spelling and punctuation; nothing has been removed. Speaker names appear as they did in the chat. Spanish-language comments appear as written; SDTA is glad to provide translations on request.

Part One · June 29, 2026

Session for individuals, families, self-advocates, and advocates · 489 attendee comments

1. Self-Determination Program choice, flexibility, budget authority, and negotiated rates (87 comments)

Kathy Rowe · 11:03 AM

For SDP, how will “reasonable” rates be set for direct caregiver staff?

Monique Moraga · 11:05 AM

Good afternoon.

I am the parent of a Self-Determination Program participant, and I appreciate the Department's efforts to define "cost-effective" as directed by AB 143.

My concern is that the proposal appears to redefine the very flexibility the Legislature intended SDP participants to have.

The purpose of Self-Determination was to allow families to purchase the services that best meet an individual's unique needs—not simply the services available at Department-established rates.

If a participant remains within their certified annual budget, I respectfully ask the Department to explain why a Department-established reimbursement rate should become the standard for determining whether that participant's negotiated rate is reasonable.

How does that preserve the participant direction and individualized purchasing authority that the Legislature intended when it created the Self-Determination Program?

Thank you.

Anonymous attendee · 11:05 AM

If a consumer already has an approved budget and is working within it, why does it matter what rate is given to the chosen providers? Doesn’t capping rates violate the entire idea of self-determination? This looks like just moving back to a set rate vendoring system.

Gail Silver · 11:08 AM

If you don't use a "vendor" for SLS but have your own staff in SDP, who will decide how much you are able to pay your own staff?

Beth Martinko · 11:09 AM

keep cost control at the budget level, where it already operates, and add no rate rule on top of it.

Kecia Weller · 11:09 AM

Yes, why with this cost effectiveness proposal is DDS making SDP partipants have to use vendor services rate. As long as I remain within my certified SDP budget why must I even use verndored services in SDP?

Karen Cull · 11:10 AM

For SDP, many families currently pay a higher rate to staff so that they are able to retain staff that are a good fit. Will staff retention be included in the definition?

Secondly it is difficult for SDP to make some purchases becuase vendors are required to agree to the complexity of billing the FMS - eg a no cancellation policy. Will this be taken into account in comparing services available in the community?

Will the LRE still be taken into account?

Carmen Silva · 11:11 AM

"Hola. Entiendo perfectamente la responsabilidad de definir el término 'costo efectivo' para proteger los fondos públicos. Sin embargo, considero que la propuesta actual restringe la flexibilidad que define a la Autodeterminación. Si limitamos los costos a las tarifas vendorizadas, el programa se convertirá en un reflejo del sistema tradicional, eliminando la capacidad de las familias de buscar soluciones personalizadas y eficientes. Les pido reconsiderar este enfoque."

James Moraga · 11:12 AM

If the Department agrees it is not changing participant purchasing authority under the Self-Determination Program, would DDS consider adding language to the proposal explicitly stating that nothing in the definition of 'cost-effective' is intended to limit a participant's ability to negotiate individualized rates within their approved annual budget? If not, why not?"

Anonymous attendee · 11:13 AM

Good Morning, my feedback is to be more clear on the defintion for "reasonable rate" in SDP. How it's worded now, I feel that regional centers will not have clear examples when working with providers that are not typical to the traditional system rates or government agencies. Regional centers need assistance to

clearly define what reasonable is. This is also driving away from the standardization that the law includes. 21 regional centers without a clear interpertation of what "reasonable" is will cause less standardization especially when there still isn't current guidance avaible on the individual budget development or spending plan process (in terms of timelines and how many processes it has to go through at each regional center).

Simie T · 11:14 AM

1. will the new language " Cost Effective " change the ability to negotiable rate in the spending plan ? for individuals who require higher level support, like behavior challenge individuals.

2. will the new "Cost Effective" effect independent facilitator negotiable rates?

Miriam Erberich · 11:15 AM

The Certified Budget already provides an overall mechanism for cost control and cost neutrality in SDP. Participants should retain flexibility within that budget to determine how funds are used to achieve IPP goals. Cost-effectiveness should be evaluated within the context of the person's overall budget, assessed needs, and outcomes, not by comparing one provider's hourly rate in isolation.

Anonymous attendee · 11:15 AM

Many families have experienced regional centers interpreting "cost effectiveness" in a way that encourages or requires them to select lower-cost providers, even when that interpretation extends beyond what current regulations appear to permit. This is one reason why the proposed changes have generated concern among Self-Determination Program participants and advocates.

How will this be prevented?

Beth Martinko · 11:15 AM

For "other services" purchased from local businesses and community resources, it proposes:

"Reasonable rate is a rate not higher than what similar community providers charge."

DDS, Proposed Definition of "Reasonable Rate" in the SDP, June 2026 I oppose this cap because it adds friction without adding protection. The Self-Determination Program already caps total spending at the person's individual budget. Within that budget, the family and planning team decide how to spend, and the system's dollars are already bounded. A rate rule does not protect a dollar the budget has not already protected. It only dictates how a family may spend their own fixed budget, and lays a second layer of review on top of a limit that is already in force. What the cap does change is the family's freedom to choose the best solution. It does not cost the same to provide individualized support to a person with a disability as it does to serve the general public, and the supports families buy through SDP are frequently not "similar" .

Anonymous attendee · 11:17 AM

SDP already controls costs through the Certified Budget. This means that the budget as a whole could be considered "cost effective" as long the whole set of supports and services meet the IPP goals and improve disability-related quality of life.

Anonymous attendee · 11:17 AM

Is this info true?: "DDS recently released what their definition could be, and it risks significantly reducing flexibility, freedom, and autonomy in SDP." "...it would not allow you to pay staff or vendors more than the vendored rate for services – which would cap staff wages, for example, at about $30.00 an hr or less, which many of you know will not allow you to hire the quality of staff you need to meet your, or your loved one's, needs. It may also limit what you can pay community providers..."

Beth Martinko · 11:17 AM

Keep cost control where it belongs, at the budget level. The individual budget is the cost control. Allow a rate question to help pick the provider only when providers are truly comparable. Never let it deny a real need, and never force a family into an exception process simply to pay the going rate for the right person.

Anonymous attendee · 11:18 AM

Does the "cost effective" or "reasonable" rate take into consideration rates that providers may increase due to the administrative burden for potential providers that go into SDP? Comparing how vendors get paid directly through a regional center vs now having to get paid through an FMS vendor (that in some cases have a higher administrative and financial burden for getting paid on time or correctly).

Karla Izeppi · 11:19 AM

Somos padres de un joven en Self determination y no es justo que DDS no tome en cuenta que la libertad del programa nos da como padres determinar la Calidad , efectividad en la elección de los vendors y empleados pagándoles lo justo de acuerdo al potencial de cada persona o entidad ..La Propuesta no ayudaría en las espectativas de nuestro hijo .

Maria Berumen · 11:21 AM

Esta propuesta elimina la flexibilidad del programa de SDP y agrega mas barreras para contratar personal calificado que apoye con las necesidades individuales de cada individuo.

Anonymous attendee · 11:23 AM

how does the conduct of the regional center fit into this definition? At the last rceb bd meeting, a number of parents said it took almost a month on sdp issues to get a response and then it was another month waiting on the back and forth. Dir Cervinka has also been raising the issue of timeliness.

Anonymous attendee · 11:24 AM

reasonable rate is not what regional center pays and I do not feel the Dept really sees how much it truly costs and then the SDP FLEXIBILITY will no longer be effective and sometimes this really keeps an individual in their own home

Melissa Jones · 11:24 AM

what about traditional vendors that charge individuals in SDP a higher rate. how will this new definition help ?

Tina Ewing-Wilson · 11:25 AM

It is not "intended" that this change will remove our choice and control, but what we are worried about is the unintended side effects of well meaning but unfortunate barriers that will occur if you are not careful enough in the way this plays out

Rosa Diaz · 11:25 AM

My concern is that “cost effective” could possibly limit the freedom we currently experience under SDP.

Erica Hernandez · 11:26 AM

Cost effectiveness should never override person centered planning. I ask DDS to clearly state that this definition will not be used to restrict individualized services or limit the choice and flexibility guaranteed under self determination.

Yanny Cabrera · 11:26 AM

Hello, good morning and thank you for this opportunity.

How are Regional Centers expected to determine payment rates when the term "reasonable" is open to so many interpretations? Under the law, that standard could easily be applied based on convenience rather than on the individual's actual needs.

A support worker's compensation can reasonably vary depending on the participant's unique circumstances, the complexity of the support provided, and the responsibilities involved. That is precisely why the Self-Determination Program allows flexibility in establishing a reasonable rate that reflects the specific services and needs of each participant, rather than applying a one-size-fits-all standard.

Anonymous attendee · 11:27 AM

How will this specifically apply to Self-Determination Program (SDP)?

Adam Ruddle · 11:27 AM

This definition is the problem. Department negotiated rate is lowest possible standard of care (or lower) and does not represent the reality for most families trying to hire competent individuals.

Adam Ruddle · 11:30 AM

True General market rate outside of those on SDP budgets (truly private and self-funded) are massively above the rates SDP are being pushed towards.

Yadir Morales · 11:30 AM

If a provider is a vendor, can they still charge different rates if the service they're providing in SDP differs from their program plan for a vendored service?

Julia Rogoff · 11:30 AM

yes, we have many vendors upcharging SDP clients from traditional clients

Elena Tiffany · 11:31 AM

none of my SLS/320 staff are through a vendor/agency, so this is just confusing when it comes to rates for DSPs in SDP

Maria Berumen · 11:32 AM

Como familiar de un participante del programa de SDP me preocupa que la propuesta redefina la flexibilidad que la ley otorga a los participantes de SDP. El proposito de SDP es permitir que las familias adquieran los servicios que mejor respondan a las necesidades unicas de cada persona, no simplemente los servicios disponibles a las tarifas establecidas por el DDS. Si un participante se mantiene dentro de su presupuesto expliquen por que una tarifa establecida debe convertirse en criterio a determinar si es razonable o no, eso elimina la autodireccion y flexibilidad del programa.

Adam Ruddle · 11:33 AM

SDP families trying to recruit services are at a disadvantage compared to Departments who have much greater volumes of resources they are purchasing.

Clarissa Kripke · 11:33 AM

We should end service providers charging SDP more than they charge people in the regular program for the same service if it is offered to both and family members in SDP paying themselves more than service providers in the community charge.

Anonymous attendee · 11:34 AM

I am unclear about the comparable services in the reasonable rate in the SDP slide. What does this mean for IHSS providers and SDP Personal Assistance? Is the hourly rate going to change for SDP PAs to be reduced to match IHSS providers?

Rebecca Laby · 11:34 AM

What information is going to be used for "comparable rates". My experience with one RC is they use indeed to tell their clients in SDP what rates they should be paying for their privately hired staff.

Alison hunter · 11:34 AM

Other Services: Typically, no two providers providing similar services charge the same rate. Will a Coordinator do this work when a non-vendored service is included in a spending plan? Will this create significant delays?

Anonymous attendee · 11:35 AM

Reasonable rate should not be defined as lowest available rate or vendor rates or median rates or comparable rates. This violates the whole point of SDP's principles of freedom and choice. If the budget is certified as cost neutral, reasonable rates have already been met in the budget. By removing choice, you are limiting the unique IPP needs and the freedom and choice to meet those needs in a unique way. You are limiting better outcomes and being short sighted in reducing long term costs.

Sonni Charness · 11:35 AM

In SDP, some providers have taken a type of service that is available in the traditional system, and customized and improved it to better meet the needs of the SDP participant and result in better outcomes for the person. But, the cost is higher. Participants have had the flexibility to choose to spend more on their most important services, and less on other services to be able to purchase the best set of services for them within their individual budget. This definition eliminates this choice

Deniz Oyman · 11:35 AM

For some services, such as caregivers, while a rate may set by a comparable rate in the area, it does not ensure that providers can actually be found. So many other factors are involved in hiring a caregrive-avaialblity, distance, cost of living in the area, etc. This will not work in a "real situation!" This is why families switched to SDP ! We need to be able to use the spending plan in a way that is most supportive of the client!

Anonymous attendee · 11:35 AM

You're pretty much just saying self-determination as a concept is ended because you don't trust consumers to determine their own services.

Anonymous attendee · 11:35 AM

Why is the focus in the spending plan? The drivers that raise the cost in SDP is in the budget development process. The emphasis should not be how the rates are distributed in the spending plan.

Carla Lehmann · 11:36 AM

As written, this could conflict with the SDP principles of Freedom and Authority if "reasonable rate" is interpreted as the lowest-cost provider. Please clarify that participants retain the right to choose the qualified provider that best meets their needs, even if another provider charges less.

Irene Litherland · 11:36 AM

The criteria for reasonable rates under SDP aren't at all clear! Yes, more information is definitely necessary to make the process for SDP very clear and not cause delays in getting regional center review approval of a spending plan and for the selection of a new hired staff person.

Maria Berumen · 11:36 AM

Imponer un limite a las tarifas contradice el principio fundamental de SDP. Parece que una propuesta al sistema tradicional y elimina principios fundamentales de programa de SDP la FLEXIBILIDAD y LIBERTAD de eleccion que es lo que SDP garantiza

R Kopito · 11:37 AM

The application of "Reasonable Rate" to SDP violates the intent of the SDP law. It requires the Regional Center to approve each rate in the spending plan. The law requires the Spending Plan to "Certified" not

approved. An SDP spending plan that meets the other criteria of being effective, is by definition reasonable, because it is based on an SDP budget that is certifiied by the Regional Center. The SDP budget is always equal or less than that required to provide the services in the traditional system.

Julie LaRose · 11:37 AM

DDS guidance should also make clear that vendored rates may be considered as one point of reference but should not be treated as the sole determining factor or as a maximum allowable rate within the Self-Determination Program.

Finally, any guidance should reinforce that the purpose of Self-Determination is to provide individuals with choice, control, and flexibility while ensuring responsible stewardship of public funds. A service should be considered cost-effective when it provides the best value in meeting an individual's unique needs—not simply because it is the lowest-cost option.Something like: "A service should be considered cost-effective when it provides the best value in meeting an individual's unique needs—not simply because it is the lowest-cost option."

Penelope Fode · 11:37 AM

It all sounds good for the RC and not the client! Too much is listed as them making determinations and not the client or conservator for the client.

Alissa Haggis · 11:38 AM

How to we make sure that determination of “reasonable” and “cost effective” does not mean massive delay while RC tries to get approval for rates from DDS for each line item on a spending plan if there is a disagreement.

Anonymous attendee · 11:38 AM

SDP already has cost controls because each participant must stay within their certified budget. If the total spending is already limited by that approved budget, adding separate limits on what can be paid to each provider creates a second layer of restriction that reduces the flexibility SDP was meant to provide.

Cost-effectiveness should not be judged only by which provider charges the lowest hourly rate. It should also consider whether the service is actually effective for the individual over time. In many cases, a provider who charges more may still be the more cost-effective choice because they are able to keep the same staff in place, provide more consistent support, prevent service breakdowns or crises, and help the individual make real progress toward their IPP goals.

Anonymous attendee · 11:38 AM

I believe that when SDP was initiated, the language said it had to be cost neutral. This is what we have to consider when looking at Cost effectiveness. Higher rates to keep staff is one thing offering 1.5 times the standard pay rate for the field does not seem to make sense. Families outside of SDP would like to see consistent staff too and remain within the vendorizing system. I think that those families who have opted to pursue SDP have a mistaken belief that it is a blank check with no balances.

Yadir Morales · 11:39 AM

I agree that the certified budget already controls cost within the SDP. Restricting negotiated rates in SDP goes against the goals of the program.

lisa Bourne · 11:39 AM

Cost Effective feels limited to choice of vendor. I don’t like it at all.

Anonymous attendee · 11:39 AM

This seems like it is going to create an additional barrier in SDP for getting services approved

Claudia Castillo · 11:40 AM

Why is the cost effective being impose and scrutinize to SDP and traditional services when not even medical imposes rates to Kaiser permanente.

Anonymous attendee · 11:41 AM

Some Regional Centers seem defensive and irritated during the process. many SCs do not understand what sdp is and why its important.

they deny everything and make it hard and complicated to get anything done. its a painful process for many families.

Adam Ruddle · 11:41 AM

The definition of Cost Effective as it applies to Self Determination is not acceptable to myself and my family as proposed here. The use of the rates negotiated down to an absolute minimum Federally do not represent a good or fair rate for individuals / individual families to use to obtain competent, quality services and providers.

Christopher Wecks · 11:41 AM

Although DDS' intention is NOT to remove individual choice, Market access to unique services by providers will likely reduce if an attempt is made to apply traditional rate comparison in the traditional system to self-determination program services on a spending plan. Market depression through provider-exit because of rate ceilings will hurt participant access to services, effectively reducing indiviudal choice.

It would be an error to presume services on a spending plan have a cost-comparison standard that is easily identifiable in the traditional system or in the community. Self-Determination is chosen by participants who need unique or unusual needs met that often aren't clearly articulated through traditional Regional Center or DDS lenses.

Additionally, budget authority, a common right afforded to participants in self-determination, is effectively curtailed if a participant can no longer decide what to pay providers due to rate ceilings for a perceived-comparable category.

Additionally, "cost effectiv

kenneth radcliffe · 11:41 AM

We are in SDP. I want to see if you can clarify labels that we have being caregivers and vendors and what are the comparable terms under DDS.

Maria Berumen · 11:42 AM

Exigir la aprobacion de cada tarifa negociada impone una limitacion que no contempla la ley, debilita la flexibilidad, autoridad y autonomia, lo cual son las bases del programa de SDP, ya bastantes limitantes teemos con los centros regionales que no conocen el programa y limitan los planes de gastos que quieren APROBAR cuando nadamas deben certificar, con esta propuesta se crearian mas barreras.

Letty Lopez · 11:42 AM

SDP gives participants the ability to use their Certified Budget to recruit and retain qualified staff, build consistent support teams, access community-based providers, and choose services that best meet their individual needs and IPP goals.

I am concerned that the proposed changes regarding "reasonable rates" will reduce participant choice, limit freedom, and take away the control that is at the heart of the Self-Determination Program. The Certified Budget already provides cost control and cost neutrality. Participants should continue to have the ability to determine how to use their approved budget based on their assessed needs and desired outcomes, rather than having decisions limited by predetermined hourly rates.

As it is, families already struggle to find qualified providers who are willing to work with our loved ones. Many individuals have complex support needs that require patience, experience, specialized skills, and consistency. If rates are restricted, it will become even more difficult to recruit

Anonymous attendee · 11:42 AM

One particularly powerful question is:

Can DDS identify a single protection in this proposed definition that gives consumers more rights than they currently have? If not, how can DDS assure participants that this proposal will not reduce the flexibility and person-centered nature of the Self-Determination Program?

Irene Litherland · 11:42 AM

It looks like this will effectively remove choice for self-determination participants. It will also cause additional delays in processing SDP spending plans with the regional center on top of the current delays which are often several months. Just the processing of all of these review steps will have a huge negative impact on those in SDP. And the limitations on rates, making them equivalent to traditional services, will severely limit the choices of participants and undermine the key principals of the SDP.

R Kopito · 11:42 AM

The proposed definition of "Reasonable Rate" to SDP will effectively shut down the program, as the Regional Centers are not staffed or trained to review each line of a Spending Plan to determine whether it meets the definition. The Regional Centers are barely able to keep up with making sure the requested service meets IPP needs, is eligible for the program reimbursement, and that the overall Spending Plan meets the budget. The fact that any certified Spending Plan must meet the budget automatically requires that the services be delifered at a reasonable rate, since it is based on the Traditional Service cost model

Vicki Jones · 11:42 AM

For SDP participants, we are able to offer better pay to service providers because we do not pay the overhead for an organization like Maxim for example. This means attracting more qualifed service providers and retaining them. Nothing in what I heard today addresses this.

Anonymous attendee · 11:42 AM

This seems to go against the characteristics of the Self Determination Program

Julie LaRose · 11:43 AM

"Nothing in this definition shall be interpreted to limit the participant's right to choose providers consistent with the principles of the Self-Determination Program."

Suzy Requarth · 11:43 AM

The “reasonable rate” inclusion concerns me deeply

For traditional services, rates are already set or shaped by the Department. This language changes little. But SDP operates differently by design. Introducing an undefined standard like "reasonable rate" into a self-directed program does not create a guardrail. It creates 21 different guardrails, one per regional center, applied inconsistently, negotiated case by case, and experienced by individuals and families as arbitrary barriers to the flexibility SDP was built to provide.

I have seen well-intentioned policy cause unintended harm at scale. This provision, as written, will do that. For many of the people we serve, SDP is not a program. It is the difference between thriving in the community and returning to a system that was never designed to truly meet their needs.

I urge the Department to remove the reasonable rate component from this definition and work alongside community partners to identify the problem this provision is intended to solve and colla

Kimberly Schreiber · 11:43 AM

Every regional center will define "reasonable" differently. Every spending plan becomes a negotiation. Every provider faces delays. The participants who depend most on this flexibility — those in rural areas, underserved communities, and with the most complex needs — will be harmed most.

We believe in fiscal responsibility and guardrails. But there are better ways to ensure cost-effectiveness and prevent fraud that don't strip participants of the flexibility this program was designed to provide. We urge DDS to remove the reasonable rate provision and work with the community on an approach that protects both.

Anonymous attendee · 11:45 AM

I cannot believe you are not actually listening to the people being impacted by this definition. Hear their voices. Their fear. The destruction this does to a program that has been long fought for. This will destroy SDP

Rosie Lasca · 11:46 AM

Will regional centers have a required timeline to review cost-effectiveness when certifying a new or revised spending plan?

Shirlys Gruber · 11:46 AM

Could DDS clarify what objective criteria will be used to determine when a negotiated rate above the published rates will be approved? Will those criteria be published so families and Regional Centers apply them consistently throughout California?

Letty Lopez · 11:48 AM

I am concerned that these proposed changes will create additional barriers to accessing and successfully implementing the Self-Determination Program rather than improving it.

The purpose of SDP is to give participants greater choice and control over the services and supports they need to live safely and meaningfully in their communities. However, these proposed changes appear to move the program in the opposite direction by limiting participant choice, increasing barriers, and reducing the ability to recruit and retain qualified providers.

Irene Litherland · 11:48 AM

Re: application to SDP: The cost of implementing this will most likely outweigh any savings in direct provider costs. It would make more sense to just definite a high level of cost per service provider that would require review by the regional center. Otherwise we will have delays in SDP renewals and spending plan changes that will cost alot more money in staff time--regional center staff (probably at least 3 involved if no appeal gets filed), IF time involved, FMS time involved. I think that in most cases the salary cost of the hours spent working through all these limitations to a SDP spending plan will far outweigh any dollars saved in the end.

Letty Lopez · 11:49 AM

Rather than creating additional restrictions, DDS should focus on reducing barriers to SDP participation, and preserving the participant choice, control, and person-centered flexibility that are the foundation of the Self-Determination Program.

Irene Litherland · 11:49 AM

Will the SDP law be changed to incorporate this rate review process? It is really a big change to self-determination!

Aminah Abdul-Hakim · 11:50 AM

How will individual choice be protected?

The slide says individuals will still be able to choose who provides their services. How will that choice be protected if a regional center decides a chosen provider's rate is not reasonable? What process protects the person from being pushed into a provider who is cheaper but not appropriate?

Jeannet Cardenas · 11:50 AM

La comunidad latina siempre a sido golpeada, y ahora traen mas desafíos para enfrentar con su propuesta de ley, están violentando los derechos del participante en SDP de seleccionar el personal con el que el participante desea colaborar, pudieran empezar con controlar sus salarios y reducirlos quizá eso sea costo efectivo 💰.

Anonymous attendee · 11:52 AM

I know this was already mentioned but many families do SDP because they can select the person that they want to provide the service. Ex: Many families complain that the respite worker just sits their. In SDP we can write their job description. Turn over is huge at agenvies but in SDP consistent staff is awesome very good. Im hearing what you say...We still have choice. Thats wonderful. But we also need choice on the hourly wage. A retired teacher should get paid higher then an 18 year old with min. experience. PLEASE dont takd this choice away from families in SDP.

How can a parent prove that this Karate instructor is a better fit then another karate teacher. Sometimes its just their demeanor, the way they explain things, etc. If the client is meeting their goals that should be enough. Having the wrong instructor doesnt accomplish anything.

Tere Lara · 11:52 AM

emEsta propuesta elimina la flexibilidad del programa SDP Creando aun mas barreras , afectando a los clientes directamente.

Adam Ruddle · 11:54 AM

Within an already controlled Self Determination Budget, applying these restrictions rolls back the who principle of self determination. If the budget is governed then allow the individuals to negotiate and trade off costs and services to best support the individual. We are having to fight this while a no-bid contract for the Reflecting pool goes un-examined by Congress by the way.

Elizabeth Barrios Gómez · 11:55 AM

I know this coment is not in response to what you have asked of us in this meeting . However, Today, many families experience a system that has effectively stopped responding. Requests remain unresolved for months. Meetings occur without decisions. Accountability is often absent, and because these experiences rarely reach the Department in a meaningful way, it becomes difficult to fully understand why trust has eroded so significantly. The new defintion in the law should include how will the client be supported to find the right balance. It is concerning when families do not have access to generic resources and also when generic resources are the reason why they stop or hold implementation of services during an IPP meeting.

One more concern: For SDP particpants The new defintion needs to apply to the budget allocation but Not to the spending plan.

Rocio sigala · 11:55 AM

On Autonomy: "The core of the Self-Determination Program is the freedom to choose our own providers and set our own rates. How can you say this proposal preserves that freedom if the Regional Center can now veto our choices based on an arbitrary 'reasonable rate'?"

Erica Hernandez · 11:56 AM

SDP is built by choice and flexibility. Cost effective should be defined by how a service meets an individuals need, not solely by its price.

María Gutierrez · 11:56 AM

lo que estoy escuchando más barreras y restricciones para los clientes eso trai más problemas a su calidad de vida ellos ya tienen un fondo ya dado para ellos no hay necesidad de tocar puertas para ver donde sale más barato y al final regresar lo que se ahorro .

2. Reasonable-rate definition and rate-setting methodology (40 comments)

Ana-Paula Ferreira · 11:07 AM

How do you determine "what reasonable"?

Anonymous attendee · 11:07 AM

How will consumer choice be protected when the preferred provider charges above a benchmark?

Claudia R · 11:08 AM

ESTA DEFINICION DE COSTO EN EFECTIVO DEBERIA DE LLAMARSE (CARGO EN EFECTIVO) POR QUE DEPENDE DEL CARGO DE TRABAJO CON NUESTROS HIJOS SEA PAGADO EL COSTO EN EFECTIVO

Claudia R · 11:10 AM

DEFINICION

CARGO EN EFECTIVO !!NO

COSTO EN EFECTIVO !!

Beth Martinko · 11:13 AM

A definition this consequential should not rest on a misreading of what federal law requires, and the draft's per-person rate cap is not federally required.

For the waivers that fund these services, the only federal cost test is whether the program's average per-person cost stays at or below the cost of institutional care, measured across everyone, not person by person. Depending on the federal authority involved, that aggregate test applies, or there is no cost-neutrality test at all. Either way, a per-person dollar cap is optional state policy, not a federal mandate. SDTA strongly opposes California adding this as policy.

Bob Charney · 11:14 AM

When determining reasonable rates, will you be considering the fact that vendored providers charge more to engage "their" employees, with less going to the actual provider; even when under SDP the hourly rate paid to the employee is more, but less than the vendored agency?

Alison hunter · 11:15 AM

Will "reasonable rate" be quantifiable? Will there be a different weight given to each factor before concluding whether it is reasonable, depending on need, services options available in the community where the participant lives? How important will rate be in comparison to the other factors? What if there is only one provider in the participant's community?

Kimberly Schreiber · 11:15 AM

What specific problem is the 'reasonable rate' provision designed to solve, and what evidence supports that this approach will achieve it?

Claudia R · 11:16 AM

Dependiendo del cargo de trabajo en el Cliente es el Costo

No depende del costo es el trabajo en el cliente

Emily Scholl · 11:19 AM

Who is going to make this determination, RC, DDS...who?

what if a person needs something higher than that threshold. Will cost effectiveness make a cap for those instances?

Anonymous attendee · 11:20 AM

Thanks for this. Reasonable rate and qualified provider definition is not clear to me.

Miriam Erberich · 11:21 AM

Could you please give examples of what you consider reasanable rates for services comparable to personal assistance and respite? What is the range? Do you require any justification for a higher end rate? A process to request rates outside of the range?

Anonymous attendee · 11:21 AM

Consider adding clarification to the definition of cost-effectiveness to include both cost and quantity of services provided. The definition should consider the amount of social recreation requested compared to what is typical for the general population.

This would help ensure decisions consider whether the frequency and amount of social recreation requested are reasonable, while also recognizing parental and personal responsibility for participating in and accessing recreational activities.

Including this clarification in an enclosure or guidance document would be helpful to support consistent understanding and application of the definition.

Melissa Amster · 11:22 AM

For the self determination clients, It will all come down to a reasonable rate since in everything else is already required in SDP. This definitin doesn't help understand what cost effective is. Regional centers will just use the traditional rates as the reasonable rate. There is no help in defining as a reasonable rate. I understand you say it is not to cut down on choice, but there is nothing in the definition that keeps the choice in it.

Alissa Haggis · 11:22 AM

How will DDS ensure Regional Centers do not use “cost-effectiveness” to impose unofficial rate ceilings for each individual service?

Chelsea Coffin · 11:23 AM

What is a reasonable rate? Are we talking about vendored rates? Those are significantly lower than they should be. Paying an adequate rate to providers is how clients find and keep providers that meet their needs. Paying minimum wage to a direct support provider is not reasonable. You get what you pay for and the lower the rate the less qualified and dedicated staff you get. These definitions are too broad. At this point they are really left up to individual interpretation.

lisa Bourne · 11:24 AM

It sounds like reasonable rates come first and choice of vendor is second. The Regional center will definitely slow down approval using the excuse that they rate is not approved. Therefore delaying services for an extended amont of time.

Susan Corry · 11:24 AM

It seems reasonable that rates currently in use by SD participants also be considered.

Shirlys Gruber · 11:25 AM

I recommend that DDS clearly define what constitutes a “reasonable rate” by considering factors such as provider experience, specialized expertise, regional cost of living, provider availability, and the complexity of the participant’s needs.

Karina Monje · 11:25 AM

The definition must establish that consumer preference and individual goals are the primary benchmarks of whether a service is "effective." A service cannot be deemed cost-effective if it fails to achieve the individual's specific goals, regardless of how inexpensive it is.

Carla Lehmann · 11:27 AM

Thank you for requesting stakeholder feedback. I believe the definition would benefit from additional clarification, particularly regarding the terms “qualified provider” and “reasonable rate.” These terms should be clearly defined to ensure they are applied consistently across all Regional Centers and do not unintentionally limit participant choice. I recommend clarifying that “reasonable rate” should be based on the provider’s qualifications, experience, specialization, geographic market,

Kavita Sreedhar · 11:28 AM

With regard to Reasonable Rate, please clarify how this will work for ARF facility rates for SDP Participants. It is really important since there are many in residential settings who are not able to participate in the program since the Administrators are worried that the rates will not match and what the Reasonable rates would be

Beth Beswick · 11:28 AM

The current rate studies provide a single rate regardless of a provider's skill level or years of experience. I am concerned about how we will be able to pay a provider with 20-30 years of experience an appropriate rate when the study assumes everyone providing that service should be paid the same.

Have you considered implementing a rate table similar to those used by school districts? This would allow for tiered rates based on education level and years of experience.

Wren Rother · 11:28 AM

In SDP, will "reasonable rates" be partially dictated by how far they deviate from dds rate standards? I understand that other things will be considered in the planning process, but is there any verbage about comparing provider rates to dds rates? for instance, is there any chance there would be like a window of acceptability of 20% higher than dds standards? if so, that would be very limiting to people with more extreme needs and would put undue burden onto participants to prove why they need to pay someone more than that. all this to say, I would encourage that you avoid suggesting any sort of cap. service coordinators vary wildly from person to person and will leverage language in different ways.

Janet Grillo · 11:29 AM

Tie reasonable rates to the level of training, education, degree of the provider: not just the Agency head but the staff they hire. Too often those people are paid at minimum wage and are NOT skilled or effective. BUT if rates were tied to the training and education level of the STAFF not just the Agency Director of founder, they will be able to hire competent and dedicated staff.

Julie LaRose · 11:30 AM

I believe the concern is not with defining "cost-effective" itself, but with the proposed definition of "reasonable rate." I respectfully suggest that the definition of "reasonable rate" focus on whether a rate is

necessary to meet the individual's person-centered needs rather than whether it matches an existing government-established rate.

For example:

"A reasonable rate is one that is necessary to recruit and retain qualified providers who can meet the individual's unique needs and achieve the outcomes identified in the Individual Program Plan (IPP). In determining whether a rate is reasonable, consideration should be given to local market conditions, provider qualifications, the complexity of the individual's support needs, and the participant's informed choice. Vendored rates may serve as one point of reference but should not be the sole determining factor or establish a maximum allowable rate within the Self-Determination Program."

Karina Monje · 11:31 AM

Under law AB 2423, DDS has the obligation to review and update the cost assumptions of tariff models every two years, starting this year 2026, to reflect real expenses such as insurance, transportation and inflation. However, these revisions are not implemented unless the Legislature explicitly funds them. If current tariff models are still late from the real inflation faced by suppliers, how will DDS prevent regional centers from using the 'cost-effectiveness' argument to cut services?

Wren Rother · 11:32 AM

please define "schedule of maximum rates" . I think that was the whole phrase but it was moved on from quickly

Anonymous attendee · 11:34 AM

So far these definitions are filled with mentions of "reasonable rates" which is what we are trying to define. I don't find this to be more clear than the current definition.

Anonymous attendee · 11:34 AM

Will parents be able to be paid the same rates as vendors if parents have received comparable training?

Rebekah Acosta · 11:34 AM

How will we determine reasonable rate? Let’s say for instance for recreation funding we are doing cheerleading? How would one determine what is reasonable for every type of service that sounds exhausting.

Yadir Morales · 11:35 AM

many SDP participants work with community providers to create custom services and programs to best meet their unique and individual needs. How will "reasonable rates" be determined if there are no other services that are truly comparable?

Anonymous attendee · 11:36 AM

This is very unclear, we need to not just examples but a clear way to understand any caps and exceptions.

Rebecca Laby · 11:36 AM

Who is going to put the examples together? We need real life examples, if this is going to be used

Anonymous attendee · 11:40 AM

Thank you for doing this zoom. I agree that market rate for services must be set for IF, Parent providers, and line items much strictly align with client’s IPP.

Melanie Tritt · 11:42 AM

Cost effective still not totally clear.

Defined ‘reasonable rates’? Need an example.

Will there be a rate cap?

Still able to choose providers?

Mary Mora · 11:42 AM

Would there be price transparency for providers to the public? For example , a comprehensive rate sheet for all service providers m

Families would not know how to compare what is reasonable if they do not know what rates service providers are charging

Deniz Oyman · 11:42 AM

Who will review and determine a reasonable rate used by each SDP client? This is will terribly time consuming and the system of coordinators is already backed up and impacted. This will hold up services unless there is some very clear manner to determine this.

Melissa Amster · 11:45 AM

It is not clear to me if indepdendent faciliators will be forced to say at the 099 rate. That is for a different service.

Karen Mulvany · 11:50 AM

We are assuming that the standard rates set by the Department are cost effective, but we need measures to ensure that choice exists at those standard rates.

3. Comparable services, community rates, availability, and local market conditions
(23 comments)

Rosie Lasca · 11:05 AM

Does “cost-effective” mean the least expensive option, or the least expensive option that actually works for the participant? The current law refers to the “least costly available provider of comparable service,” but only if that provider can accomplish the IPP and is consistent with the particular needs of the consumer and family.

Anonymous attendee · 11:17 AM

what if a less costly provider won't have an opening for 6 months out and a higher cost provider has an opening now

Rebecca D'Ornellas · 11:17 AM

Thanks for having this webinar. What if you live in an area where there are not a lot of services provided locally that fit into individual's schedule?

Miriam Erberich · 11:18 AM

If a service is purchased from a local business or community resource, how will “similar community providers” be identified, and who decides what is similar? I know private trainers who charge $50/hour, and I know some who charge $500/hour. I am sure there are more expensive once.

Francesca Calloway · 11:24 AM

Thank you, I am in agreement with most of the commenters - in Los Angeles, rates are more expensive than in other communities. We found this to be very challenging when we were traditional Regional Center clients.

Yadir Morales · 11:26 AM

If a community provider needs to do extra work to support a RC client who needs a high degree of support, will they still be expected to charge the same as what they charge a member of the general public?

Tina Ewing-Wilson · 11:27 AM

But the general public is not disabled, and some providers will adjust their services to fit us. They may charge more for these modifications, so this must be taken into account on a case by case

Francisca Salcedo · 11:31 AM

I think it's important to consider the high cost of living in California when setting pay rates for providers.

Shirlys Gruber · 11:31 AM

DDS should establish and publish clear, objective criteria for approving negotiated rates that exceed the established rates when justified by the participant’s complex needs, provider shortages, or the need for highly specialized services.

Yadir Morales · 11:33 AM

Who determines what is an appropriate "comparable service"? Can participants determine whether a service is actually comparable to what they want? SDP is all about using funding that would be paid to providers or services that do NOT fit the needs well, to pay providers that are a better fit.

Anonymous attendee · 11:33 AM

How does a PDS provider that's a public entity and HCBS compliant lowered their rates to meet DDS standards? How are you asking these entities to charge less than the public?!

Kristina Grubbs · 11:33 AM

Comparable services" must account for individualized need. Two providers carrying the same service code are not automatically comparable for a given individual. Factors that differentiate providers in ways that are directly relevant to the participant's outcomes include: the provider's specific expertise or training relevant to the participant's diagnosis or profile; the length and quality of the established relationship; cultural and linguistic match; availability in the participant's geographic area; and the participant's own documented preference and therapeutic response.

For SDP participants with complex behavioral, sensory, or communication profiles provider fit is not a luxury; it is a necessity. A directive that permits Regional Centers to reject a spending plan simply because a participant's chosen provider charges more than another provider with the same service code fails to account for the individualized nature of disability.

Tina S · 11:34 AM

Is location considered in Comparable Services? It may be cheaper to recieve a service in a different city within the county or RC purvue but the location is inaccessiable to the client?

Kim Albrecht · 11:34 AM

Comparable services and vendored service rates often yield a high staff turnover thus leading to additional costs in the long term.

Susan Corry · 11:35 AM

Cost of living in the participant's service area should also be considered, since that varies widely across California.

Kavita Sreedhar · 11:38 AM

What happens where there are no vendored services and no comparable services in the traditional model? For example, a participant may need support in being able to build, pursue a career in technology and network in those spaces; yet typical vendored job coaching and comparable ILS / Job Coaching services/ Job Supports do not address this need. Day programs may not provide this level of engagement in the specific areas - How do you establish rates for someone like this ?

Deniz Oyman · 11:39 AM

The defintion which says rates may be set by “comparable services” is very problematic. The comparable services do not take many factors into consideration. This will not allow families to hire providers at a rate that is workable. Language needs to be added that “comparable services” may not always be avaialble given each clients needs, living area, schedule, etc.

Lisa Nguyen · 11:39 AM

1) Define qualified provider

2) provide examples of similar community providers in SDP. What is considered “ community” ?

3) in SDP vendored services, do we use the ILS rate used in the RC budget calculation as the rate used for our service provider

4) define comparable services descriptions . Does it mean we go by the current service codes and descriptions in the traditional system

Alison hunter · 11:40 AM

An RC wanted to pay $50 for Riding lessons an hour from where I live. It was $85 in my community. Is that how comparison will be made? Ignoring commumity intergration.

Anonymous attendee · 11:41 AM

How will DDS define “comparable service” in real situations? A cheaper provider may not be comparable if they are not available, not qualified, too far away, unable to meet the person’s schedule, unable to support the person’s disability-related needs, or not culturally or linguistically appropriate.

Will regional centers be required to put their cost-effective determination in writing? If a regional center says a service or rate is not cost-effective, will they have to explain what they compared it to, how the alternative meets the person’s needs, and how quality and availability were evaluated?

How will this apply in the Self-Determination Program, where services may not fit neatly into traditional vendor categories or standard regional center rates? Will DDS give specific SDP examples so regional centers do not apply the definition inconsistently?

How will DDS prevent this definition from being used as a blanket reason to deny, delay, or reduce services? What guardrails will be in place for individuals

Anonymous attendee · 11:42 AM

“Reasonable rate is a rate not higher than what similar community providers charge” If we do this, the competetive rates that reduce turnover in the SDP will be gone. And we all know getting new staff can take months. This will leave many people with gaps in services if the turnover rate increases.

Anonymous attendee · 11:43 AM

“Comparable services” do not address unique individual needs as identified in the IPP. It assumes a one size fits all approach which violates the principles of SDP and The Lanterman Act. Expect participants to be harmed by DDS’s new definitions of cost effectiveness and comparable service definitions.

Yasmin Herrera-Vilchez · 11:50 AM

A service is not truly available or comparable unless it can actually be delivered safely, consistently, and effectively for the individual.

4. Individual needs, person-centered outcomes, quality, continuity, and integration
(64 comments)

Angela Cardinale · 11:08 AM

I believe general services vs. specialized services should be considered for any determination of what is reasonable, as well as county medians. Costs are much different county by county. Outcomes, evidence-based, etc. can also factor in.

Beth Martinko · 11:11 AM

Self-direction is not a costly indulgence. The largest federal study of participant-directed services, covering about five thousand people, found higher satisfaction, no loss of safety across dozens of measures, and fewer unmet needs, all at roughly neutral cost. Community living already costs the state less than institutional care and provides demonstrably better outcomes. Letting families direct their own services is the affordable choice and the effective one. A good definition of “cost-effective” should make that easier to acheive.

Karina Monje · 11:12 AM

The Lanterman Act guarantees the right to services that meet individual needs, yet when fiscal policies prioritize the 'least costly' option, we see high provider turnover and service interruptions. How will the new definition of cost-effectiveness explicitly account for the cost of workforce instability and service failure, ensuring that regional centers are not pressured to choose the cheapest provider over the most qualified one?

Karina Monje · 11:13 AM

Under the Self-Determination Program, participants are granted the authority to manage their own budgets to meet IPP goals creatively and uniquely. There is a deep concern that a rigid definition of 'cost-effective' will be used by regional centers to restrict innovative, person-centered spending. What guardrails will DDS implement to ensure that the new definition does not conflict with, or override, the federal and state mandates governing individual choice in the Self-Determination Program?

LARA ASHTON · 11:13 AM

is it considering PCP and not just IPP

Michelle Del Rosario · 11:14 AM

It should focus on what is person effective, not cost effective.

Miriam Erberich · 11:15 AM

DDS should clarify that cost-effectiveness includes more than price. It should include continuity of care, retention of qualified staff, specialized expertise, established relationships, communication compatibility, cultural and linguistic fit, safety, reliability, participant preference, community integration, measurable progress toward IPP goals, and long-term value. A provider who costs more per hour may be more cost-effective if they prevent crisis, reduce turnover, support greater independence, improve safety, or help the person achieve meaningful outcomes.

Beth Martinko · 11:17 AM

1.Anchor the definition to institutional cost. Adopt Minnesota’s standard: cost-effective means community services and living arrangements in aggregate that cost the same as or less than institutional care. This gives the term a real benchmark rather than an open-ended judgment.

2.Pair “cost” with “effectiveness,” and restore the integration override. Define the standard as the least costly and effective means to meet the person’s needs, and reaffirm the integration protection of WIC §4648(a)(6)(D) verbatim so it operates alongside the surviving clause (i). Cost and outcome should be co-equal, not sequential.

3.Account for cost across the lifecycle. Incorporate the CMS principle that crediting a purchase which would decrease the need for other Medicaid services counts as cost-effective. A support that prevents a costlier future crisis is an efficient use of funds, not an expense to be minimized in isolation.

- continued in next Q&A

Beth Martinko · 11:17 AM

Recommendations, continued:

4.Reject the “community rate” cap, and reverse the burden of proof. Pegging SDP rates to “what similar community providers charge” is the wrong yardstick, because individualized disability supports legitimately cost more than general-community services and often have no community comparison at all. The individual budget already controls total spending, so a rate cap is unnecessary and counterproductive. In its place, require the regional center to demonstrate in writing, before denying, that a less costly option will not diminish outcomes. Today families lose for “failing to establish” cost-effectiveness; the party holding the information should carry the burden.

5.Require a transparent, individualized formula balancing efficiency, economy, and quality. Replace categorical caps with individualized assessment and a published methodology, treating efficiency, economy, and quality as co-equal standards consistent with Social Security Act §1902(a)(30).

Kim Albrecht · 11:17 AM

Cost-effectiveness means achieving desired person-centered outcomes while using public resources responsibly. A cost-effective service is one that provides the greatest value over time by balancing cost, quality, outcomes, and sustainability. Evaluation of cost-effectiveness should consider not only the immediate cost of a service, but also the impact on long-term stability, independence, health and safety, service continuity, and the avoidance of higher-cost interventions.

Anonymous attendee · 11:19 AM

I would like to see the definition include a return on investment (ROI) metric for the individual's portfolio of services -- reflecting individual's overall satisfaction / impact felt from the full set of IPP services, not just at the individual service / provider level.

Anonymous attendee · 11:20 AM

This means the service should address what the person actually needs based on their circumstances, disability-related needs

preferences and planning process- define preferences and circumstances

Oscar Mercado-ICC · 11:20 AM

What guarantee will families have to ensure that service coordinators oblidge with the essence of the participant's IPP or PCP goals instead of outright utilizing the language of "cost-effective" to deny services?

Carmen Silva · 11:20 AM

Hola. Entiendo que se busque cuidar el presupuesto con la definición de 'costo efectivo', pero igualar los topes al sistema tradicional es un error técnico. Un proveedor especializado puede cobrar más por hora, pero resuelve una necesidad en menos tiempo debido a su experiencia. Si nos limitan el presupuesto, tendremos que contratar servicios de menor calidad que extenderán el tiempo que el participante necesita el servicio, generando un gasto mayor y continuo. Lo barato sale caro; la efectividad debe medirse por resultados, no por la tarifa por hora."

Maribel Óliver · 11:21 AM

The Lanterman Developmental Disabilities Services Act guarantees services based on individual needs—not the lowest cost. When the least expensive option is prioritized, it often leads to high staff turnover, service disruptions, and poorer outcomes, creating greater long-term costs. Cost-effectiveness should include provider quality, workforce stability, and continuity of care—not just price.

Maribel Óliver · 11:21 AM

How will the new definition of cost-effectiveness ensure that regional centers are not pressured to choose the lowest-cost provider instead of the provider best qualified to meet an individual's needs?

Karina Monje · 11:24 AM

As DDS establishes this definition under the mandate of Assembly Bill 143, it is vital that the term is not weaponized to mean "the cheapest option available." The ultimate beneficiary of every tax dollar spent is the individual with an intellectual or developmental disability (IDD). Therefore, cost-effectiveness must be measured by the long-term value, equity, and human outcomes it creates, rather than short-term balance sheet reductions.

Clarissa Kripke · 11:24 AM

The new definition should include the clarification that cost effectiveness cannot require people to move to services that are less integrated. This will be misused to force people into center based or institutional care.

Shirlys Gruber · 11:26 AM

Continuity of care should be an important consideration. Changing providers solely because of price differences may disrupt the participant’s progress and ultimately increase long-term costs.

Karina Monje · 11:26 AM

The definition of "cost-effective" should reflect California’s values: supporting independence, self-determination, productivity, and full community integration. True fiscal responsibility means investing efficiently to help individuals with IDD thrive in the least restrictive environment possible.

Sally Yoon · 11:28 AM

How does the government plan to manage service quality while fixing rates amidst continuous inflation?

Karina Monje · 11:28 AM

Define cost-effectiveness through a long-term lens, acknowledging that investing adequately in robust, high-quality services today prevents costly systemic emergencies tomorrow.

Carla Lehmann · 11:28 AM

(My prior comment got cut off), ...and/or the individual's unique needs—not simply the lowest available cost. Additionally, the definition should explicitly state that nothing in this provision requires participants to choose the lowest-cost provider or limits their right to select the qualified provider that best meets their needs and supports their IPP goals.

Yadir Morales · 11:31 AM

How are we factoring in outcomes and the difference in outcomes that may result from using higher quality or better fit services or providers?

Gladys Lizarraga · 11:32 AM

This limitation continues to setback our children's quality of life. Given that even the vendors that are vendored via RC's do not accept our children with disruptive behaviors. There needs to be a better stramline for this vendors to accept RC consumers.

Maribel Óliver · 11:33 AM

The Self-Determination Program is based on individual choice, person-centered planning, and flexibility in achieving IPP goals. An overly rigid definition of "cost-effective" should not be used to limit innovative and individualized supports simply because a lower-cost option exists. I respectfully request that DDS establish clear safeguards to ensure that any definition of "cost-effective" is consistent with state and federal Self-Determination Program laws and protects participants' right to choose the supports that best meet their individual needs.

Penelope Fode · 11:33 AM

I have a major concern with "cost effective" term. Who determines what is "cost effective?" My son is non-verbal, can't work and I am his conservator, not RC. RC coordinator would only provide his old agency which wasn't meeting his needs, was stating that he had major behaviors and I was forced to look for an appropriate agency. They refused me to speak on his behalf and stated that they knew better. They would provide one of their supervisors that came out ONCE! and would listen to their recommendations based on only being with my son for a total of 15 minutes. NOT GOOD and I have many fears that we would be forced to use them again. I have a Great agency now that looks at my son as a whole person, including me.

Clarissa Kripke · 11:34 AM

Communication Supports need to be individualized and maximize choice and should be participant directed and very flexible.

Claudia R · 11:34 AM

PRIMERO REVISARAN LAS TARIFAS Y DESPUES REVISARAN LA NECESIDAD Y SALUD DEL CLIENTE ??

Rocio sigala · 11:35 AM

On Quality: "How does this new definition account for the quality and stability of a service? If a provider charges more but prevents a participant from regressing or requiring more expensive crisis care, isn't that more 'cost-effective' than a cheaper, ineffective option?"

Anonymous attendee · 11:37 AM

Regional center are already creating barriers and this will create more barriers to access effective HCBS compliant providers. Most regional centers vendors don't meet HCBS compliance as they don't provide inclusive environments or engagement. So now this community will be limited and unable to access inclusive activities and environments.

LARA ASHTON · 11:37 AM

in SDP we have a PCP with individual needs and goals that are more detailed than the participants IPP. it is consistantly mentioned that IPP goals are considered. are PCP goals considered as well?

Julia Rogoff · 11:37 AM

how does this new definition benefit the client? How does it improve their outcomes?

Shirlys Gruber · 11:37 AM

Cost analysis should consider quality of life, stability of supports, and participant outcomes, because the lowest cost does not always represent the best value for the participant or for public resources.

Wren Rother · 11:37 AM

guidance on how unique needs are considered would be helpful, but please avoid suggesting caps in this area. if service coordinators have the option to kick the can down the road and avoid doing work to

actually consider things deeply, they will. if you suggest any sort of cap, they will use that to deny people unique services/rates and just shrug their shoulders and point to the rules.

Daysi F · 11:37 AM

Veo que DDS, nunca piensa que Costo-Efectivo será un obstáculo más a la vida de nuestros hijos. Primero se debería pensar cómo afectaría la vida y el desarrollo de nuestros hijos.

Anonymous attendee · 11:38 AM

I don't see any mention of measured outcomes as part of this definition. I strongly oppose a definition that does not consider highly the specific need sand measured outcomes of the specific services. If a more expensive service has a better outcome, then it may be cost-effective in the long term. This is completely different from just saying that "reasonable rate" is that matches another rate.

Kim Albrecht · 11:38 AM

Is the “cost effective” focusing on short term costs or long term costs? What is cost effective today often will lead ot additional costs later associated with crisis care, onboarding rotating staff, etc

Janet Guillen · 11:38 AM

The discussion should not begin with what is most cost-effective. It should begin with what is most effective for the person. A service that costs less but does not help the individual achieve their goals is not truly effective. Consumer preferences, individual goals, and meaningful outcomes should remain the primary benchmarks when determining whether a service is appropriate.

I also believe the definition of “reasonable rate” needs to be much clearer. As currently written, it does not provide

Anonymous attendee · 11:39 AM

Requiring families to choose a lower-cost provider simply because the rate is lower can interrupt services, increase turnover, and undermine progress. Those disruptions can create greater costs later, both for the family and for the system. For that reason, DDS should define cost-effectiveness in a way that reflects long-term value, stability, and outcomes, not just short-term hourly cost.

Veronica Del cid · 11:39 AM

as the very name implies, person-centered plan focuses on the individual, the cost should'nt matter. what mattersis how much it helps the person progress

Anonymous attendee · 11:40 AM

What specific problem is DDS trying to solve with this proposed definition, and how will DDS measure outcomes to make sure “cost-effective” is not interpreted by regional centers as simply “cheapest”?

Fernando Gomez - ICC · 11:42 AM

The word Cost in Cost Effectivness can easily be misenterpeted. The focus instead of cost should be in Value, so Cost effectiveness should be interperted Value-Effectiveness. Cost-Effectiveness should be understood as the responsible stewardship of public resources in ways that maximize long-term value, expand opportunities, strengthen independence, promote inclusion, and improve meaningful life outcomes for individuals with intellectual and developmental disabilities. Lastly, when this interepertation is not honored how will DDS address? How will community be able to communicate issues?

Anonymous attendee · 11:42 AM

Thank you for the opportunity to provide feedback.

We respectfully ask DDS to ensure that the updated definition of "cost-effective" does not rely primarily on market rates or the lowest available cost. In the Self-Determination Program, services must remain person-centered and based on each participant's unique needs, goals, and circumstances.

Many individuals with developmental disabilities require providers with specialized skills, unique expertise, cultural and linguistic competence, or long-established relationships built on trust. It often takes months or even years for a provider to understand an individual's communication style, behavioral supports, and personal preferences. These factors are essential to the success of the service and cannot be replaced simply by selecting a lower-cost provider.

In addition, many participant-directed services are innovative and highly individualized. Some services do not have an equivalent within the traditional Regional Center vendor system, making it inappropria

Julie LaRose · 11:42 AM

some other examples: "Cost-effectiveness should include consideration of service continuity and provider retention, recognizing that stable supports often improve outcomes and reduce long-term costs."

Erica Hernandez · 11:42 AM

DDS should clarify that vendor rates are a reference point not a maximum limit. Cost effective should prioritize meeting an individuals unique needs !!

Aseneth Casanova · 11:42 AM

Cost-effectiveness should be measured by long-term outcomes, not short-term expenditures. Paying more for the right service today may prevent crisis placements, hospitalizations, law enforcement involvement, provider turnover, and institutional care tomorrow. That is truly responsible stewardship of public funds.

Aminah Abdul-Hakim · 11:43 AM

My overall feedback is that DDS should clearly explain what problem this new definition is intended to solve and how success will be measured. Cost-effectiveness should not be interpreted as simply choosing the cheapest option.

Kimberly Schreiber · 11:43 AM

My name is Kimberly Schreiber, founder of NeuroNav, the largest Independent Facilitator organization in California. We serve over 600 individuals across all 21 regional centers and we see every day the tremendous positive impact this program has on people's lives.

The Self-Determination Program was built on a simple but radical idea: that people with developmental disabilities, given control over their own budget and the freedom to direct their own services, will achieve better outcomes than any system can achieve for them. That idea is not philosophy — it is evidence. Research on consumer-directed care shows that when people control their own budgets and choose their own providers, they have fewer unmet needs, greater community participation, and better quality of life. Not marginally better. Significantly better.

The mechanism that produces those outcomes is budget authority. This definition puts that at risk. This definition puts positive outcomes at risk.

Julie LaRose · 11:43 AM

When determining whether a service is cost-effective, consideration should include:

the individual's assessed needs

person-centered planning outcomes

participant choice

provider qualifications

local labor market conditions

continuity of supports

responsible use of public funds

availability of qualified providers

comparable community rates

Janet Grillo · 11:44 AM

Preventing hospitalization and other potential outcomes is hard to measure and claim but essential to justify higher cost of more qualified providers who will necessarily charge more. As they say, ‘you get what you pay for.’

Anonymous attendee · 11:44 AM

Regional centers aren't person centered! They violate civil rights!!

Rosie Lasca · 11:45 AM

How will DDS make sure regional centers do not pressure participants to choose a cheaper provider instead of the provider they trust? Keeping consistent with Person-Centered choice.

Janet Guillen · 11:45 AM

I respectfully encourage DDS to clarify that a reasonable rate must first be evaluated based on whether it is effective in helping the individual achieve their person-centered goals, while also considering fiscal responsibility. A clear statewide definition would promote consistency, reduce unnecessary disputes, and better uphold the intent of the Self-Determination Program.

Julie LaRose · 11:45 AM

"When comparing services of comparable quality and expected outcomes, consideration should be given to cost while preserving participant choice and individualized needs."

Janet Grillo · 11:46 AM

Is the Federal Govt requiring the term “cost effective” in the definition? Is the Fed Govt stipulating as outcomes to justify costs?

Aminah Abdul-Hakim · 11:46 AM

My concern is simple: if DDS does not clearly define cost-effectiveness with safeguards, this could become another tool for denying, delaying, or reducing services. Cost-effectiveness should be measured by whether a service meets the person’s needs, supports IPP goals, protects health and safety, prevents crisis or regression, and promotes meaningful outcomes.

Yadir Morales · 11:47 AM

There needs to be a way for participant to try out providers and services even if they are significantly more costly if they believe they may be better able to meet a need. If after trying the service they can show positive outcomes, especially compared to less costly services, then that has proven to be cost-effective because it is more effective long-term.

Evelyn Rodriguez · 11:50 AM

I am speaking today as the mother of a son with significant support needs and as an Independent Facilitator who works with many Hispanic families in the Self-Determination Program across 10 Regional Centers in California.

I encourage DDS to define "cost-effective" based on **long-term value and outcomes**, not simply the lowest price. The least expensive service is not always the one that best meets an individual's needs.

A quality service can prevent behavioral crises, hospitalizations, injuries, and more restrictive placements, ultimately reducing long-term costs to the State. I also believe the definition should recognize the importance of **continuity of care**, because changing a trusted provider solely to save money can lead to regression and higher costs later.

Cost-effectiveness should be evaluated based on each person's individual needs, health and safety, IPP goals, and long-term outcomes. It should mean making the best investment in the person's success, not simply choosing the cheapest option.

Shirlys Gruber · 11:51 AM

DDS should clarify that “cost-effective” means achieving the best value in meeting the participant’s needs and desired outcomes, rather than simply selecting the lowest-cost service or provider.

Yadir Morales · 11:51 AM

The definition absolutely must include not moving participants to more restrictive settings.

Cesilia ORTIZ-BARAJAS · 11:54 AM

Good morning.

My name is Cesilia Ortiz. I am an Independent Facilitator, Executive Director of Parents United for Autism, and the mother of two adults with developmental disabilities.

I am deeply concerned that the new definition of "cost-effective" could become a tool to deny services simply because they cost more. The question should not be "Which service costs less?" The question should be "Which service actually works for this person?"

The Lanterman Act recognizes that every individual is unique and has unique needs. The Self-Determination Program was created to honor that individuality, not to force families into choosing the cheapest option.

If a participant remains within their approved annual budget, the focus should remain on achieving their IPP goals and receiving individualized supports—not on reducing costs.

I respectfully ask the Department to make it clear that cost can never replace a person's needs, preferences, and outcomes. Services should be selected because they help the person live a

Penelope Fode · 11:56 AM

Least restrictive setting: must always include the individual’s needs (even for the conservator). I am my son’s conservator and voice (he is non-verbal and non-communicative) and I don’t claim to always know what he would say, but I am more right than the RC who sees him 4 times a year as opposed to my weekly visits to him.

Rocio sigala · 11:57 AM

On Unique Needs: "For families with complex needs like mine with multiple SDP participants

.. staff pais the traditional hourly rates are often not qualified to ensure safety and community integration. Will there be an automatic exemption for participants who require specialized, higher-cost providers?"

5. Workforce wages, recruitment, retention, and provider capacity (18 comments)

Rebekah Acosta · 11:07 AM

As a parent I fear that no one will provide respite care for our children for minimum wage. Especialy because of the medical needs of my children.

Miriam Erberich · 11:13 AM

One of the primary reasons many families and participants choose Self-Determination is that the traditional service system and vendored rates often do not provide the individualized supports needed for a person to live a meaningful, safe, integrated, and successful life. The flexibility to determine appropriate rates within a Certified Budget has allowed participants to recruit and retain qualified staff, build

consistent support teams, access community-based providers, and design services that truly meet individual needs.

Anonymous attendee · 11:16 AM

Good morning! I am a vendor of a staffing agency; my rates may be higher than the average individual, but I provide things that an individual can't such as backup staffing, alternative people if the fit isn't right the first time, ability to expand services to meet needs quickly, and more. It should also be understood that some people just don't have their own village or people to hire. Some of these are invaluable and participants shouldn't be discouraged from utilizing staffing agencies especially as we can save money in many areas longer term.

Claudia R · 11:19 AM

No tenemos asistentes personales para trabajar con nuestros hijos menos tendremos PA calificados DONDE ESTAN LOS ASISTENTES PERSONALES CALIFICADOS ? USTEDES LOS PROOVERAN ??

Anonymous attendee · 11:20 AM

Everyone providing services as caregivers or personal assistant (PA's) deserve to earn a fair and livable wage. It is already difficult to find people willing to take this level of responsibility. Fair wages will help find and retain good providers. This should apply to Traditional and SDP.

Anonymous attendee · 11:22 AM

First we need to ACTUALLY meet someone's needs and be accessible. we can not hire someone to do personal assistance for $20 or a behavior trained person for $25 an hour plus when the budget puts in monies for Behavior PA as an example there is still a burden as if you go through an agency for vendor its much higher more like $50 or $60 or more per hour.

Michelle Del Rosario · 11:26 AM

The service also needs to be accessible. For example, a social recreation activity, social skills class, or employment internship is completely ineffective if the person doesn't have their Personal Assistant, ILS or TDS staffing.

Anonymous attendee · 11:26 AM

NUESTROS HIJOS SON SEVEROS Y SE GOLPEAN SOLOS Y GOLPEAN A LOS CUIDADORES TIENEN USTEDES ASISTENTES PERSONALES CALIFICADOS PARA EL CUIDADO DE ELLOS?? CON UNA TARIFA NEGOCIADA ??

Karina Monje · 11:28 AM

A true definition of cost-effectiveness must consider preventative value. Choosing a cheaper service provider that lacks specialized training often leads to service failure, behavioral regression, or caregiver burnout. This ultimately forces individuals into more restrictive, higher-cost crisis interventions or residential placements later.

Danielle Alvarado · 11:29 AM

How are you going to pay a worker minimum wage to deal with behavior and complete care and expect someone to stay working

joseph buchroeder · 11:31 AM

who can live on minimum wage in CA.

Dora Contreras · 11:36 AM

Comparable rates, does this include staff compensation ?

John O'Leary · 11:39 AM

Unfortunately this presentation clarified very little for me — it was too abstract and the interpretation of the language would vary wildly across regional centers and case managers. What I really care about about is whether I can continue to pay my son's personal assistant the rate he deserves — it is higher than minimum wage and the going rate for babysitting in our area, but I am certain that we could not hire someone who could meet my son's goals and needs at those rates.

Anonymous attendee · 11:42 AM

My greatest concern is that respite care rates are unreasonably low. Anchoring a comparison to already set rates (e.g. minimum wage) is the reason there is a dangerous shortage of care providers to support disabled Californians. We need to set a different bar to ensure families get the quality help they need and that care providers can earn truly livable wages. Care providers supporting individuals with complex needs charge $30-50/hour which is far beyond the paltry minimum wage.

Adam Ruddle · 11:42 AM

I very much agree with the point that agency rates who drive down employee wad

Jan Opsvig · 11:53 AM

I understand the concerns regarding certain vendor and employee rates. What DDS needs to understand is that the Traditoinal system has failed participants including my daughter due to poor staff quality and staff avalaibility. The vendors pay staff minimum wage which is not appropriate for the level of support our children/adults need. We are in a very competetive market when it comes to wages and need to be able to have a pay rate higher than MCDonalds. Also,businesses and vendors have opened their doors for Regional Center Clients and the billing is much more difficult in addition to the vendoringprocess with the FMS or RC. This needs tobe taken into consideration. Over the past 6 years I have seen community classes go from zero classes to several per week. Classes are full. Since everythng you noted is very subjective I dont see how it will be sustainable to have each "cooking class" compared to another and choose the least expensive option. unrealistic. RC's will decide what they think is best not famil

Adam Ruddle · 11:56 AM

Our family has experienced providers who were asleep instead of caring. Recruiting good, motivated providers is tough. Making them work for minimum wage will make the good ones ever more likely to quit and leave only those too incapable in the pool of providers to recruit from.

Melissa Ardon · 11:56 AM

It's difficult enough finding staff to work for my clients, the reason they have employees is because they pay more than the minimum wage. It's important to compensate people who will cook and make sure you are safe a LIVING Wage so they don't have to go out and get 3 jobs and be stressed, tired and grumpy when caring for a person with special needs

6. Qualified provider standards, credentials, and lived experience (26 comments)

Rosie Lasca · 11:07 AM

What evidence must a participant or IF provide to show that a higher-cost option is more cost-effective? Will DDS provide examples of acceptable evidence, such as PCP notes, IPP goals, provider qualifications, failed prior services, participant/family statements, clinical recommendations, staffing history, transportation barriers, language needs, or documentation showing that lower-cost providers are unavailable or ineffective?

Clarissa Kripke · 11:15 AM

Remove the word "qualified". While that sounds good, the unintended result is that it gives more power to professional organizations who control credentialing. That comes at the expense of families and clients who know best who works well with them. It is also horrible for tax payers to allow professional organizations and service providers to drive up costs by forcing people to use their "qualified" providers. Develomental servcies have become big business and increasingly corrupt. Giving families more control over chosing who works well with them and defining what is effective is a better approach. Proprietary therapies and professional organizations are often backed by venture capitalists. Don't give them a way to control who people can use to provide servcies. The Boom in Autism Therapy Is Medicaid's Fastest-Growing Jackpot: https://www.wsj.com/health/healthcare/autism-therapy-medicaid-payments-640aa435?. mod=article_inline.

Julia Rogoff · 11:19 AM

what constitutes a qualified provider? Will Regional Centers be approving the qualification of our staff?

Anonymous attendee · 11:20 AM

"qualified" and "reasonable" should be explained within the same statute or regulation without someone having to track down a different regulation for the definitions.

Chelsea Coffin · 11:21 AM

Who determines what a qualified provider is? Obviously, if it is a service that requires a license or certificate, like a medical doctor, that is easily defined. But who determines if a respite provider is qualified? Who determines if a social rec provider is qualified?

Penelope Fode · 11:21 AM

Concerns start with who determines qualified? Recently had an agency providing my son his SLS, however the agencty was only hiring untrained individuals and advising them not to talk to me. Due to this he missed being taken to doctor appointments and was not aware of whether he had enough medications for the month, etc. I did my best to keep the agency informed and yet they never did anything based on what I told them. This is an agency that does the least amount of work and calls it qualified.

Anonymous attendee · 11:22 AM

For SDP providers, who is responsible for determining the qualified provider, how, and when?

Anonymous attendee · 11:23 AM

What makes a provider qualified? Because support staff only need background checks if they're providing personal care or if the FMS requires it. Different FMS and Regional Centers have different standards for "qualified".

Eileen Fernandez · 11:23 AM

we had a problem with a choice our son made but the qualifications were questioned. this made his choice null. the person was an experienced artist but had no degree in art. In art schooling is not the only by schooling. itnis by their portfolio.

Kavita Sreedhar · 11:25 AM

Furthermore, what would be considered an effective service and a qualified provider. Case in point being the START YAI Crisis program made available to higher support individuals but does not meet their requirements since they do not provide in person crisis support or timely response. There are several higher support needs consumers with Crisis Plans in place and funding but unable to utilize the same, due to the limitations of so-called Qualified providers. There could be a Support team or a family member (not necessarily immediate parents) who can help de-escalate situations which a supposed qualified provider may never be able to achieve due to the lack of hands on experience

Shirlys Gruber · 11:25 AM

The regulations should recognize that qualified providers are limited in many communities. When there is a provider shortage, a higher rate may still be cost-effective if it ensures timely access to services.

Nestor Nieves · 11:27 AM

It is already hard to find providers, setting the rates too low and not accounting for quality of service or the relationship with a service provider and client will mean less service providers available. And finding providers will also be harder when qualification requirments only look at degrees/certicicates and not lived experience.

Eileen Fernandez · 11:28 AM

The Dept must allow for choice and not only for degreed individuals but also experienced individuals. ive seen poor bcbas who are not as effective as other counselors with more experience .

Alissa Haggis · 11:30 AM

You should also note that the Livescan done for SDP has a higher standard to pass than the fingerprinting done for other services such IHSS and by some respite agencies. I have seen many IHSS workers FAIL an SDP livescan.

Rebekah Acosta · 11:30 AM

I know you are trying to speak in plain language but I still feel like I need a law degree to understand all of this. It feels in my opinion that DDS is just trying to deny and cut costs and budgets where ever DDS can. I do agree that there should be some cap on cost and rules across regional centers, but I fear that as written it is just meant to deny.

Michelle Smith · 11:33 AM

Who is going to decide on the qualifications?

Susan Corry · 11:35 AM

Rates should consider the provider's qualifications (ex: someone with a master's degree should have a higher rate than someone with only a HS diploma.)

Whitney Jacks · 11:36 AM

My question is - will this really “save” money?? If we are capped with a low budget we may not be able to find a provider that is qualified for our client or family member - and this without qualified providers we will reduce the ability to meet safety goals, progress towards indepdence, and community integration needs. That set back would mean more adults needs ongoing care that possibly could have been avoided with the right support, or instititions and less families being able to provide ongoing supervision and support. Adult care is always going to be more expensive and ongoing. Early intervention - fueled by the support of self determination - obviously is more cost effective then a lifetime of unmet needs.

Eileen Fernandez · 11:37 AM

Regional Centers do not always agree on the same terms , defintiions or qualifications. it would help if DDS guided qualifications criteria so that it would be consistently supportive and meets thr IPP Goals and choices.

Nancy Crocker · 11:42 AM

Would like criteria for "qualified provider" defined clearly for situations for non-traditional providers. Eg, a specific life coach we found has transformed our son's life. However, life coaches don't necessarily have standardized credentialing

Silvia · 11:42 AM

Thank you for the presentation. My concern is that several key terms remain undefined or are subject to interpretation, including “comparable services,” “qualified provider,” “reasonable rate,” and “cost-effective.” I respectfully encourage DDS to provide clear, objective, and statewide criteria to ensure consistent implementation and reduce variations in interpretation among Regional Centers.

Letty Lopez · 11:44 AM

As it is, families already struggle to find qualified providers who are willing to work with our loved ones. Many individuals have complex support needs that require patience, experience, specialized skills, and consistency. If rates are restricted, it will become even more difficult to recruit and retain qualified staff, resulting in fewer choices and reduced access to the supports participants need to achieve their IPP goals and live safely in their communities.

Cost-effectiveness should be evaluated based on the participant's overall Certified Budget, assessed needs, and outcomes—not by comparing one provider's hourly rate in isolation.

Kavita Sreedhar · 11:44 AM

Also, PLEASE do specify guidelines on the “qualified” providers - please review my prior comment on the Crisis Intervention or support services.

Sonia Morales · 11:49 AM

If we already have a certificate budget, why are you trying to question how much we can pay to employees if we are only using the certificate budget?

Rosie Lasca · 11:50 AM

Can regional centers deny or delay a spending plan while they search for a cheaper provider? If the participant has identified a qualified provider who meets the IPP goa, can the regional center delay certification by requiring additional comparison shopping? If yes, what timeline protects the participant from service gaps?

Fernando Gomez - ICC · 11:56 AM

Will there be a 3rd party non-biased entity that will handle issues for individuals who do not meet the qualification criteria? What options will people have to resolve these issues that the process is not overwhelming and intimidating and penalizes individuals with limitied resources or capabilities?

7. Generic services, family responsibility, and federal financial participation (23 comments)

Marty Omoto · 11:09 AM

Thanks Pete as a;ways. And absolutely appreciate the great work of Mission Analytics! One question for later is explaining to people who may not know what is meant by the term "generic services" .That is a term that is not used in other service system we use (ie IHSS, Medi-Cal, behavioral health, special ed)

Kavita Sreedhar · 11:13 AM

What is the family responsibility portion? Please elaborate on that ? IS it largely for children or for adult individuals as well ?

Dora Contreras · 11:15 AM

Can you please define a “ family’s responsibility ($$$, “natural support” or something else?

Karen Mulvany · 11:19 AM

regarding "not replace generic services", consider amending this to read "not replace AVAILABLE generic services"

Angela Cardinale · 11:20 AM

What does eligible for federal financial participation mean?

Kavita Sreedhar · 11:21 AM

This generic service language element is problematic. For example with IHSS services, it does not meet the needs of individuals with higher behavioral support needs and IHSS actually will discharge a client with maladaptive behaviors. Individuals who have IHSS hours maxed out, usually end up without having appropriate behavioral supports due to the lack of behavioral training. Please consider this.

Linda Chan Rapp · 11:22 AM

1. I don’t understand what federal financial participation means.

2. how is “reasonable” defined?

William Leiner · 11:22 AM

There are Lanterman Act services that are not eligible for federal financial participation. Rental subsidies are one of those services. Are there other services that are not eligible for federal financial participation? Will this definition prohibit these services?

Anonymous attendee · 11:22 AM

If a generic service is continually not provided by another organization (lack of care trhough IHSS and HCBA) can regional center be resposible for providing the service.

joseph buchroeder · 11:22 AM

when a generic service is funded by state and federal $$ how is it considered generic? like ihss you rob from peter to give to paul.

Susan Corry · 11:22 AM

In addition to "reasonable rate," will "generic services" and "qualified provicer" be defined?

Daisy Jimenez · 11:22 AM

Generic services such as Dept of Rehab? Often DOR makes it difficult for RCEB clients to get services under DOR umbrella.

Rebekah Acosta · 11:23 AM

What does federal financial participation mean?

Yadir Morales · 11:23 AM

When considering generic services, the generic service must be actually available to the individual. If they do not currently have access to it then it should not be factored in.

Dora Contreras · 11:27 AM

Is there a change of federal rates ?

Anonymous attendee · 11:28 AM

For generic resources- please define better and name those services specifically- example Eater Seals should not be listed as a generic services. Also define and clarify the timeline by which a generic service should be available to provide help. Families are sent down a lengthy rabbit hole- trying to hunt down a generic service that doesn't actually apply or they can't get a response or denial bc the generic resource isn't applicable. The generic resource must be immediately available.

joseph buchroeder · 11:29 AM

I was abused by a IHSS provider TCRC told me to go back to my abuser because they could not fill in the hours.

Janet Grillo · 11:33 AM

What services are subject to or funded by the Fed Govt? Please clarify and provide examples.

Aaron Carruthers · 11:40 AM

This definition seems to change the standards for FPP, moving from "considered" to confirmed. Please list which services are not receiving FFP, so may not be considered cost effective. Please describe how people with unsatisfactory immigration status will be impacted by this definition, since their services are not eligible for FFP

Sandra Van Scotter · 11:40 AM

There really needs to be a rubric to explain all the criteria that are used to determine "cost effective". The other question I have is, will the HCBS wiaver definition for "cost effective" be used in these situations? It is clear that the Centers for Medicare and Medicaid Services are being diligent regarding how they examine the billing from all states and they have a right and an obligation to make sure they are being good stewards of taz dollars. It seems that California and DDS have no choice but to make sure they are parallel with the Feds to make sure the state is reimbursed for the funds they already paid out.

Anonymous attendee · 11:42 AM

If regional centers don't help clients/participants access services from generic resources, will the client/participant be responsible for accessing services from known or unknown generic resources?

Dora Contreras · 11:42 AM

I am concerned about the safety and health waivers . Are the requirements changing? Definitions? Aspects?

Kavita Sreedhar · 11:53 AM

@andrew - please see my comment about the segment of the population that has higher behavioral support needs and co occurring mental health conditions - if the rates are determined based on exceptions processes, or if their generic service utilization of IHSS is to be exhausted (which would not meet the need) then it could cause bottlenecks and delays, which in these cases can be life or death (especiall for

aging caregivers who provide IHSS support to their high needs children or family members) There needs to be defined supports or language to be able to address this segment of supports for this segment of the population

8. Regional center consistency, guidance, oversight, and accountability (22 comments)

Karen Yingling · 11:12 AM
how are the key factors "weighted in determining the service? Is there a rubric or metric?

Rebekah Acosta · 11:16 AM
I also think that it is important to define things clearly for the individual regional center some regional centers would deny using the definition while another would approve. All regional centers seem to understand things differently.

Shirlys Gruber · 11:27 AM
DDS should publish uniform statewide criteria to prevent inconsistent interpretations among Regional Centers.

Alicia Flores · 11:29 AM
No mas a personas Fantasmas en los Centro Regionales,clinico Team

Julia Rogoff · 11:35 AM
the issue is each regional center interprets guidelines wildly different.

Maureen Fitzgerald · 11:37 AM
When a definition is adopted, will DDS have training for the 21 regional centers to facilitate the definition being implemented uniformly? How will the department assess over time, say the first year, that the regional centers are uniformly implementing the use of this definition?

Anonymous attendee · 11:38 AM
must also establish clear, uniform standards for how Regional Centers evaluate cost-effectiveness. Without explicit criteria, each Regional Center will apply its own interpretation, creating a system where a spending plan approved in one region is denied in another for identical services. The directive should define the specific factors Regional Centers are required to consider, require written justification for any cost-effectiveness objection tied to those factors, and establish that participant-documented need, not Regional Center discretion., is the primary standard. Anything less allows the cost-effectiveness requirement to function as an unchecked gatekeeping tool rather than a meaningful fiscal accountability measure.

Karen Yingling · 11:38 AM
The lack of true guideleins for the implementation are of the most concernto me about the definition - the defintion does not identify the "wieght" of cost effectiveness with the other factors - leaving the implementation "up to" whomever is administering

Maureen Fitzgerald · 11:38 AM
The issue of the cost effectiveness of the conduct of the regional centers needs to be a part of this discussion.

Janet Guillen · 11:40 AM
Does not provide sufficient guidance for Regional Centers when working with providers that fall outside the traditional vendorized system or government established rates. Without a shared definition, each of the 21 Regional Centers may interpret "reasonable" differently, creating inconsistent implementation across the state.

This is particularly concerning because families are already experiencing significant differences in how Regional Centers develop Individual Budgets and

Elizabeth Barrios Gómez · 11:42 AM
How will the department provide support to families. Today, many families experience a system that has effectively stopped responding. Requests remain unresolved for months. Meetings occur without decisions. Accountability is often absent, and because these experiences rarely reach the Department in a meaningful way, it becomes difficult to fully understand trust has eroded so significantly. The definition and implementation are concerning for many of us here today. The Ombudsman office should respond to families in real time. The way they respond at this time is also very concerning.

Melissa Arvizu · 11:45 AM
Regional Center Consistency

DDS states that one reason for this proposal is inconsistent statewide interpretation. What specific guidance will DDS provide to ensure every regional center applies the rules consistently?

Will DDS issue written statewide policy before implementation?

Will DDS monitor regional centers for inconsistent application of the new definition?

Silvia · 11:45 AM

Thank you for the presentation. My concern is that several key terms remain open to interpretation, particularly “comparable services,” “comparable quality,” “qualified provider,” and “reasonable rate.” I respectfully encourage DDS to provide clear, objective, and statewide criteria for these terms to ensure consistent implementation across all Regional Centers.

Odilia Bamaca · 11:45 AM

Monitor and disclose internal data from the 21 regional centers to ensure more resources reach direct services; for example, ILS providers charge around $50 per hour, yet the worker assisting the client receives much less. That is where the funds should be drawn from. Thank you.

Silvia · 11:45 AM

Thank you for the presentation. My concern is that several key terms remain open to interpretation, particularly “comparable services,” “comparable quality,” “qualified provider,” and “reasonable rate.” I respectfully encourage DDS to provide clear, objective, and statewide criteria for these terms to ensure consistent implementation across all Regional Centers.

Silvia · 11:48 AM

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Anonymous attendee · 11:49 AM

What about the fraud that takes place with service coordinators selling clients to vendors?! You allow these regional centers to operate like modern gangsters intimidating and withholding services from the population theyre designed to serve!!!

Penelope Fode · 11:49 AM

The conservator must be able to be heard at the RC level. This sounds like a means to save money only (for the Gov’t). I agree with all those that have shared their concerns regarding who determines the need is evident. Also that not all RC’s are alike (even though they are suppose to be).

Jinsook Baek · 11:50 AM

How will DDS ensure that the updated definition of "cost-effective" is applied consistently across all 21 Regional Centers? Will there be clear statewide guidance and oversight to prevent different interpretations or inconsistent rate determinations from one Regional Center to another?

Irene Litherland · 11:52 AM

If one of the factors is the a provider must be "qualified", under self-determination that will require a whole set of definitions and a clear rubric for regional center review. Who is developing that? Will it be ready by July 1? Will regional center staff who are implementing be trained on how to apply it consistently? And will the FMS use the same criteria or different ones? (Right now each uses their own interpretation.)

Anonymous attendee · 11:53 AM

What about the misappropriation of funds and fraud at the happens internally at these regional centers?!

Silvia · 11:55 AM

I understand that the concept of “cost-effective” is already established in law. My concern is not the concept itself, but how it will be implemented.

Throughout the presentation, terms such as “comparable services,” “comparable quality,” “qualified provider,” and “reasonable rate” were used. I believe these terms remain open to interpretation and could result in inconsistent application.

I respectfully request that DDS establish clear definitions, objective criteria, and statewide implementation guidance for these terms. Doing so will help ensure consistent implementation across all Regional Centers while ensuring that decisions continue to be based on the individual’s unique needs, in accordance with the principles of the Lanterman Act.

9. Appeals, exceptions, burden of proof, timelines, and administrative burden (40 comments)

Anonymous attendee · 11:04 AM

* What exactly qualifies as a “reasonable rate”?
* Who makes that determination?
* What documentation is required to justify higher rates?
* How will regional centers ensure consistency statewide?
* What appeal rights exist if a rate is deemed unreasonable?
* How will unique disability-related needs outweigh cost considerations?
* How will consumer choice be protected when the preferred provider charges ab

Beth Martinko · 11:10 AM

When a family hears that a service is “not cost-effective,” they do not hear a budgeting term. They hear no. Our review of fair hearings shows that about three out of four Self-Determination Program appeals end in denial, and that the cost-effectiveness language is the reason cited most often. Families are losing today under a standard that is supposed to be a tiebreaker. The community worry is simple: if the draft turns that standard into a pass-fail gate, the families who are already losing will lose faster, and the ones who might have prevailed on the merits will not get the chance to

Beth Martinko · 11:13 AM

The consequence is measurable. In fair-hearing decisions, cost-effectiveness provisions drive denials between 73 and 100 percent of the time, and roughly 85 percent of budget-increase requests are rejected. The draft does not introduce a risk so much as remove the remaining checks on a documented pattern.

Anonymous attendee · 11:14 AM

Who determines when services are comparable and what process will individuals have to go through to justify that higher priced providers offer higher level of services and are not comparable to lower priced alternatives identified by the RC?

Beth Martinko · 11:16 AM

The draft’s only relief is a single sentence, that “rate adjustments can be explored to meet the unique needs of the individual.” It names no process, no decision-maker, and no right to appeal. There is also a deeper problem that better drafting would not solve. Every rate cap requires an exception process, and exception processes fall on the family. In the states SDTA surveyed, a unique-need exception exists in many programs, but in every one of them the burden of invoking it sits with the family. Layering a rate-exception review onto an already overburdened system adds delay, and families pay for that delay twice: in the time it takes, and in the services a person does not receive while the review is pending. The families least able to absorb that wait are the same families the system already underserves. The escalation process it will require also adds needless costs to the administration of the system, with zero payback in return, a waste of taxpayer dollars.

Anonymous attendee · 11:20 AM

Who is responsible for determining the client’s need, how, and when?

Kavita Sreedhar · 11:22 AM

There needs to be clear explanation of exceptions to the rule in these cases.

Yadir Morales · 11:25 AM

Who decides whether a specific provider or service can actually meet the participant's needs? Or whether a service or provider is comparable to what is needed?

Shirlys Gruber · 11:28 AM

If a Regional Center determines that a rate is not reasonable, it should provide a written explanation describing the criteria and evidence used to reach that decision.

Teressa Borrayo · 11:29 AM

If a rate needs to be negotiated, is this on the IF/Client to justify the rate or the vendor?

Michelle Smith · 11:29 AM

Who gets to decide whether or not the services are cost efective for indidvuals as per new definition.

Anonymous attendee · 11:29 AM

Are you saying we as consumers have to do way more research and make “proof” for you that our vendors are worth approving? That is so much work and not appropriate to ask for many to put the burden on the consumer.

Susan Corry · 11:30 AM

Rates currently in use by SD participants should also be considered. These rates are living proof that they're effective bc families are currently using them with success.

Anonymous attendee · 11:34 AM

Hope you're planning to increase your rates for Independent Facilitators because the burden you're about to put on them is gigantic.

Erica Hernandez · 11:35 AM

If an individualized service exceeds a cost benchmark will DDS ensure that medically or clinically necessary, person centered services are still approved when no appropriate lower cost alternative exists??? We should be given a reason to why a service or rate is being denied and the right to appeal

Odilia Bamaca · 11:38 AM

NO more spending money on unfair hearing

joseph buchroeder · 11:38 AM

the biggest cost of SD is all the constance paper work service coordinators must do lets address that.

Anonymous attendee · 11:39 AM

Thank you for seeking community input on a definition that will have a meaningful effect on whether people can access the services and supports identified through their planning process.

I support a clear statewide standard. However, the proposed definition needs more specificity before it is implemented across regional centers and service delivery models.

In my family's experience, disagreements about whether ABA can be obtained at an adequate and sustainable rate have been deferred to the appeals process rather than resolved through individualized planning. This is precisely why the definition must be clear now. Once standardized, it should guide regional centers to make transparent, fact-based decisions at the planning table—not leave families to prove, through a lengthy appeal, that a lower-cost option was never truly workable.

Sonia Morales · 11:41 AM

The word "reasonable " is not clear and the regional center is already using it to approve the rates participants wants to pay to their employees and because of that we are receiving a lot of NOA because we don't get in agreement because of the confusion of Regional Center think they have the authority to do it.

Janet Guillen · 11:41 AM

process Spending Plans. There is still no standardized statewide guidance on timelines or the review process. Adding another undefined term will only increase inconsistency and uncertainty for families.

Michelle Ramirez · 11:41 AM

What isn't clear is the process a family would go through if they didn't agree with approved vendor and wanted to continue with a vendor in their community or with a vendor they have a long standing relationship with. If the regional center does not approve, would this be the standard appeal process? Also the RCs implement things very differently. There would need some guidance.

Anonymous attendee · 11:41 AM

The "Cost-Effectiveness" of Administrative Burden and Appeals: Has the Department formally evaluated the actual cost-effectiveness of the administrative burden this proposal will place on both Regional Centers and participants? By capping Self-Determination Program (SDP) rates and requiring participants to continuously provide "proof" of alternative community prices or request "rate adjustments" to meet their unique needs

, the Department is creating a massive paperwork bottleneck. Has DDS calculated the financial cost of processing these constant exception requests and defending against the resulting surge in fair hearing appeals, and will those administrative costs outweigh any perceived savings from the rate ceilings?

Kristianna Moralls · 11:42 AM

Preventing "Denial by Delay": How will the Department ensure that Regional Centers do not use the "reasonable rate" and "qualified provider" criteria as a mechanism to second-guess Individual Program Plan (IPP) team decisions? Adding redundant requirements for families to prove provider qualifications and justify rates risks creating new barriers to care. How will DDS guarantee that this policy update does not simply increase instances of "denial by delay" for families waiting for critical services?

Kavita Sreedhar · 11:43 AM

With regard to the Generic service utilization - especially for those with special behavioral needs - it needs to be clarified - not as an exceptions process as that is going to cause bottlenecks and timeline delays Please specify language with regard to those with Higher support needs

Yasmin Herrera-Vilchez · 11:43 AM

The definition must require regional centers to resolve the facts during planning—not defer whether a service is truly available to an appeal after access has already failed.

Shirlys Gruber · 11:44 AM

DDS states that rate adjustments can be explored to meet the individual's unique needs. I recommend that DDS clearly define what qualifies as a unique need, identify who has the authority to approve a rate adjustment, establish objective approval criteria, and create a transparent and timely review process that is applied consistently across all Regional Centers.

Miriam Erberich · 11:45 AM

Are you prepared for the onslaught of NOAs? Is this by design? Will there be an alternative process?

Aminah Abdul-Hakim · 11:46 AM

If cost-effectiveness is not the same as choosing the cheapest service, what specific safeguards will DDS require so regional centers cannot use this definition to deny, delay, reduce, or pressure people into lower-cost services that do not actually meet their needs?

Rosie Lasca · 11:48 AM

What does "rate adjustments can be explored" mean? Please define with more detail.

Anonymous attendee · 11:48 AM

If unique services must now be fought for on an individual basis as an exception- this will further burden already overworked and understaffed Regional Center staff and essentially cause denial by delay. More red tape is the opposite of person centered and SDP. How sad.

Josefina Romo de Sharp · 11:48 AM

the only definition I can see and hear it's more fair hearing more denials more barriers for the clients

Yasmin Herrera-Vilchez · 11:49 AM

Could DDS consider requiring a written, individualized determination during the planning process when there is disagreement about whether a lower-cost option is truly comparable?

Families and participants should be able to understand what was compared, what evidence was considered, and why the alternative is believed to meet the person's needs. Clear planning-stage decisions may help resolve concerns earlier and reduce avoidable service gaps, turnover, and reliance on the appeals process.

Sonia Morales · 11:52 AM

Regional center is spending more money send it NOA's when they run out of time because all the process is delay, what about that? Check the times frames the regional centers takes to finalize all the revisions.

Aminah Abdul-Hakim · 11:53 AM

Who has the burden of proof when a regional center says a service is not cost-effective — the family/participant, or the regional center making that determination?

Aminah Abdul-Hakim · 11:53 AM

When the slide says SDP rate adjustments "can be explored," who is responsible for initiating that process, and what documentation is required?

Rosie Lasca · 11:53 AM

Will DDS require written explanations when a regional center says a service is not cost-effective? To make the standard reviewable, will DDS require regional centers to identify the specific criterion not met, the evidence relied on, and the comparable options considered?

Anonymous attendee · 11:54 AM

Health & Safety waivers are a significant barrier, and it seems this definition would increase their usage, particularly in Self-Determination. Regional Centers may not agree to submit them, do not have the time to do additional work even if they do agree, and DDS may take months to approve them - during which time, the participant is not receiving adequate support. Fair Hearings will also increase and participants and families in underserved communities will be at even more of a disadvantage. It would make more sense to say something like "Rates more than double the traditional services rate must be approved by the Regional Center," to keep the discussion at the level of the planning team and avoid DDS involvement in every case.

Aminah Abdul-Hakim · 11:54 AM

Will DDS review denial, delay, reduction, and fair hearing data after implementation to see if the new definition is being misused or applied inconsistently?

Aminah Abdul-Hakim · 11:54 AM

Who has the burden of proof when a regional center says a service is not cost-effective?

Sonia Morales · 11:57 AM

Regional Centers believes that they have the authority to denied anything because they interpret the directives their way and that affect services for clients. Than we have to go to fair hearing to try to make them understand the directive but that results in more time the family and participants have to spend and learn about the process.

10. Equity, disparities, and culturally and geographically responsive access (15 comments)

Beth Martinko · 11:10 AM

The community does not experience this system equally. Hispanic and non-English-speaking families self-direct at roughly half the rate of English-speaking families. That gap is not a difference in what families want for the people they love. It is a difference in what the system makes reachable, and a new cost gate will widen it, because the families with the most help navigating the system will clear the new hurdle and the families with the least help will not.

Beth Beswick · 11:21 AM

Does the definition of "cost effective" includes consideration for travel time?

My clients live in a small, rural community with limited resources. I am concerned that they may be expected to travel 30 minutes to reach a more "cost effective" provider, which would make services inaccessible for most of them.

Rebecca Laby · 11:21 AM

I think we all agree we want costs to be fair however, this feels like another barrier for individuals to access SDP, it already takes too long due to a long list of delays, if families have to jump through more hoops to an even more complicated on boarding process. As an IF, I serve a number of non English speaking families, who are traditionally under served. How will DDS ensure there is parity across all individuals being served regardless of race.

Karen Yingling · 11:24 AM

There is huge disparity between regional centers aleardy - how will implementation be standardized?

Karina Monje · 11:26 AM

Ensure the definition explicitly accounts for geographic availability, linguistic capabilities, and cultural competencies so that marginalized communities are not disproportionately harmed by restrictive cost caps.

Odilia Bamaca · 11:27 AM

Hello! My name is Odilia Bámaca, and I am the mother of a child with multiple diagnoses. We are asking for greater transparency and for data regarding the Latino community—which is always the most affected—to be released every six months. We also want to know exactly who the ombudsman and the clinical department representative are; we want a visible, accessible person, not just a shadow or a name on paper—we want names. Furthermore, we want data published every 3 to 6 months on cases resolved by

Karina Monje · 11:32 AM

As of July 1, 2026, 10% of the total rate of suppliers will be conditioned on compliance with QIP metrics (such as verification of electronic visits and tax audits). Smaller suppliers or those who serve marginalized communities often lack the administrative infrastructure to process this quickly, which reduces their actual funding to 90% of the base rate. How will DDS guarantee that conditioning this 10% of the rate does not create a desert of services in vulnerable communities?

Odilia Bamaca · 11:35 AM

NO to discrimination

NO more disrespect towards the IDD community

NO more directives that directly impact clients services providers

Kristianna Moralls · 11:42 AM

Impact on Existing System Disparities: Has the Department analyzed the impact these additional bureaucratic requirements will have on a system already struggling with severe racial and ethnic disparities in the purchase of services

? Complex administrative hurdles and negotiation processes always disproportionately harm underserved communities. Has the Department considered this impact, and what specific oversight mechanisms will be implemented to ensure these new rate rules are applied equitably across all demographics?

Rosie Lasca · 11:42 AM

What does “comparable” mean in SDP?

Does it include more than the service description, such as provider skill, availability, language access, cultural match, disability experience, location, and the participant's needs?

Aminah Abdul-Hakim · 11:45 AM

This issue is also directly connected to inequities and disparities. If "cost-effective" is not clearly defined, it may be applied in ways that disproportionately harm people and families who already face barriers, including people of color, non-English-speaking families, rural communities, low-income families, and individuals with complex support needs.

A service may appear cheaper on paper, but it may not be equitable or effective if the provider is unavailable, too far away, does not understand the person's culture or language, lacks disability-specific expertise, or cannot provide the level of support needed. Families with fewer resources may be less able to challenge those decisions, locate alternative providers, or absorb gaps in services.

DDS should ensure that cost-effectiveness is not used in a way that widens disparities. The definition should require regional centers to consider access, availability, cultural and linguistic appropriateness, disability-related needs, quality, outcomes, and whether

tamra pauly · 11:49 AM

That restricting people to vendored rates disproportionately affects people in marginalized communities and those with higher needs . Additionally, usual and customary rates vary according to region -

Aminah Abdul-Hakim · 11:56 AM

DDS should include an explicit equity and disparity standard in the cost-effective definition. A service should not be considered cost-effective if it is cheaper but creates unequal access, lowers quality, ignores cultural or linguistic needs, or leaves people with complex needs without appropriate support.

In real life, people of color, non-English-speaking families, rural families, low-income families, and people with complex support needs often have fewer provider options. If regional centers compare rates without considering provider shortages, language access, transportation barriers, cultural competency, disability-specific expertise, or availability, the definition could unintentionally widen disparities.

Cost-effectiveness should not only ask, "Is this rate lower?" It should also ask, "Is this service actually accessible, appropriate, safe, culturally responsive, and capable of meeting the person's needs and IPP goals?"

Aminah Abdul-Hakim · 11:57 AM

1. Will DDS add equity and disparity language directly into the final definition so cost-effectiveness cannot be applied in a way that disproportionately harms people of color, non-English-speaking families, rural communities, low-income families, or individuals with complex support needs?

2. How will DDS require regional centers to consider provider shortages, transportation barriers, language access, cultural competency, and disability-specific expertise when deciding whether a lower-cost service is truly comparable?

3. If the only lower-cost provider is not culturally or linguistically appropriate, not available in the person's area, or not experienced with the person's disability-related needs, will DDS clarify that the provider should not be considered a comparable cost-effective option?

4. Will DDS monitor cost-effectiveness decisions by race, ethnicity, language, diagnosis, age, regional center, geography, and service type to identify whether the definition is increasing disparities?

5. How will DD

Aminah Abdul-Hakim · 11:57 AM

How will DDS make sure this definition does not turn "cost-effective" into a policy that looks neutral on paper but creates unequal access in practice?

11. Legal authority, statutory interpretation, and rights protections (12 comments)

James Moraga · 11:09 AM

Thank you for the opportunity to comment.

I appreciate that AB 143 directs DDS to define the term "cost-effective," and I fully recognize the Department's responsibility to implement that legislation.

My question is whether this proposal goes beyond implementing AB 143 and instead modifies the Legislature's intent for the Self-Determination Program.

When the Legislature created SDP, it intentionally established a participant-directed model based on person-centered planning, individualized budgets, and flexibility—not the traditional vendor-rate system.

If the proposed definition of a "reasonable rate" becomes the rate established by the Department or another entity, how is that consistent with the participant-directed purchasing authority the Legislature granted under Welfare and Institutions Code section 4685.8?

Could the Department please explain the statutory authority that allows it to substitute Department-established rates for participant-negotiated rates that remain within an approved SDP budget?

Beth Martinko · 11:12 AM

The existing standard treats cost as a comparative tiebreaker: among providers who can meet the person's needs, support their Individual Program Plan goals, maintain integration, and qualify for federal funding, the regional center selects the least costly (WIC §4648(a)(6)(D)(i)).

The draft reorganizes these elements into six standalone pass-fail criteria, with cost recast as a "reasonable rate" test. This produces two shifts I strongly opposes:

1.Cost moves from tiebreaker to denial gate. A service can satisfy every other criterion and still be denied on cost alone.

2.The integration safeguard is removed. Current law provides that a consumer "shall not be required to use the least costly provider if it will result in the consumer moving ... to more restrictive or less integrated services or supports" (WIC §4648(a)(6)(D)), a protection the Self-Determination Program inherits through §4685.8. The draft drops this language and substitutes "not replace generic services." The first protects the person; th

Beth Martinko · 11:12 AM

One point of statutory construction frames all of this. AB 143 did not delete clause (i) of WIC §4648(a)(6)(D), which still provides that the "least costly available provider ... shall be selected." The new definition in clause (ii) therefore qualifies clause (i); it does not replace it. The Department's framing that it is "replacing least costly" is misleading, because both clauses remain in force and must be read together. This is precisely why the new definition must restate the integration override rather than omit it. If the definition is silent on integration while clause (i)'s least-costly mandate survives, the strongest consumer protection in the country is not reformed, it is destroyed.

William Leiner · 11:13 AM

Thank you for the opportunity to give feedback. This comment is about the slide that goes over the "current definition of cost-effectiveness." What you are showing is not the current definition of "cost-effectiveness" in the Lanterman Act, which is not currently defined in statute. It is the definition of "least costly provider." These are two separate but related concepts in the Lanterman Act, but they are not the same thing and should not be viewed as the same thing.

Beth Martinko · 11:18 AM

Institutional-comparison definition (the single best borrowable line):

"'Cost-effective' means community services and living arrangements that cost the same as or less than institutional care."

Minn. Stat. §256B.0911

Beth Martinko · 11:19 AM

Downstream cost avoidance, in CMS's own words:

A purchase counts when it "would decrease the need for other Medicaid services."

CMS, Individual Directed Goods and Services definition

Co-equal standards: efficiency, economy, and quality are treated as co-equal under Social Security Act §1902(a)(30).

Clarissa Kripke · 11:23 AM

The regulation should not be tied us to federal reimbursement. The Lanterman Act is a state law and the entitlement is made by Californians. Federal rules are changing rapidly and unpredictably which could lead to many unintended consequences. We shouldn't be deisgning our system around chasing Federal dollars.

Clarissa Kripke · 11:31 AM

One has to be able to actually hire someone at the rate. Setting rates nobody (or not enough people) will take is destroying the entitlement. People with more complex needs who are harder to serve due to medical, developmental, communication or behaivor issues are disadvantaged. While exceptions may be available, people with complex needs are already overwhelmed with mananging exceptions with multiple generaic and regional center agencies.

William Leiner · 11:37 AM

There is already a definition of "cost-effectivness" in DDS regulations, which states that "Cost Effective means obtaining the optimum results for the expenditure." Consider building on this definition instead of

developing a brand new definition from scratch that risks all of the unintended consequences described in this Q&A.

Odilia Bamaca · 11:42 AM

Why are they overriding the parents? Why aren't they following the Tatherman Law?

Alicia Flores · 11:45 AM

No mas violaciones de los derechos de nuestros hijos,

No mas violacion de HIPAA para la conunidad IDD

Liliana Benjamin · 11:54 AM

ES importante que este criterioNO LIMITE la planificacion centrada en la persona, la libertad de elecion ni la flexibilidad que garantiza el programa AUTODETERMINACION Y LA LEY LANTERMAN.....El costo no debe ser el factorprincipal para aprobar o negar un servicio.....las deseciones deven basarce del individuales de la persona .

12. Implementation, transition, and protection of existing services (11 comments)

Tina Ewing-Wilson · 11:08 AM

If you make a big change like this to SDP, please make sure you apply the changes at plan renewal so as to avoid catastrophic plan failure that leaves people unprotected

ksusha miretski · 11:19 AM

Lets say your happy with your services and they meet your needs does that mean that your provider s and programs get removed or become less used

Anonymous attendee · 11:25 AM

What does this mean for SDP participants who set there own rate for providers? Will current spending plans need to be updated? What is a "qualifed provider" for care? One of the most important aspects of SDP is beinhg able to set wages to find better quality providers. If my wages are capped it will be devasting for my own care as a disabled adult and devasting for my clients as an independent faciliatotor.

Danielle Alvarado · 11:38 AM

I get their needs to be reasonable but if we go with minimum wage and what happens to what individual one to one staff make now do we take it away and lose much needed staff???

Vicki Jones · 11:41 AM

I'm in SDP. We pay our staff much better than they could receive through traditional. With the porposed changes, we anticipate we'd have to cut pay. That would be detremental for the care our SDP participant family members receive. Is this being considered?

Dominika · 11:43 AM

Does this mean that we can not move money in the spending plan to cover a higher rate?

ksusha miretski · 11:43 AM

Can you keep your currant care team if you are happy with them and they meet your needs

Rosie Lasca · 11:45 AM

If a participant has already tried a lower-cost provider and it failed, will that history be enough to show the lower-cost option is not comparable?

Shirlys Gruber · 11:45 AM

DDS should also recognize continuity of care as a valid basis for approving a rate adjustment when changing providers would likely disrupt the participant’s progress or compromise the achievement of IPP goals.

ksusha miretski · 11:50 AM

Can i keep my services because of my unique needs im very happy with my care team and my service s will my care givers lose their jobs

Rocio sigala · 11:57 AM

On Continuity: "What happens to the staff that families have employed for years if their rate is suddenly deemed 'unreasonable'? Is DDS prepared for the massive disruption in care and the emotional trauma this will cause participants?"

13. Public engagement, transparency, and webinar access (78 comments)

Sandra Van Scotter · 11:02 AM
Good morning! Please remember to use acronyms as little as possible. If you need to use acronyms, please also state the full name.

Kavita Sreedhar · 11:04 AM
Will this webinar be recorded and posted for future reference

Beth Martinko · 11:04 AM
How will you accomodate hearing from the fulll community. There will be more questions and feedback than you will have time for in this session. Strongly recommend you set up additional sessions to hear from all community members on this important topic. We appreciate you listening to the full community.

Anonymous attendee · 11:05 AM
I see the ASL interpreter, but it is not spotlighted.

Kecia Weller · 11:05 AM
The ASL interpretor is highlighted

Fernando Gomez - ICC · 11:08 AM
Can you please provide a little extra time at the end of the presentation for those who are still typing in the questions section. In addition, if there is a survey at the end of the webinaire can you please let people know of how they can access that link and fill-out. Thank you.

Suzy Requarth · 11:08 AM
The opportunity to provide feedback is appreciated. With an end date for feedback of July 31st and a statutory requirement to release the definition on August 1st, what is DDS's plan for meaningfully incorporating public feedback in one day?

Susan Corry · 11:08 AM
If feedback is open through July 31, 2026, how can the new definition be finalized the next day?

Kavita Sreedhar · 11:09 AM
Thank you and will it be sent to registered attendees of this webinar ? or could you please post the link here of the page

Sandra Van Scotter · 11:09 AM
Who is Mission Analytics and why are they in attendance in this meeting?

Joy Diddee · 11:10 AM
Is it just me or is the Audio on echo?

LAURA PIVA · 11:13 AM
the audio has an echo, it is very annoying

Paula Rodarte · 11:13 AM
Can I get this information by emal or a specific place in the regional center?

Elena Tiffany · 11:16 AM
its not so much an echo, it sounds like bad head/earphones being used

Anonymous attendee · 11:18 AM
It is disrespectful that Mr. Yang Lee keeps laughing and fidgeting. This is a very serious matter, and it should not be treated so lightly.

Beth Martinko · 11:21 AM
This restricts the community feedback and this topic is too central and important to be delegated to one way communication with no department response:

How will you accomodate hearing from the fulll community. There will be more questions and feedback than you will have time for in this session. Strongly recommend you set up additional sessions to hear from all community members on this important topic. We appreciate you listening to the full community.

Miriam Erberich · 11:21 AM
How many participants are in this meeting?

Sandra Van Scotter · 11:24 AM
Is this the first time Mission Analytics has "facilitated" a meeting for DDS? I do not remember seeing them in a DDS webinar previously.

Debbie Zimmer · 11:31 AM
The language interpretation available notation is blocking the last sentence in every slide. Can you move that?

Soo Lee · 11:31 AM
How does the DDS intend to inform and gather feedback from non-English speaking families and community members by the deadline? The feedback form has only English and Spanish translations.

Anonymous attendee · 11:32 AM
will be there a copy of this meeting available via link etc?

Karen Mulvany · 11:34 AM
Can DDS provide a transcript of this webinar? There's a lot of information being delivered verbally that isn't on the slides.

Beth Martinko · 11:35 AM
it is very challenging to hear Breck - not exactly an echo but some kind of interference

Angela Cardinale · 11:35 AM
I would like to share this info with other family members of people with disabilities. How can I do that?

Julie Phanstiel · 11:36 AM
when delivering page 13, “other services”, almost last things she says before changing the page- Cathy describes the factors that would allow for an increase of the allowed rate- for example the qualifications of the provider and the behavioral needs of the individual. Could you post the script for this area of the presentation? Thank you.

Anonymous attendee · 11:37 AM
Why are you even asking the public for help making a definition when your policy begins July 1st? You’ve already made the policy.

Maria Lopez · 11:37 AM
Can you allow time for community feedback

Adam Ruddle · 11:38 AM
Using the Q&A format is not working. The comments are jumping around so fast because so many people are not happy with this proposal that it is impossible to thumbs up all comments I agree with.

Hadassah Foster · 11:38 AM
Will it be possible to capture these questions/comments and share them as well?

araceli lopez · 11:38 AM
How will DDS use the feedback and concerns shared by families, self-advocates, and providers during this process? Specifically, how will DDS ensure that the final definition of “cost-effective” does not unintentionally reduce access to individualized services and supports for people with developmental disabilities?

Anonymous attendee · 11:38 AM
The feedback form DOES NOT translate so you broke your commitment to the almost 40% Spanish speaking community. Write your answer boxes is the only phrase translated. This is a major reason why they’re disparaging comments.

Kristianna Moralls · 11:39 AM
Not being able to raise hand makes this feedback inaccessible to those that cannot type.

Christina Cannarella · 11:39 AM
Thank you for this webinar. Where can we access these sliides?

Julie Phanstiel · 11:39 AM
Could we please get a copy of the script?

Maureen Fitzgerald · 11:39 AM
can we get a list of these comments for our use in making our comments?

Lucia Lorenzo · 11:40 AM
This meeting shouldn't be a webinar

Evelyn Rodriguez · 11:40 AM
Feedback Form no cambia el lenguaje a espanol

Rebekah Acosta · 11:41 AM
If I’m confused the regional centers will be confused I assure you! I think that a committee of self advocates, families, regional centers, and DDS need to set the definitons. We all need clear rules and regulations but EVERYONE needs an equal voice in this.

Anonymous attendee · 11:41 AM
Can public comments be submitted in languages other than English? If so, will they be translated and considered equally during the review process?

Audrey Vernick · 11:41 AM
Are you going to answer any of the questions in the Q&A?

Shirlys Gruber · 11:42 AM
para empezar porque siempre hacen este tipo de webinars de 1 hora y con tanta información, para cumplir con informar ala comunidad ? porque si es para que tengamos una opinión es muy poco tiempo y además con el chat desabilitado no entiendo cual es el propósito podríamos empezar por eso por favor.

Anonymous attendee · 11:42 AM
The slides not avalable in Spanish or other languages creates a barrier for community and only providing English and Spanish intepretation too. Will this request for feedback and education be provided in aditional languages ?

Yadir Morales · 11:42 AM
is feedback here considered the same as the form?

Janet Guillen · 11:42 AM
The form does not allow enough space to provide feedback. What's another way to submit feedback?

Janet Guillen · 11:42 AM
There's also glitches

Daisy Jimenez · 11:43 AM
alot of information, will you also send us a link to review this presentation again? thank you

Anonymous attendee · 11:43 AM
This has been a terrible webinar.

Shirlys Gruber · 11:43 AM
If the webinar is until 12 and we have to write

Debbie Zimmer · 11:43 AM
If feedback is being received up thru July 31st, how is all feedback going to be included in consideration if the due date is August 1st for proposal?

Linda Chan Rapp · 11:43 AM
Could you allow us to save this chat?
Q&A I mean

Adam Ruddle · 11:43 AM
The Q & A is failing

Daysi F · 11:43 AM
Es justo y necesario que no sea un webinar?

Anonymous attendee · 11:43 AM
Will the proposed definition be revised based on the public comments received, or is today's webinar primarily intended to explain a decision that has already been made?

Anonymous attendee · 11:43 AM
So, no answering of questions?

Maria Berumen · 11:43 AM
Necesitamos mas tiempo para que ustedes entiendan a la comunidad, es muy malo que siempre hagan webinares de tan poco tiempo, pueden crear mas sesiones informativas para que pueda quedar clara la informacion

Vicki Jones · 11:44 AM
Today's session was misleading. We were not given a chance to hear any of our questions addressed. We were talked to for most of the session. Thank you for not ending it 15 minutes early.

Judy Mark · 11:44 AM
So you aren't answering any of the questions posed today???

Fernando Gomez - ICC · 11:44 AM
Was there to be an interactive Q&A discussion?

Sabrina Epstein · 11:44 AM
Is DDS going to use this time to respond to any of the questions?

Linda Chan Rapp · 11:44 AM
How can I save the Q& A ?

Faviola Cruz · 11:44 AM
I don’t support that DDS makes changes without the input of families and self advocates

Anonymous attendee · 11:45 AM
What would've been more helpful and meaningful is a chance for people to engage with you (the DDS) and have an interactive Q&A.

Carolyn Robinson · 11:45 AM
Is there a way to save what's in the chat?

Linda Chan Rapp · 11:45 AM
(Having access to the Q&A can help me in thinking through and formulating my feedback — Linda Chan Rapp)

Flerida Meza · 11:45 AM
Favor de notar que el formulario de feedback no se cambia a Español desde su barra de idioma

Anonymous attendee · 11:45 AM
DDS have to stop to bring us here to inform us” DDS have to ask us first if we agree, we are sick and tired of this

Sonia Morales · 11:45 AM
If still time why we don’t have the opportunity for public comments?

Judy Mark · 11:46 AM
I want to know whether you answered questions in the webinar with the regional centers this morning?

Maribel Óliver · 11:47 AM
I feel that DDS is not adequately considering the feedback from the community and the participants it is meant to serve. I believe these webinars should not be limited to a closed format, and that chat functions should not be restricted. It would also be important to allow open participation, including access to microphones. In its current form, this format feels exclusionary to the community and participants.

Carolyn Robinson · 11:47 AM
Correction, Is there a way to save full dialogue in Q & A?

Beth Martinko · 11:48 AM
to those asking to save chat - highlight some text, go up to Edit in toolbar, select all, then copy

Kavita Sreedhar · 11:48 AM
If we have suggested or made comments here - are we required to submit the feedback on the feedback form again ? Kindly advise

Odilia Bamaca · 11:49 AM
NO to regional center board webinars

Anonymous attendee · 11:49 AM
It is very unfair for our children that DDS makes changes without the input of families and self advocates. Doing it after doesn't make it better.

Erica Hernandez · 11:50 AM
Without safeguarding cost effectiveness is just another way to deny services!!!! We are all asking questions but are left with no answers where’s the interaction!?

Clarissa Kripke · 11:51 AM
There is language in the Lanterman Act that requires regional centers/DDS to pay a rate that ensures stable services. That language should be echo'ed so people are authorized for services that nobody will proivide because the pay is too low or which are so unstable as to be useless or which have long dangerous gaps while agenices for families try to hire.

Anonymous attendee · 11:52 AM
They aren’t going to answer them

Carla Lehmann · 11:52 AM
I would recommend another session where you address all our questions and comments so it feels that we are being heard

14. Broad opposition, support, and system-level concerns (30 comments)

Yasmin Herrera-Vilchez · 11:04 AM
Good morning, Thank you for having this webinar this morning.

Carolyn Robinson · 11:04 AM
Good Morning

Carolyn Robinson · 11:07 AM
Thanks for the webinar. Hoping to hear lots of great information for clarity with great discussion.

Sandra Van Scotter · 11:13 AM
https://www.missionanalyticsgroup.com/

luis zavala · 11:15 AM
MR PETE CERVINKA im luis zavala from intergrated community collaborative and i don't agree with you you will affect us with this so i say no to this cost effective you will affect us the self advocates with this

Beatriz Garcia · 11:23 AM
My experience has been very negative with the providers, specially the IF's. I watch every penny very carefully and then get punished for voicing out the abuse of funds by IF

Elena Tiffany · 11:36 AM
I got pretty much nothing out of this except a headache, lol. I'm actually more confsued

Miriam Erberich · 11:37 AM
I really appreciated that you went beyond just reading the presentation, which is often how DDS approaches these meetings. Your suggestions, interpretations, and perspective are helpful.

Jadolphus Fraser · 11:37 AM
What other factors?

Odilia Bamaca · 11:37 AM
NO more spending fund on regional center event that yield no results that or benefits

Elizabeth Grigsby · 11:40 AM
My name is Elizabeth Grigbsy, im the rights advocate for Golden Gate Regional Center, I just have a comment, and what I want to say is , I know we are trying to make things easier for the people that we serve I just wonder with these new changes that is being talked about will people still have to jump through hoops just to get the services that they want and need.

Anonymous attendee · 11:40 AM
Nomás ha un director de DDS, sin empatía ; sin sentimientos hacia la comunidad.

ANITA Rios · 11:41 AM
No me parece que todo su explicación esté ayudando a nadie... no puede rentabilizar una discapacidad... es mi opinion

Miriam Erberich · 11:41 AM
What are you trying to accomplish with these changes? Why do you feel the need to change the definition, which is not clearer than the current one.

Anonymous attendee · 11:42 AM
I smell a class action coming

Lucia Lorenzo · 11:42 AM
My question is why this DDS director is only interested in making changes that significantly affect the clients.

Marty Omoto · 11:42 AM
Thanks everyone

Vicky Wheeler · 11:43 AM
Thank you for your feedback!

Melanie Tritt · 11:43 AM
Thanks for calling this meeting.

Lucia Lorenzo · 11:44 AM
NO to discrimination, NO more disrespect toward the IDD community, NO more directives that directly impact client service providers, NO more spending funds on Regional Center events that yield no results or benefits, NO more spending money on unfair hearings, NO to a DDS that lacks empathy for its IDD community, NO to a DDS Director who lacks feeling or compassion for their community, NO to DDS

giving coordinators more tools to deny services, NO to the destruction of services and systems, NO more "ghosts" at DDS—specifically, the Clinical Ombudsman teams at Regional Centers, NO to Regional Center board webinars, NO to further DDS directives that negatively impact services, NO more violations of our children's rights, NO more HIPAA violations affecting the IDD community, NO more "ghost" ombudsmen, NO more "ghost" personnel in Regional Center clinical teams.

Janet Guillen · 11:44 AM
Appreciate the suggestion Pete! 👏🏽

Anonymous attendee · 11:46 AM
Stop going to these advisory hearings and go to court!!!

Odilia Bamaca · 11:47 AM
NO to the dismantling of services and sisters

Anonymous attendee · 11:47 AM
Imposition, more barriers , more retaliation, etc there is nothong that this admistration is doing to help the community on the contrary

Odilia Bamaca · 11:48 AM
NO DDS giving coordinators more tools to deny services

Ana Batres · 11:49 AM
The IDD community already faces so many barriers to access services we don't need more barriers we need solutions. Real solutions that ready help the IDD community

Elizabeth Grigsby · 11:51 AM
Hello, its me again, Elizabeth Grigsby. I just want to know, when are we going to accept people with disabilities as real people and not cases or codes? Also, when are we going to see them as real people nobody with a disability has ever asked to be disabled, it is not our fault, we just want to be accepted with the upmost dignity and respect. Just like everyone else. Thank you. Sincerely, have a blessed day!

Alicia Flores · 11:51 AM
No mas directors de DDS sin sentimientos ni compasion por su comunidad.

Anonymous attendee · 11:52 AM
Police the dirty directors, service coordinators and vendors!!!!!!!

Liliana Benjamin · 11:57 AM
COST EFFECTIVE .....Es una Barrera mas ??????es mas clara que el agua .....DIOS santo

Part Two · June 30, 2026

Session for service providers · 95 attendee comments

1. Self-Determination Program choice, flexibility, budget authority, and negotiated rates (9 comments)

Yadir Morales · 9:26 AM

Spending plans are not the correct place to introduce standardization. The purpose of SDP is to allow for unique and individualized supports. Having a conversation is appropriate to safeguard against exploitation, but attempting to standardize and restrict rates will generate undue work for RC staff and restrictions of participant freedoms of choice. A rubric to guide RC staff in discussing spending plans with the planning team rather than defining "reasonable rate" would be more beneficial.

Miriam Erberich · 9:34 AM

DDS states that individuals will still be able to choose who provides their services. However, the proposed definition does not explain how that choice will be protected in practice if regional centers are allowed to deny a participant's chosen provider or negotiated rate based on a vague "reasonable rate" standard. DDS should explain exactly

how the proposed definition will preserve participant choice, individualized planning, and the intent of the Lanterman Act and Self-Determination Program.

Kristianna Moralls · 9:34 AM

The Department is asking stakeholders to clarify a definition that is inherently flawed. By inserting arbitrary cost caps into the definition of 'cost-effective,' the Department is merging 'cost-effective' with 'least costly.' You cannot fix this definition by simply clarifying its vague terminology; the very inclusion of rate ceilings fundamentally removes a participant's federally recognized budget and employer authority and must be struck from the framework.

Miriam Erberich · 9:35 AM

Many participants entered SDP precisely because traditional regional center services were not sufficient. If generic services, vendored providers, or traditional rate structures had adequately met the person's needs, many of us would not have needed SDP in the first place. DDS should ensure that the final definition does not recreate the limitations of the traditional service system inside SDP.

Anonymous attendee · 9:38 AM

It is not make sense, this definition is limiting choices

Miriam Erberich · 9:41 AM

Can a Regional Center require a participant to first use the least costly provider, even when there are multiple providers capable of meeting the individual's needs?

If that provider proves unsuccessful, is the participant then expected to try the next least expensive provider, and then the next, until they eventually reach the most appropriate provider? Who decides which provider is the "cost-effective" one, and based on what objective criteria?

Is this really the process DDS intends to create? Are participants and their families expected to repeatedly change providers, disrupt established supports, and delay needed services simply to demonstrate that progressively less expensive options were inadequate?

If a participant disagrees with the Regional Center's determination, does DDS expect Regional Centers to issue NOAs denying the requested provider, forcing families into the appeals process? Or is the expectation that participants will simply give up and comply with the Regional Center's preferred provider?

Andrew Perez is typing an answer...

Yasmin Herrera-Vilchez · 9:45 AM

Building on Kristianna Moralls's example: a $1,000 piece of equipment that lasts 10 years with no maintenance may be more cost-effective than a $300 item that fails within a year and requires repeated repairs.

The same principle should apply in SDP. As wages, operating costs, and community-provider rates rise, a participant should not lose choice simply because a preferred provider costs more than a reference rate. A higher rate may be the more cost-effective option when it secures stable, qualified support and avoids failed services, turnover, gaps, and repeated changes.

Anonymous attendee · 9:48 AM

What happened to an individual's right to make mistakes, and honoring personal preference? It might look like a mistake to the state to get less support hours at a higher payed rate but that is just personal

preference. Neurotypical people do that all the time without the goverment interceding. If the individual feels more supported by specific people, are we really going to deny the ability to choose one's own support staff and for those support staff to make a living wage? There are people in place to help guide and monitor spending, so isn't it the participant's right to spend their allotted money in a support system that makes sense to them? Even if it is a mistake? There are people who can and should step in if its clear that person is being take advantage of or causing harm to themselves, but we shouldn't force individuals to subpar service. Especially when it seems like the sdp supports the economy and lessens the burden on regional centers as it is.

Kristianna Moralls · 9:49 AM

Suggested Clarification: DDS must clarify that a "reasonable rate" accommodates the participant's federally recognized Budget Authority, explicitly allowing them the flexibility to negotiate competitive, above-average wages to successfully recruit and retain qualified workers. Real-world example: It worsens the caregiver shortage. By preventing families from negotiating wages above the "reasonable rate" community average, participants cannot offer competitive pay to secure reliable workers for difficult-to-fill shifts. This traps families in the exact same staffing crisis and high turnover rates that traditional agencies currently face.

2. Reasonable-rate definition and rate-setting methodology (18 comments)

Anonymous attendee · 9:25 AM

In SDP With Regards to defining “reasonable rates” rather than using the vendored rates as a maximum amount - use it as a starting point then add a multiplier to it (like 2—3 times) as a guideline and anything higher than that rate could go through a review process similar to what has been implemented when a budget is increased by $20,000 - i.e provide a checklist that justifies the higher rate.

Anonymous attendee · 9:25 AM

That's exactly what should happen. Pay providers the standard rate that other non regaional center business charge in the area.

Sonni Charness · 9:28 AM

By setting pre-determined unit (hour) COST without consideration for EFFECTIVENESS, you reward inefficiency and disincentivize meeting the needs of those whose needs are not met by standard services. There is no longer reason for providers to attempt to innovate, customize, improve their offerings to meet the unique needs of individuals. The use of the word comparable is vague does not consider whether they are comparable in terms of effectiveness, value or impact, just intent on paper.

Giovanny Sarabia · 9:28 AM

How does DDS account for differences in organizational structure, including nonprofit and for profit providers, when evaluating cost effectiveness? Given that nonprofits may receive tax advantages but often pay similar wages and operating expenses, how does DDS ensure the initiative creates a level playing field and does not unintentionally favor one business model over another?

Kristianna Moralls · 9:28 AM

It is not clear when You use reasonable in the definition of "reasonable rate".

Julie LaRose · 9:29 AM

Maybe each type of service delivery models (Traditional. PDS and SDP) need their own definiitions of cost effective (since they are all very different) rather than trying to have one definition that covers everything

Anonymous attendee · 9:29 AM

Education, design of service, outcome based rates on performance, maybe start at a comparable service rate and then negotiate if services within a company etc is superb.

Sarah Burgett · 9:30 AM

Are Health and Safety Waivers considered “Negotiated Rates?”

edith fierro · 9:33 AM

Will Outcome measure be part of determining the reasonable rates?

Mike Pereira, Ala Costa Centers · 9:33 AM

Please note that Vendored Services- or services that match the vendor's program design being noted as the "reasonable" rate is the vendored rate, can be skewed. Service Providers in SDP reserve the right to make appropriate adjustments to their rates offered to participants based on cost structures, and it is permissible. Although many service providers are using their DDS rates appropriate to them, that may not be the case in the future.

Greg Scholl · 9:34 AM

Is there a detailed directory with explanations for rates including the rate amounts.

Celeste Rulli · 9:36 AM

If we are looking at the current market, how often is DDS analyzing the rates of vendors? What does that process look like for DDS, and how does that translate at the regional level to Regional Centers or FMS Companies so that rates are reflected as current, not dated info?

Katie Dempsey · 9:36 AM

It is unclear how DDS and regionals centers will determine comparable rates across two different waivers and sets of service codes. What will the methodology be for translating a service or rate under one waiver into a comparable service or rate under the other. One recommendation is to apply the definition to the indiviudal budget rather than the spending plan.

Alham Garcia · 9:40 AM

A cost-effective rate structure is one that is dynamic, sustainable, and person-centered, reflecting changes in economic conditions such as inflation and rate study findings while ensuring long-term viability for both service providers and the individuals they support. It promotes individual choice by allowing access to quality services that meet personal needs and preferences. Cost effectiveness is further informed by affordability considerations identified by direct service providers and through ongoing annual feedback from individuals served, ensuring rates remain equitable, accessible, and responsive to evolving service delivery needs.

Dynamic: Adjusts to inflation, market conditions, and rate study outcomes.

Sustainable: Supports long-term financial viability for providers while maintaining access to services for individuals served.

Person-Centered: Preserves individual choice and access to preferred services and supports. and equitable

Thank you

Kristianna Moralls · 9:42 AM

To help clarify the standard we should be aiming for, here is the core difference between "Cost-Effective" and "Least Costly":

Cost-Effective: Focuses on return on investment and overall value. A cost-effective choice might require a higher upfront cost, but it produces a superior outcome or longer lifespan, making it the most economical choice over time

.

Least Costly: Focuses purely on minimizing immediate expenditure. It is the lowest-priced option on paper, even if it compromises quality, durability, or functional goals.

The Key Differences:

Primary Goal: "Cost-Effective" maximizes value and achieves desired results. "Least Costly" simply spends the least amount of money upfront

.

Focus: "Cost-Effective" evaluates quality, reliability, and long-term benefits. "Least Costly" evaluates only the immediate price tag.

Kristianna Moralls · 9:42 AM

A Real-World Example: Purchasing a $1,000 piece of equipment that lasts 10 years with zero maintenance is cost-effective. Purchasing a $300 piece of equipment that breaks in a year and needs constant repairs is least costly.

Understanding how these concepts apply to our service system is crucial. We must ensure our policies make decisions based on true long-term value, not just the lowest immediate price ceiling.

Sonni Charness · 9:49 AM

Instead of focusing on the unit cost, focus on overall cost and effectiveness. Perhaps we should look at the total spent per goal or service area for the year in SDP. So if someone gets $30,000 for ILS for the year at the traditional rate of $35 (just an example), they should be allowed to hire a better, more effective provider for a slightly higher hourly rate (say $40) and slightly fewer hours if they choose, as long as the goal is addressed, needs are met, and budget is not exceeded.

Anonymous attendee · 9:57 AM

the phrase "at a reasonable rate" shifts the standard away from cost-effectiveness and toward a least costly purchasing model. These are not the same concepts and should not be used interchangeably.

A cost-effective service is one that delivers the best overall value by considering quality, outcomes, sustainability, and long-term benefit relative to the cost. While it may not be the lowest-priced option, it

represents the strongest return on investment because it achieves better, more durable, and more person-centered outcomes.

By contrast, a least costly approach focuses almost exclusively on minimizing immediate expense, regardless of whether the lower-priced option provides the same quality, individualized support, or long-term value. This approach risks sacrificing effectiveness, continuity, and participant choice in favor of the cheapest available service.

The inclusion of the term "reasonable rate" effectively introduces a price ceiling that encourages selection based primarily on cost rather than value

3. Comparable services, community rates, availability, and local market conditions
(11 comments)

Doug Pascover · 9:24 AM

A valid concern I think is not clarified in the proposed definition is that “reasonable rate” and “qualified provier” do not clearly account for the ways that a creative or customized service might be intentionally different from services that in many ways look similar. Something might look like personal assistance or behavioral support but be intended to meet an additional need within the same service which requires different qualifications or a different rate.

Just to take a stab at how to address in an example the rates from the rate study could be amended to say “Rates related to the rate study as adjusted for unique qualifications and duties set by the participant”

Miriam Erberich · 9:28 AM

"Rates charged to the public" vary widely. Will you force the participant to choose the cheapest? This is alrady happening. Who has to find alternatives if you don't accept participants' choice?

Mary Mora · 9:32 AM

Will there be a rate sheet from Service Providers so we would know what is comparable rate?

Mary Mora · 9:33 AM

I was just confused because Breck mentioned comparing rates to other states.

Doug Pascover · 9:33 AM

With both vendored and comparable services I think you can include in the definition a comma and “adjusted for uncommon duties or qualifications established by the participant.”

Just to give an example of why this matters, Imagine Supported Living provides SLS-like services to a participant who does his own program planning and initiates the disciplinary and training processes. His rate is below the published rate to adjust for taking over those responsibilities.

We provide SLS type services with RBTs for another individual who had been funded for each. The rate is above the rate study rate but is cost effective because it combined RBT providers with SLS caregivers.

Henry Aviles · 9:35 AM

For SDP services that are already being authorized under a service category such as Community Integration Supports, how should regional centers and FMS providers evaluate cost-effectiveness when the service uses movement or physical activity as the method, but the actual outcomes are IPP-related goals like socialization, communication, independence, regulation, community participation, confidence, and safety? Should those services be compared to generic gyms and fitness classes, or to comparable adaptive/community integration supports that can meet the same individual needs?

Doug Pascover · 9:36 AM

It’s also important that the definition include room for supports not generally available but invented or evolved uniquely for the individual.

There are already some supports being used through SDP which do not have an obvious analog in the rate study or the general market.

It might help to include another category for things that are original in SDP such as “based on the qualifications, the market rate for people with similar qualifications and a reasonable overhead.”

Henry Aviles · 9:36 AM

When determining whether a lower-cost option is truly comparable, what guidance will DDS give regional centers so they evaluate whether that alternative can actually meet the individual’s support needs, including low-ratio support, adaptive modifications, safety, communication support, regulation support, and successful participation in a community setting?

Henry Aviles · 9:39 AM

The proposed definition is generally clear and moving in the right direction, but it needs stronger guidance on how regional centers, FMS providers, and reviewers determine whether a lower-cost option is truly comparable.

Cost-effective should not mean cheapest. A service should only be considered comparable if it can actually meet the individual's assessed needs, support their IPP goals, and provide the level of support required for safe and meaningful participation.

This is especially important for services that may use movement, recreation, or community activity as the method, but whose actual purpose is community integration, socialization, communication, independence, emotional regulation, safety, confidence, and quality of life. These services should not automatically be compared to generic gyms, standard recreation programs, basic fitness classes, or ordinary personal training if the individual requires adaptive support, low-ratio supervision, individualized modifications, communication support, regu

Henry Aviles · 9:40 AM

I recommend the definition include a clear "comparable service" standard for SDP services.

Specifically, a lower-cost option should only be considered cost-effective if it can actually meet the individual's needs, support the person's IPP goals, and provide the level of support necessary for safe and meaningful participation.

For example, some SDP services may use movement, recreation, or physical activity as the method, but the actual purpose may be community integration, socialization, communication, independence, regulation, safety, confidence, and quality of life. In those cases, the service should not automatically be compared to a generic gym, standard fitness class, basic recreation program, or ordinary personal training if the individual requires adaptive support, low-ratio supervision, individualized modifications, communication support, regulation support, or disability-specific coaching.

I suggest the definition clarify that cost-effectiveness should consider the individual's actual support need

Bijan Nelson-Mejia · 9:53 AM

The final definition should recognize interdisciplinary providers. Some providers combine multiple professional skills—such as beauty, wellness, mentorship, life skills, employment readiness, and community integration—into one individualized service. These comprehensive services may not have a direct equivalent within traditional provider models and should not be considered less cost-effective simply because they are different.

4. Individual needs, person-centered outcomes, quality, continuity, and integration

(6 comments)

Leslie Pacholski · 9:32 AM

Individualization is the foundation of the Lanterman Act. How does DDS ensure "reasonable rates" are determined based on the participant's unique needs—not a one-size-fits-all comparison to the lowest available price?

Leslie Pacholski · 9:36 AM

Will DDS include language stating that reasonable rates must consider individualized outcomes, continuity of care, participant choice, and long-term effectiveness—not simply the lowest cost?

Sonni Charness · 9:37 AM

Consider this example: a traditional employment services vendor has struggled to produce the outcomes it desires in the traditional system, largely due to cost restrictions and staff turnover. In SDP, they created an improved version of that service, hired more experienced staff, trained them more, paid them better, and delivers that service to SDP participants at a slightly higher hourly rate and dramatically improved outcomes. Is this considered comparable to their traditional service?

Gina Woodruff · 9:38 AM

Focus on quality services that meet the individuals needs and is reasonable based on other similar services that non disabled people enjoy

Leslie Pacholski · 9:38 AM

Cost-effectiveness must also measure outcomes. If a lower-cost provider fails to meet the participant's needs while a higher-cost provider succeeds, shouldn't the successful provider be considered the more cost-effective option?

Gina Woodruff · 9:39 AM

Quality services save the state money 10 x

5. Workforce wages, recruitment, retention, and provider capacity (8 comments)

Mary Mora · 9:28 AM

I don't think it's reasonable to compare CA rates to other states due to the cost of living.

Also, for high support needs individuals the minimum wage will not be sufficient. It will be impossible to get service providers.

Anonymous attendee · 9:33 AM

The rates for supported living are so far below the general cost of in home services. Child baby sitters now receive $30 an hour. Home tutors $60. Personal training and coaching $100 to 150. The cost savings should not fall on providers. If budgets need to be cut it needs to happen at the layers above direct services providers. Show you actually care about individuals with developmental disabilities. The providers are achieving the Mission. We are going bankrupt.

Kathy Rowe · 9:38 AM

If vendors can only charge their “traditional “ rate to a SDP Participant, they have no incentive to take an SDP participant nor are they compensated for the additional cost an SDP participant incurs. Each FMS has unique payment processing systems and delays.

Jonas Maceda · 9:41 AM

The main reason families choose SDP is because regional centers do not have enough service providers. Service providers do not sign up as a vendor for regional center due to the set rates which result in not having enough providers/vendors.

Jan Opsvig · 9:44 AM

It is clear that DDS wants to change the rates and seems to want to only allow the vendored rate for a particular Regional Center. This has been a failure in the traditional system. No one will work for years for the same wage with no wage increase. Appropriate providers will not work for lower wages, we also have some parents that hae had to quit their jobs to assist their loved one losing a livable wage. I do think a cap is more appropriate not a vendored rate. Since DDS is far removed from the real world of disability living it is impossible for you to understand the true need. The IPP is not a team at regional centers as you would hope so the RC would try to determine the rate, qualifiations(do you require resumes for a respite worker? PA? They do not have choice if we cannot pay a competetive wage. What about the employer burden? What about independent contractors and the self-employment tax burden.

Amy Wall is typing an answer...

kathy zimmerman · 9:47 AM

We need to get past the idea that minumum wage is appropriate for the people providing services. The minimum wage should absolutely not be part of a "cost effective" definition. In fact, minimum wage is rarely cost effective. Employees hired at minimu wage turn over faster leading to increased recruiting costs, training costs, etc. in addition to less effective service provision. We need to pay our direct service providers a fair wage for the work they do, and we need rates that allow us to do so. In order for an individual to have their needs met effectively, they need committed and competent support staff and often this simply cannot be gotten at minimum wage.

Gina Woodruff · 9:55 AM

I am a 36 year provider of SLS and ILS. Our quality of services extends outside of the billable in person visit. We have been quietly managing the high cost of rents in our area. Having to move individuals as many as 5 times in the last 10 years to keep them housed. We spend a great deal of time on building community partners and negotiating with landlords. I personally have used our company reserves for rents and deposits, furnishings and basic household essentials. I'm told I should not have done this. What's the alternative? I have empathy. I want the people I serve to thrive not just barely survive.

Anonymous attendee · 9:55 AM

If these changes aren't worded in way that is aimed more at supporting individuals and less at constricting rates to keep the oligarchy happy, generally, more experienced, more talented, and frankly better staff are going to be penalized with these changes because they'll have to find new jobs or work for the same rates as non-experienced or less competent staff, which is doing a disservice to our clients and creating a great amount of discontent in our community. The final definition needs to respect that better support will cost more, and be okay with that.

6. Qualified provider standards, credentials, and lived experience (1 comment)

Sonni Charness · 9:32 AM

How will you define qualified provider for every type of service (in traditional and SDP)? Will the department set provider qualifications, or will this be up to 21 different regional centers and 20+ FMSs?

How will you ensure consistency across the state? What if a “qualified” provider is not available (ie, not the level of training or education), such as in rural areas, but there is someone willing and able. Will the person be allowed to access the service?

7. Generic services, family responsibility, and federal financial participation (1 comment)

Will Sanford · 9:28 AM

One challenge is that other department rates, especially for speciality services, the Medi-Cal/Denti-Cal rates are so low that they eliminate access to those services for many individuals with I/DD, however are required as they are generic.

8. Regional center consistency, guidance, oversight, and accountability (3 comments)

Bijan Nelson-Mejia · 9:49 AM

How will providers know whether their rates are considered “reasonable” or “cost-effective”? Will DDS publish statewide guidance or objective criteria? If providers establish public market rates that are charged consistently to all clients, will those rates be presumed reasonable, or will regional centers compare them to other providers? If so, what standards will be used to determine whether services are truly comparable?

Sonni Charness · 9:50 AM

When you say ventured rate, do you mean the 100% rate or the 90% rate from the rate study? This needs to be clearly written or will result in different interpretation and application across RCs

Sonni Charness · 9:58 AM

Andrew said “Thank you for your feedback. The cost-effective definition is only one item that the IPP planning team considers when selecting services. These other factors can be considered.” But this is not true in the real world. In real IPP meetings, RCs unilaterally and arbitrarily apply rules and “policies,” sometimes fabricated on the spot, to control people and restrict choice. If cost-effectiveness must be considered and this is the definition, it WILL be the primary determinant.

9. Appeals, exceptions, burden of proof, timelines, and administrative burden (9 comments)

Will Sanford · 9:34 AM

Is DDS considering the "Cost-Effectiveness" of adding significant bureaucratic costs to Regional Centers (currently unfunded for the most part) to create and track SDP rates in the community and consistency in their application.

Kyle Jones · 9:35 AM

Is the fms going to have to conduct market pricing research and will our fms rates be increased to accomodate this heavy operational burden?

Will Sanford · 9:36 AM

SDP Budgets are set based on the Traditional Service System rates and cost effectiveness as applied there. Adding an additional Cost-effective portion to the SDP Spending Plan, simply adds "sand into the system" slowing down access to services and increased Notice of Action requests, increased hearings to try and get resolution.

Will Sanford · 9:38 AM

In the words of a former DDS Chief Deputy Director - Keep it Simple!!

Kyle Jones · 9:45 AM

Since the fms is not part of the planning team, it ultimately isnt appropriate for us to play a role in deciding or confirming rates are reasonable. How does dds envision this becoming operationalized?

Anonymous attendee · 9:47 AM

The proposed changes place significant emphasis on controlling the cost of consumer services, but they do not address what measures DDS and Regional Centers are taking to control their own administrative and operational expenses. Before reducing or limiting services that individuals rely on for their health, safety, and community integration, DDS should explain how it is ensuring that internal administrative costs are being managed as efficiently as possible. Cost-containment efforts should begin with system operations before shifting the burden onto individuals with developmental disabilities and their famili

Jan Opsvig · 9:49 AM

Each of the topics for decision making will overburden the already maxed out Regional Center staff making the timeline for renewals, movement of funds etc take more than the current 2-3+ months. IS the RC to review resumes? Review costs for all social rec activities and choose the cheapest one? My clients try an activity and if it does not work they look for something new. This will take away all of the Freedom of choice in SDP and Spendng Plan authority. Rememver RC's do not dialog with parents or IF regarding their decisions this will be more of the same with decisions being made behind closed doors. IPP are a RC decision and interpretation parents are being left out so how can it be decided waht is appropriate. They do not know the client or understand their need. This is clear as we see the SDP interest increasing.

Anonymous attendee · 9:53 AM

@amy wal here is the language you requested regarding DDS and RC first needed to contain their operation expenses: Cost-effectiveness should first be achieved through improvements in administrative efficiency and operational cost reduction within DDS and Regional Centers. Changes to an individual's existing services should only be considered after these measures have been exhausted and only when the proposed alternative is demonstrably equivalent or superior in meeting the individual's assessed needs, while maintaining continuity, safety, and community integration.

Anonymous attendee · 9:53 AM

@amy wal here is the language you requested regarding DDS and RC first needed to contain their operation expenses: Cost-effectiveness should first be achieved through improvements in administrative efficiency and operational cost reduction within DDS and Regional Centers. Changes to an individual's existing services should only be considered after these measures have been exhausted and only when the proposed alternative is demonstrably equivalent or superior in meeting the individual's assessed needs, while maintaining continuity, safety, and community integration.

10. Equity, disparities, and culturally and geographically responsive access (1 comment)

Gabriela Rivero · 9:38 AM

Im worried that this language of "cost effective" is going to remove the ability for people to get services that give them a better quality of life despite the fact that it's not a traditional service. DDS needs to continue to grow towards supporting on the decrease of the desperatiy and gap between neurotypical people and non neurotpical people.

11. Legal authority, statutory interpretation, and rights protections (3 comments)

Anonymous attendee · 9:23 AM

On June 18, 2026, DOJ's Office of Legal Counsel released an opinion. It argues that states are not required by law to integrate people with mental disabilities through home- or community-based care. Could this alter the criteria that is used in terms of the other factors besides cost in determining what is most cost effective regaring community servcies? If least restrictive criteria is changed or discarded then cost effective could force you into instutuitional options over less restrictive Community base living.

Anonymous attendee · 9:31 AM

for provider information in preparing your response. This proposal does the following: 1. Cost moves from tiebreaker to denial gate. A service can satisfy every other criterion and still be denied on cost alone.

2. The integration safeguard is removed.

Anonymous attendee · 9:33 AM

For provider information in preparing your response: No federal rules require setting cost effective at the individual service level. This is far and above and beyond what is required. The SDP budget already controls for cost, this is an extra step and burden on the planning team, the family and those who serve them.

12. Implementation, transition, and protection of existing services (5 comments)

Barbara Hanna · 9:33 AM

IF THE SERVICE IS CURRENTLY NOT LISTED IN BILLING CODES IE RESPIRATORY THERAPY. IS THERE A PROCESS TO ADD IN NEW CODES FOR NEW SERVICE CATEGORIES, FOR CHANGING REGULATIONS THAT HAVE NO OTHER FUNDING SOURCE?

Henry Aviles · 9:37 AM

For renewals or spending plan updates, if a participant has already been using a service successfully and the family can show that it supports IPP goals and meaningful outcomes, should the review focus on whether that service continues to meet the individual's needs, rather than restarting the analysis as if the service is brand new?

Anonymous attendee · 9:45 AM

For SDP, Regional Centers, FMS Agencies, and planning teams will need concrete tools - not just a written definition that is open to subjective judgments. Concrete thresholds (e.g. when a rate changes by more than 10%, etc.), worksheets for spending plan rates, and tools from DDS by-way of directive are critical. In the SDP, standardized spending plan templates and standardized budget calculation tools are essential.

Doug Pascover · 9:46 AM

Not 100% on topic but how the definition will be employed in SDP has a lot to do with how important the definition will be and how expansive it has to be. I know that is not what we're talking about but many of us in the public are finding our eyes spinning imagining and remembering times we have had to answer not very well considered questions and opinions about "cost effectiveness."

I submitted this on the survey but my dream definition for SDP would be that an entire spending plan is considered cost-effective if it is cost-neutral as compared to services that would be provided through the traditional system.

I do think the rules in SDP can meet the standard of cost-effective.

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13. Public engagement, transparency, and webinar access (16 comments)

Anonymous attendee · 9:23 AM

DDS if Mission Analytics is a consulting firm to DDS, the Services Providers in this zoom room can request a California Public Records Act to DDS to ascertain if hiring Mission Analytics is actually "Cost Effective" according to DDS Cost Effectiveness proposal!

Deborah Seifert · 9:28 AM

no one really answered this question which was asked. I would like an answer to this specific question.

Deborah Seifert · 9:28 AM

It seems as if DDS has delegated the task of being responsive to the community to a 3rd party charging consulting rates, rather than working directly with the community.

Barbara Hanna · 9:32 AM

WILL YOU SEND THIS RECORDING TO ALL OF US WHO REGISTERED AND THE POWER POINT PRESENTATION?

Jay Kolvoord · 9:36 AM

will this presnetation be availble for review to provide quality feedbcak?

Mary Mora · 9:38 AM

Yes, thank you. That does clarify other states rates will not affect CA rates

Jay Kolvoord · 9:39 AM

Will the Department arrange another meeting to discuss further once we have an oppurtunity to review and send suggestions and prior to implementing?

Judy Mark · 9:40 AM

Is DDS ever going to answer any questions?

Anonymous attendee · 9:41 AM

please leave open for further comments til the end of the hour

Maria Gonzalez · 9:42 AM

hello, i see that the meeting was recorded. Will we receive the recording for future reference?

Miriam Erberich · 9:42 AM

I am sure all of us are happy to meet for a two hour townhall where we can speak up and DDS can answer.

Diane Sanka · 9:44 AM

How have you solicited feedback from people with lived experience? Is that a seperate Webinar?

Miriam Erberich · 9:49 AM

I have received feedback from several Self-Determination Program participants who attended yesterday's presentation. Many left the meeting confused. Some left before the presentation ended because they could not understand what was being proposed or how the proposed changes would affect them.

As a result, they do not know how to provide meaningful feedback because the proposal and its practical implications remain unclear to them.

What they do understand is why they chose the Self-Determination Program. They know how it has improved the lives of their loved ones by providing the flexibility, choice, and individualized supports that were often not available through the traditional system. They are deeply concerned about losing those benefits.

DDS should ensure that proposed regulatory changes are presented in plain, accessible language, with clear examples of how they would affect participants in real-world situations. Only then can participants provide informed and meaningful public comment on proposals th

Tess Speranza · 9:51 AM

I would appreciate the opportunity for those most affected by these proposed changes (individuals with disabilities) to give feedback that will be incorporated not just on how to clarify a definition that was created without their input, but to give feedback on the content of the definition. DDS is essentially asking the community to act as proofreaders and editors not as collaborators. I know the intent of these changes are only good, but the impact must be considered and that can only be done by having real conversations with the people who will experience that impact. Please open up the discussion with the disability community to include the substance of the definition not just clarifying the language.

Diane Sanka · 9:53 AM

I agree with Tess

Kate Wildwood · 9:57 AM

When will DDS let the community know when DDS has finished their cost effectiveness defitions

14. Broad opposition, support, and system-level concerns (4 comments)

Anonymous attendee · 9:28 AM

I hope the providers on this call understand the magnitude of this change in the ability of people to meet their needs in SDP - please talk with your customers - those with lived experience, not the system. and then submit your feedback accordingly. This is not about you, this is about the people you serve. Over 700 comments yesterday in the public session where people with lived experience were desperately begging DDS not to go down this path.

Sol Solorzano · 9:28 AM

The proposed use of negotiated rates raises concerns that the developmental services system could begin to resemble the health insurance model, where reimbursement rates often determine provider participation rather than consumer need. Many highly qualified providers choose not to accept insurance because negotiated reimbursement rates are insufficient to sustain the level or quality of care they provide. If Regional Centers adopt a similar approach, the result may be fewer qualified vendors, reduced consumer choice, and diminished access to specialized providers who are essential for individuals with complex support needs.

Anonymous attendee · 9:39 AM

Sounds like this is becoming more and more a managed care model

Marty Omoto · 9:56 AM

Thanks to DDS and the Analytics facilitators for doing this webinar. Appreciate it - there's a lot for us to work on

About the Self-Determination Tech Alliance

SDTA is a California nonprofit (fiscally sponsored 501(c)(3)) that puts technology to work for the developmental disability community. We build practical navigation tools, community data, and creative

and economic opportunity, created with and for the people the system serves.
sdta-np.com · support@sdta-np.com

Prepared from the session chat records captured live on June 29 and June 30, 2026.