



**CONFRONTING INEQUITIES IN CALIFORNIA'S  
FUNDING OF SERVICES FOR CHILDREN WITH  
DEVELOPMENTAL DISABILITIES:  
A SOBERING VIEW OF OUR CURRENT STANDPOINT**

**MAY 2020**



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# EXECUTIVE SUMMARY

Inequitable access to developmental services through California's regional center system has long plagued communities of color. Despite the state's concerted efforts in recent years to reduce these disparities, new research has found that gaps in funding between children of different racial and ethnic groups largely remain and in some cases have worsened over time. Now, as the coronavirus pandemic devastates California's economy, the governor has proposed a \$300 million budget reduction to the developmental services system for fiscal year 2020-2021. This crisis threatens to exacerbate long-standing inequities in access to basic necessities, health care, and services and supports for children and families of color served by the regional centers.

An analysis of available 2018-2019 data documents numerous examples of these ongoing inequities:

- Authorized per capita funding for Hispanic children was lower than for White children. In 2018-2019, each Hispanic child received 69% of the funding that each White child received, on average. Disparity between these two groups grew by 60% in four years.
- Comparing data from 2018-2019 with 2015-2016, disparities in service authorizations between White and Hispanic children decreased in only three regional centers and grew in the other eighteen regional centers.
- Authorized per capita funding for Asian children was lower than for White children. In 2018-2019, each Asian child received 84% of the funding that each White child received, on average. Disparity between these two groups grew by 68% in just the past year.
- Authorized per capita funding for Spanish-speaking children was lower than for English-speaking children. In 2018-2019, each Spanish-speaking child received 82% of the funding that each English-speaking child received, on average. Disparity between these two groups grew by 46% in four years.
- Comparing data from 2018-2019 with 2015-2016, disparities in service authorizations between English-speaking and Spanish-speaking children decreased in only four regional centers and grew in the other seventeen regional centers.
- In 2018-2019, nearly 31% of children statewide did not receive any services funding from regional centers. This rate of deprivation ranged among the regional centers from 19% to 44%.

The California Department of Developmental Services (DDS), the state agency that oversees the regional center system, has developed a set of disparity measures to track over time. However, our analysis of public data indicates that DDS' improvement targets are largely not being met by the regional centers and that disparities

in access to services between racial and ethnic groups are actually worsening. Further, some of DDS' measures are confusing, misleading, and lacking in transparency, and therefore warrant clarifying revision.

To effectively address funding disparities, we recommend that the state undertake the following actions. These recommendations should be considered now in order to mitigate against further exacerbation of inequities in the wake of the coronavirus crisis.

- Replace DDS' funding formula, which allocates funding to regional centers not according to their consumers' needs but based on what the regional centers spent the prior year, and develop a new budgeting model established by objective criteria to meet each consumer's needs.
- Require each regional center to develop, maintain, and publish language access plans that will identify each regional center's language capacity to ensure non-discriminatory processes in intake, assessment, and purchase and provision of services.
- Require DDS to study, with inclusive and transparent stakeholder participation, the efficacy of its disparity reduction efforts, make its findings public, and redirect its efforts accordingly based on the study's findings.
- Revise DDS' disparity measures so that they are clear, consistent, and transparent to the public, and make publicly available the specific data that DDS is using to measure the regional centers' improvement towards these measures.
- Enforce regional centers' compliance with the data reporting obligations and other public disclosure requirements by tying compliance to their performance contracts with DDS.
- Require regional centers to review all cases where consumers are receiving no purchase of services, to classify the reasons this is occurring, and to report these findings to the public.

More globally, we recommend that during this pandemic the executive administration and legislature spare the developmental services system any program cuts that will disproportionately and adversely impact communities of color. Significant budget cuts made to this system during the Great Recession of 2008 compounded pre-existing funding disparities. The state must not repeat this mistake, especially since these funding disparities largely remain and the consumer population served through this system continues to become more culturally and linguistically diverse each year.

# INTRODUCTION

California provides specialized supports and services to persons with developmental disabilities through a network of 21 regional centers. Regional centers are independent, private, non-profit corporations that contract with the California Department of Developmental Services (DDS) to determine program eligibility, provide case management, and purchase or secure specialized services and supports for persons with developmental disabilities and at-risk infants and toddlers. Regional centers are charged with supporting eligible individuals, referred to as “consumers,” to have the most independent and productive lives possible.

Regional center services are intended to be available to all consumers without regard to race, ethnicity, language, income level, or geographic location. Services include respite care, personal assistance services, behavioral health treatment services, adaptive equipment such as wheelchairs, nursing care, and adaptive skills and social skills training programs. “Purchase of service” (POS) is the method used by the regional centers to buy services and supports that have been mutually agreed upon by the regional center and the consumer through the individual program plan (IPP) process. Only services and supports for which the regional centers pay are counted as POS funds.

DDS and the 21 regional centers are required to collect and publish data on POS authorizations, expenditures, and utilization, broken down by consumer age, race/ethnicity, language, residence type, and other factors. Authorizations represent the extent to which the regional center is willing to purchase services for its consumers through the IPP process. Expenditures reflect the extent to which the consumer was able to successfully connect with the service provider and receive the authorized service. The regional centers report POS authorizations and expenditures on a “per capita” basis, which divides total amounts the regional center authorized or spent by the number of consumers eligible to receive services, not by the number of consumers who actually received services from the regional center.



For over 25 years, families and advocates, supported by numerous research studies, have raised concerns about disparities in service access. In recent years, the state has taken certain steps to address funding inequities, most recently establishing a disparity reduction program in 2016 that provides funding for projects intended to reduce disparities within the developmental services system.<sup>1</sup> See Appendix A.

Our report analyzes POS expenditures and authorizations data for Fiscal Year (FY) 2018-2019 by race/ethnicity and language for children and youth ages 3 through 21 and compares this data with the data from FY 2015-2016, before the disparity reduction funds were appropriated. We find that despite the state's recent efforts, disparities in authorizations and expenditures among and within the regional centers persist and, in some cases, are getting worse. Our report discusses root causes for the disparities and makes recommendations for addressing them.

## BACKGROUND

### CALIFORNIA'S DEVELOPMENTAL SERVICES SYSTEM

The Lanterman Act, codified at California Welfare & Institutions Code § 4500 *et seq.*, obligates the state to provide services and supports for persons with developmental disabilities, such as autism, epilepsy, cerebral palsy, and other intellectual disabilities, to enable these individuals to approximate the pattern of everyday living available to people without disabilities of the same age.<sup>2</sup> Further, under the California Early Intervention Services Act, California Government Code § 95000 *et seq.*, the state must also provide services to infants and toddlers who are at-risk of having developmental disabilities. Services are administered through 21 regional centers, which are independent, private, non-profit corporations that contract with DDS to develop, purchase, and manage services and supports for consumers and their families.

### CALIFORNIA'S LEGAL FRAMEWORK ON EQUAL ACCESS TO STATE-FUNDED PROGRAMS AND SERVICES

DDS allocates federal and state funds to the regional centers and must monitor them to ensure they operate in compliance with federal and state law and regulation.<sup>3</sup> Statutory provisions have given DDS the authority

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1 Assembly Bill 2X1 established the Disparity Funds Program, which awards \$11 million annually to regional centers and community-based organizations (CBOs) to implement strategies to reduce disparities and increase equity in regional center services. For more information on DDS' Disparity Funds Program, see: [dds.ca.gov/rc/disparities/disparity-funds-program](https://dds.ca.gov/rc/disparities/disparity-funds-program).

2 California Welfare and Institutions Code § 4501.

3 California Welfare and Institutions Code § 4433(a).

and the duty to ensure that regional centers comply with laws prohibiting discrimination on the basis of race, ethnic group identification, national origin, and other protected characteristics.<sup>4</sup> California Government Code § 11135 provides:

No person in the State of California shall, on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, genetic information, or disability, be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, *is funded directly by the state, or receives any financial assistance from the state.* (emphasis added)

In 2016, Senate Bill (SB) 1442 transferred responsibility of enforcing this law from the Secretary of Health and Human Services, which DDS falls under, to the Department of Fair Employment and Housing (DFEH). DFEH now has the authority to investigate, mediate, and prosecute Section 11135 complaints in the same manner it handles other discrimination claims.<sup>5</sup>

## METHODS

We analyzed POS data for children ages 3 through 21 from online reports of each of the 21 regional centers.<sup>6</sup> We focused on per capita authorizations data as they represent the extent to which regional centers are willing to offer services through the individual program plan (IPP) process. Service authorizations reflect existing policy differences among regional centers and directly affect which services consumers receive.<sup>7</sup> Additionally, we analyzed per capita expenditures to the extent that public data allow in order to align with the disparity measures established by DDS.<sup>8</sup> For more methodology details, see Appendix C.

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4 *Office of the Attorney General of the State of California, Opinion No. 79-107* (May 11, 1979) 62 Ops. Cal. Atty. Gen. 229.

5 California Government Code § 12930(f)(4).

6 We also analyzed the data for children ages 0 through 2 but did not include this analysis in our report. Although there are some disparities found in ages 0 through 2, overall disparities are less than those found in ages 3 through 21. In some cases, the disparities are in the reverse direction, with White children ages 0 through 2 receiving less than children from other racial/ethnic groups. Children ages 0 through 2 are served under the California Early Intervention Services Act, California Government Code § 95000 *et seq.*, which is a different program from the Lanterman Developmental Disabilities Services Act, California Welfare & Institutions Code § 4500 *et seq.*, which generally serves consumers over age three.

7 See Public Counsel, Assuring Equitable Funding of Services for Children with Developmental Disabilities, Appendix K, p.3 (2017), available at: [publiccounsel.org/tools/assets/files/0893.pdf](https://publiccounsel.org/tools/assets/files/0893.pdf).

8 For more information on DDS' Disparity Measures, see: [dds.ca.gov/rc/disparities/data/dds-disparity-measures](https://dds.ca.gov/rc/disparities/data/dds-disparity-measures).



# SUMMARY OF FINDINGS

Our study found the following:

- Large differences persist, and are growing within most regional centers, in the distribution of authorized services between White children and children of other racial groups and between English and Spanish-speaking children.
- Significant disparities in POS expenditures for children based on race/ethnicity and language continue, and DDS' improvement targets are not being met in most cases by the regional centers.
- The measures that DDS has created to track progress in reducing disparities lack transparency and are confusing and misleading.
- Although the statewide rates of children without any services vary little by race/ethnicity, there are certain regional centers whose rates of children receiving no services greatly exceed the statewide averages.
- The regional centers and DDS are out of compliance with the statutory data reporting requirements because the data reports from several regional centers continue to be missing, incomplete, inaccurate, and inaccessible to the public.



# RESULTS

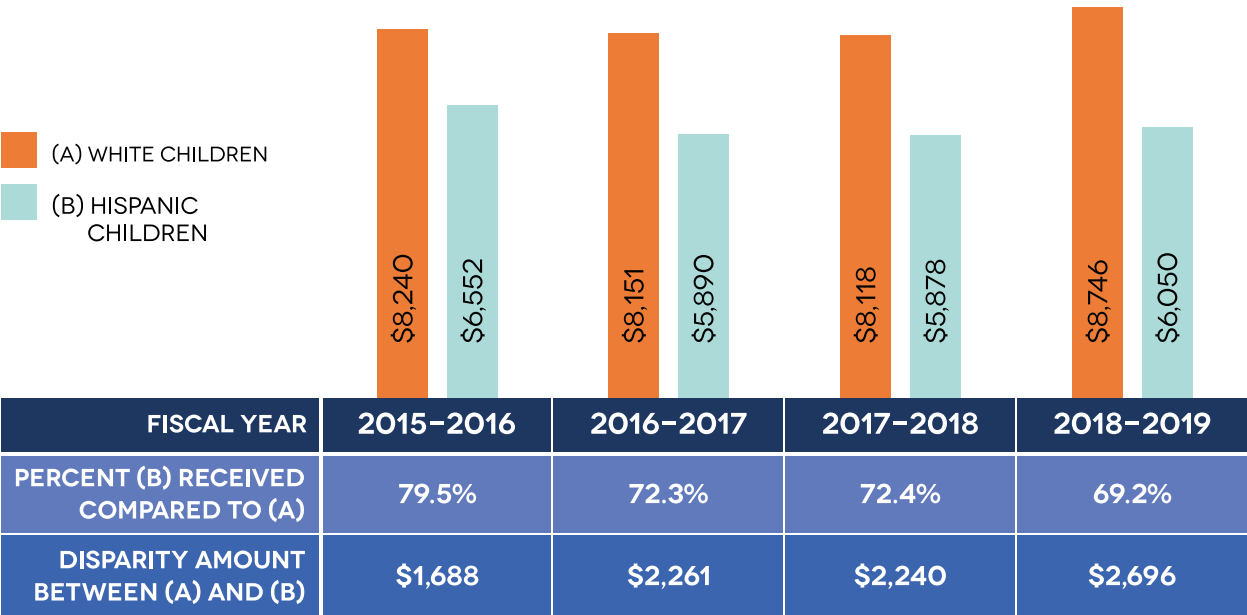


**FINDING 1:** *Disparities in POS authorizations by race and language are worsening for most children of color.*

## COMPARING POS AUTHORIZATIONS BETWEEN WHITE CHILDREN AND HISPANIC CHILDREN

Our data analysis found that inequities in per capita authorizations between White children and Hispanic children ages 3 through 21 living at home have only worsened since FY 2015-2016. In FY 2018-2019, each Hispanic child received 69% of the funding that each White child received, on average. This disparity has grown by 60% in four years, from an average disparity in per capita authorizations of \$1,688 in FY 2015-2016, to an average disparity of \$2,696 in FY 2018-2019. (Figure 1).

**FIGURE 1 • Disparity in Authorized Services Hispanic Children Received Compared to White Children (Ages: 3-21 | Residence Type: Home)**  
*Per Capita Authorizations Across Regional Centers*



Within regional centers, the gap favoring White children has worsened in 17 of the 21 regional centers when comparing data from FY 2018-2019 to data from FY 2015-2016. In three regional centers, the gap in authorization has narrowed, and in one regional center, the gap grew, favoring Hispanic children. (Figure 2).

**FIGURE 2 · Disparity in Per Capita Authorizations Within Regional Centers:  
Disparities Between White and Hispanic Children (Ages: 3-21 | Residence Type: Home)  
Goal of Disparity Amount= \$0**

REGIONAL CENTER	DISPARITY AMNT 2015-2016	DISPARITY AMNT 2018-2019	CHANGE	WORSE	BETTER	FAVORS HISPANIC
ACRC	\$873	\$1,532	(\$659)	X		
CVRC	\$1,556	\$955	\$601		X	
ELARC	\$2,149	\$4,043	(\$1,894)	X		
FNRC	(\$781)	(\$1,093)	\$312			X
GGRC	\$394	\$1,936	(\$1,542)	X		
HRC	\$969	\$2,500	(\$1,531)	X		
IRC	\$747	\$1,414	(\$667)	X		
KRC	\$2,601	\$2,652	(\$51)	X		
LRC	\$3,375	\$4,166	(\$791)	X		
NBRC	(\$528)	\$1,868	(\$2,396)	X		
NLACRC	\$2,548	\$4,989	(\$2,441)	X		
RCEB	\$250	\$1,801	(\$1,551)	X		
RCOC	\$2,644	\$4,988	(\$2,344)	X		
RCRC	\$1,542	\$1,879	(\$337)	X		
SARC	\$1,334	\$1,548	(\$214)	X		
SCLARC*	\$3,457	\$1,721	\$1,736		X	
SDRC	\$166	\$1,684	(\$1,518)	X		
SGPRC	\$673	\$1,692	(\$1,019)	X		
TCRC	\$1,506	\$2,282	(\$776)	X		
VMRC	\$821	\$571	\$250		X	
WRC	\$4,709	\$5,097	(\$388)	X		
				<b>17</b>	<b>3</b>	<b>1</b>

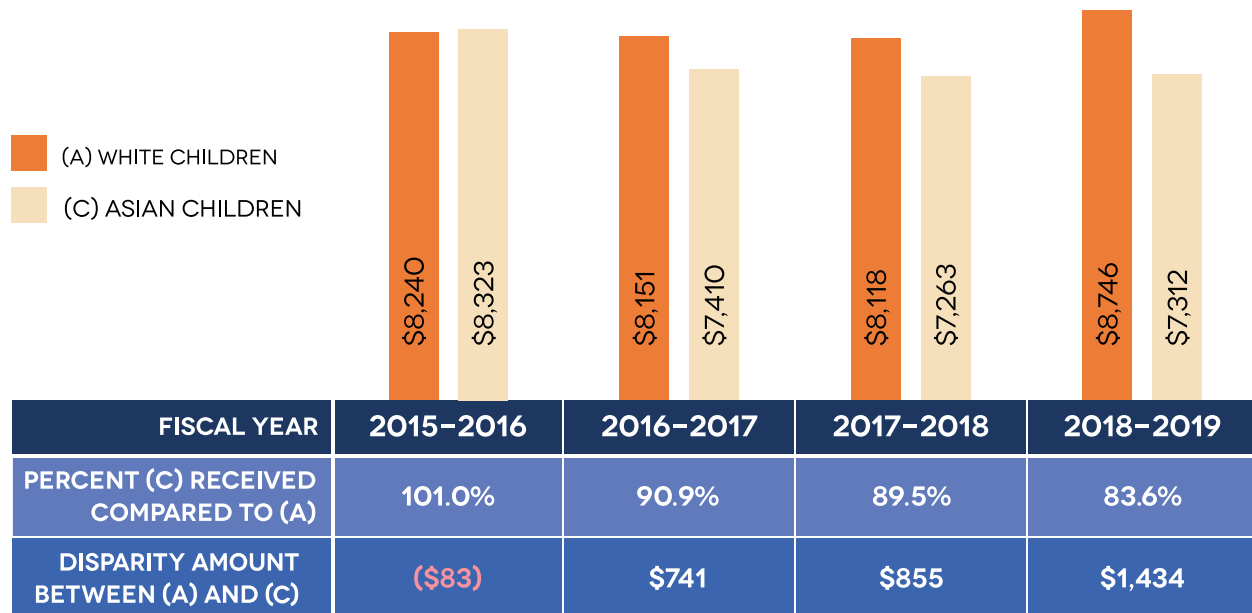
\*SCLARC's White population is 1% of the total population

In FY 2018-2019, 17 regional centers had a gap of at least \$1,000 in per capita authorizations between White and Hispanic children, compared to 11 regional centers in FY 2015-2016. Five regional centers currently have a gap of at least \$4,000 more in authorizations for White compared to Hispanic children: Westside Regional Center (\$5,097), North Los Angeles County Regional Center (\$4,989), Regional Center of Orange County (\$4,988), Lanterman Regional Center (\$4,166), and Eastern Los Angeles Regional Center (\$4,043).

## COMPARING POS AUTHORIZATIONS BETWEEN WHITE CHILDREN AND ASIAN CHILDREN

In FY 2018-2019, each Asian child received 84% of the funding that each White child received, on average. This is a significant change from FY 2015-2016 when Asian children were authorized services in slightly higher amounts than White children.<sup>9</sup> (Figure 3).

**FIGURE 3 · Disparity in Authorized Services Asian Children Received Compared to White Children (Ages: 3-21 | Residence Type: Home)**  
*Per Capita Authorizations Across Regional Centers*



In FY 2015-2016, Asian children received an average of \$83 more in per capita authorizations; now, White children receive an average of \$1,434 more. Since FY 2015-2016, Asian children have been authorized services

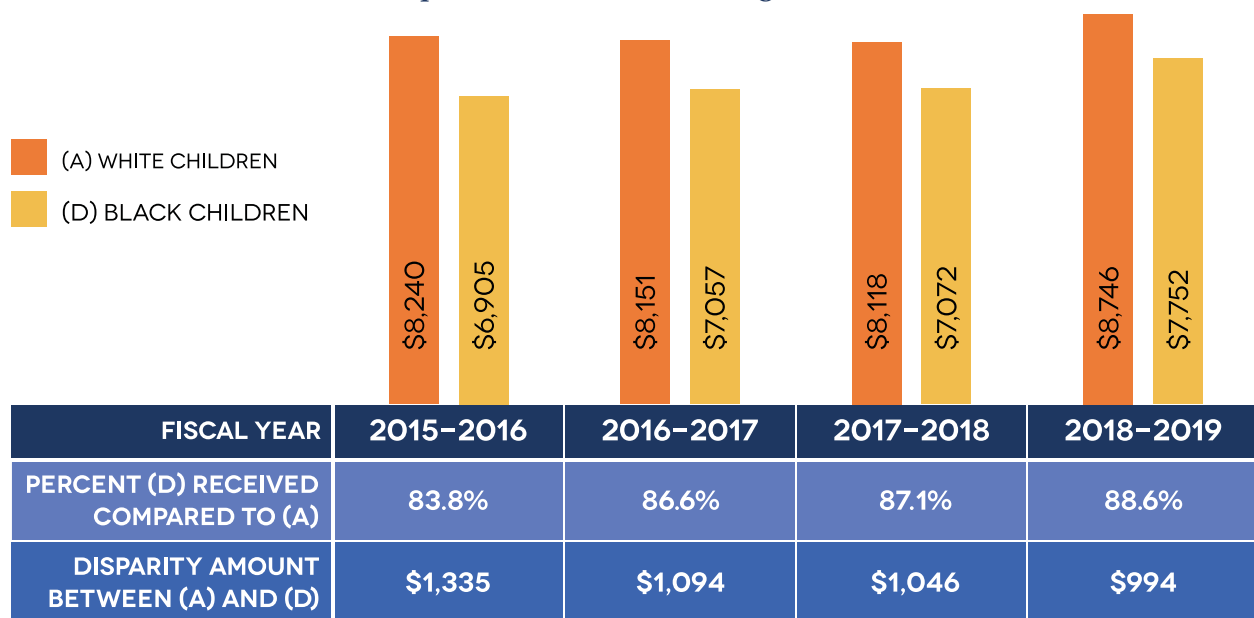
<sup>9</sup> In 2016-2017, the race/ethnicity data reporting criteria fundamentally changed to incorporate Filipino into the Asian category, whereas in prior years, Filipino consumers were reported separately. This change caused the statewide Asian population for consumers ages 3 through 21 to increase 41% from the prior fiscal year, from 10,754 to 15,208 consumers. DDS should clarify what impact the inclusion of Filipino consumers has had on the POS data relating to Asian consumers since FY 2016-2017.

at a precipitating rate versus White children. In FY 2016-2017 and FY 2017-2018, the disparity amounts were \$741 and \$855, respectively. In just the past year, from FY 2017-2018 to FY 2018-2019, the disparity in per capita authorizations between White children and Asian children has increased by 68%.

## COMPARING POS AUTHORIZATIONS BETWEEN WHITE CHILDREN AND BLACK/AFRICAN-AMERICAN CHILDREN

Disparities in statewide per capita authorizations are also seen between White and Black/African-American children ages 3 through 21 living at home. However, the disparities between White and Black/African-American children is the one instance where we found the disparities between groups to have reduced over time. In FY 2015-2016, Black/African-American children were authorized at only 84% of what White children were authorized. In FY 2018-2019, Black/African-American children were authorized 89% what White children were authorized, reflecting a reduction in disparities in per capita authorizations by almost 5 percentage points. (Figure 4).

**FIGURE 4 · Disparity in Authorized Services Black Children Received Compared to White Children (Ages: 3-21 | Residence Type: Home)**  
*Per Capita Authorizations Across Regional Centers*

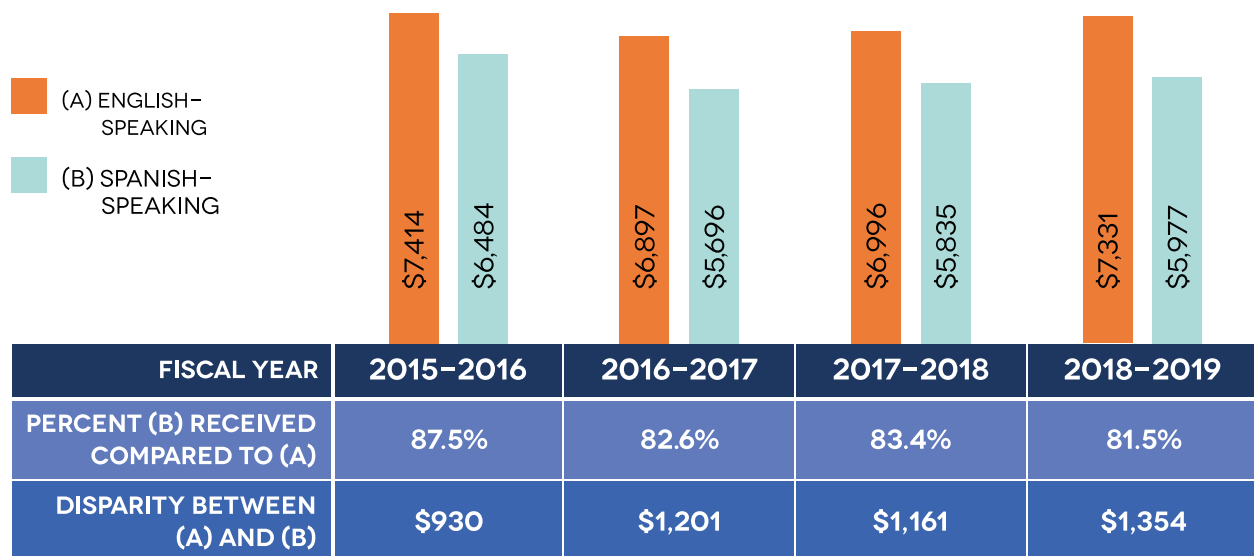


Disparity between White and Black/African-American children in authorizations has decreased by over 25% in four years, from an average disparity in per capita authorizations of \$1,335 in FY 2015-2016, down to an average disparity of \$994 in FY 2018-2019.

## COMPARING POS AUTHORIZATIONS BETWEEN ENGLISH-SPEAKING CHILDREN AND SPANISH-SPEAKING CHILDREN

Inequity in authorizations between English and Spanish-speaking consumers ages 3 through 21 living at home is increasing. In FY 2018-2019, each Spanish-speaking child received 82% of the funding that each English-speaking child received, on average. This is down from 88% in FY 2015-2016. Across all regional centers, the gap between English and Spanish-speaking children increased by 46%, from an average disparity of \$930 in FY 2015-2016 to \$1,354 in FY 2018-2019. (Figure 5).

**FIGURE 5 · Disparity in Authorized Services Spanish-Speaking Children Received Compared to English-Speaking Children (Ages: 3-21 | Residence Type: Home)**  
*Per Capita Authorizations Across Regional Centers*



Within regional centers, the gap favoring English-speaking children has worsened in 16 of the 21 regional centers when comparing data from FY 2018-2019 with data from FY 2015-2016. In three regional centers, the gap in authorizations has narrowed, and in one regional center, the gap grew favoring Spanish-speaking children. One regional center, South Central Los Angeles Regional Center, has nearly reached parity in per capita authorizations between English and Spanish-speaking children in FY 2018-2019. (Figure 6).

**FIGURE 6 • Disparity in Per Capita Authorizations Within Regional Centers:  
Disparities Between English-Speaking and Spanish-Speaking Children (Ages: 3-21 | Residence Type: Home)  
Goal of Disparity Amount = \$0**

REGIONAL CENTER	DISPARITY AMNT 2015-2016	DISPARITY AMNT 2018-2019	CHANGE	WORSE	BETTER	FAVORS SPANISH-SPEAKING	NEARLY EQUAL
ACRC	\$169	\$1,073	(\$904)	X			
CVRC	\$2,018	\$955	\$1,063		X		
ELARC	\$806	\$1,020	(\$214)	X			
FNRC	(\$1,198)	(\$1,024)	(\$174)			X	
GGRC	\$704	\$1,515	(\$811)	X			
HRC	\$297	\$761	(\$464)	X			
IRC	\$32	\$408	(\$376)	X			
KRC	\$2,234	\$274	\$1,960		X		
LRC	\$2,499	\$3,145	(\$646)	X			
NBRC	(\$404)	\$1,290	(\$1,694)	X			
NLACRC	\$1,129	\$2,088	(\$959)	X			
RCEB	(\$63)	\$2,097	(\$2,160)	X			
RCOC	\$1,967	\$3,714	(\$1,747)	X			
RCRC	(\$1,243)	\$3,020	(\$4,263)	X			
SARC	\$1,160	\$1,064	\$96		X		
SCLARC	\$438	(\$26)	\$494				X
SDRC	\$179	\$566	(\$387)	X			
SGPRC	\$392	\$759	(\$367)	X			
TCRC	\$721	\$2,172	(\$1,451)	X			
VMRC	\$469	\$541	(\$72)	X			
WRC	\$3,005	\$3,270	(\$265)	X			
				<b>16</b>	<b>3</b>	<b>1</b>	<b>1</b>

In FY 2018-2019, 13 regional centers had a gap of at least \$1,000 in per capita authorizations between English and Spanish-speaking children, compared to nine regional centers in FY 2015-2016. Four regional centers currently have a gap of at least \$3,000 more in authorizations for English-speaking children compared to Spanish-speaking children: Regional Center of Orange County (\$3,714), Westside Regional Center (\$3,270), Lanterman Regional Center (\$3,145), and Redwood Coast Regional Center (\$3,020).

## CONCLUSION

When comparing POS authorization rates between fiscal years 2015-2016 and 2018-2019, we found that disparities in per capita authorizations for children of color, in most cases, have worsened over time. POS disparities in authorizations seen in the Hispanic and Spanish-speaking children populations have grown significantly and equitable funding in authorizations for Asian children has plummeted. In contrast, although inequity still remains, gradual improvement towards equitable funding in authorizations is being made among Black/African-American children.







**FINDING 2: DDS' disparity measures lack transparency and are confusing and misleading.**

In response to a legislative hearing held by the Senate Human Services Committee on March 14, 2017, DDS developed a set of disparity measures to track progress in reducing disparities and to establish short and long term improvement targets for the measures. See Appendix B.<sup>10</sup>

DDS has chosen to measure POS expenditures even though disparities in POS authorizations are starker. Our analysis finds that most of the POS expenditure targets set forth by DDS in its disparity reduction measures have not been met by the regional centers, and DDS's method of presenting its measures is confusing, misleading, and lacking in transparency.

### **DDS' Disparity Measures Lack Transparency**

For several disparity measures, DDS is comparing per capita expenditures for consumers ages 3 through 21 living in the family home who received some POS with all consumers ages 3 through 21 living in the family home, whether the consumer received services or not, according to race and language. Assessing equity in expenditures only among consumers with some POS causes an increase in the per capita expenditure amounts from what the regional centers report, and the amount increased can vary depending on the rate of how many children did not receive services within the subgroups.<sup>11</sup>

In developing its POS expenditure measures, DDS has chosen criteria based on data to which only it has ready access. The regional centers' reports do not directly provide the data on per capita expenditures for consumers ages 3 through 21 living in the family home who received some POS, which DDS is using for these measures. DDS should publish the specific data it is using to track progress through its disparity measures in order to facilitate the public's ability to independently assess the outcomes.

In replicating DDS' disparity measures as closely as possible given these limitations, we derived from the public data the expenditures data that pertained to all consumers, whether the consumer received services

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<sup>10</sup> All references to DDS' disparity measures herein pertain to the excerpted portions of DDS' Statewide Disparity Measures that are contained in Appendix B.

<sup>11</sup> For example, assume \$1,000 will be distributed to two sets of children: one set consisting of ten White children and the other set consisting of ten Hispanic children. Prior to distributing, just eight White children and five Hispanic children are selected as the ultimate recipients of the money. The eight White children would each receive \$125 and the five Hispanic children would each receive \$200, while two White children and four Hispanic children would receive nothing. Yet, the way per capita expenditures are being reported by regional centers, the data suggests that all 20 children would have received \$100 each.

or not; however, this should have a minor effect because over 98% of consumers ages 3 through 21 live at home.<sup>12</sup>

### **DDS' Disparity Measures Are Confusing**

DDS used data from FY 2015-2016 to serve as baselines for its improvement targets within each measure and is presenting two sets of data: one set corresponding with consumers receiving some POS and the other set corresponding with all consumers. However, the population source for DDS' baselines change depending on the measure, without explanation. "Consumers with some POS" and "all consumers" are used interchangeably for baselines. It is unclear whether this was intentional. DDS used data from the "all consumers" set for its Measures #1a and #1b baselines, but used data from the "consumers receiving some POS" set for its baselines in Measures # 5 and #9.<sup>13</sup> DDS should revise its measures so that baselines, and improvement targets predicated therefrom, are consistent across all measures. Using "consumers with some POS" data for all baseline measures will provide a more accurate account of the extent of disparities occurring, but data regarding the percentage rates of consumers without any POS by race and language should also be tracked and reported to obtain a fuller picture. True equity is achieved when different groups receive 100% relative to one another and their rates of receiving no POS are the same.

For Measure #5, DDS's baseline in FY 2015-2016 for Black/African-American consumers is .94, but its improvement target for FY 2018-2019 is inexplicably lower, at .90. DDS appears to have copied this target with the one immediately below for Hispanic consumers in drafting this measure. If so, DDS should correct this apparent mistake and replace it with the appropriate improvement target.

For Measure #1, DDS states in its preface that this measure focuses on consumers ages 3 through 21 who live in their family home, yet the tables within this measure indicate "All Residences Types." For Measure #9, the inverse is the case; DDS states in its preface that the target population is consumers in all residence types, yet the table for ages 3 to 21 years (#9a) indicates "living in the family home." DDS should clarify the populations it is evaluating.

DDS has excluded "other ethnicity" from Measure #1a. However, given the abnormally high population rates of "other ethnicity" at Inland Regional Center (now over 73% for ages 0 through 2 and 17% for ages 3 through 21) and San Diego Regional Center (now over 31% for ages 0 through 2 and over 17% for ages 3

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12 We subtracted the number of consumers who received no POS, which is separately reported, and divided the total expenditures by the number of children who received some POS. Because we could not identify from the public data the portion of children living at home who received some POS, our expenditure amounts are slightly different than DDS' data. In FY 2018-2019 though, the number of consumers ages 3 through 21 living at home was 168,782 and the number of consumers ages 3 through 21 for all residences was 171,740. Thus, those living at home constituted 98.3% of the total population and we believe this slight difference produces minimal impact on the comparability of our analysis.

13 For the sake of simplicity, we only used the data that corresponds with the baseline data chosen by DDS for our Figures 7 through 12 below, even though the findings are nearly the same whether "all consumers" or "consumers with no POS" data are used. Data tables for both populations are available by request.

through 21), DDS should consider evaluating these regional centers separately. Such high numbers call into question not only the credibility of these two regional centers' general consumer demographic information, but also the validity of their own disparity data and even the validity of statewide data when assessing high level comparisons by race/ethnicity. DDS should review all regional centers' consumer classification systems to determine why Inland Regional Center and San Diego Regional Center have such large numbers of "other ethnicity" compared to other regional centers, such as Kern Regional Center (10% for ages 0 through 2 and 2% for ages 3 through 21), and DDS should establish uniform procedures for demographic data collection among the regional centers.<sup>14</sup>



### **DDS' Measures Are Misleading**

DDS has developed improvement targets related to its POS expenditures measures and has established the data from FY 2015-2016 to serve as the baseline for measuring these targets.

However, in FY 2016-2017, the race/ethnicity data reporting criteria fundamentally changed to incorporate Filipino into the Asian category, whereas in prior years, Filipino consumers were reported separately. This change caused the statewide Asian population for consumers ages 3 through 21 to increase 41% from the prior fiscal year. Given this significant change, it raises the question as to whether DDS modified the FY 2015-2016 public data for Asians to include Filipinos in establishing its baseline. DDS should clarify this key data concern and should also clarify what impact the inclusion of Filipino consumers has had on the POS data relating to Asian consumers since FY 2016-2017.

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<sup>14</sup> For the sake of brevity, data tables for "other ethnicity" are not included in this report but are available by request.

For Measure #1, DDS' use of matrices that compare White consumers with consumers of all other ethnic groups combined, and that compare English-speaking consumers with consumers of all remaining languages combined, has the effect of masking the discrete disparities that have grown detrimentally for Hispanic, Asian, and Spanish-speaking consumers over these fiscal years.

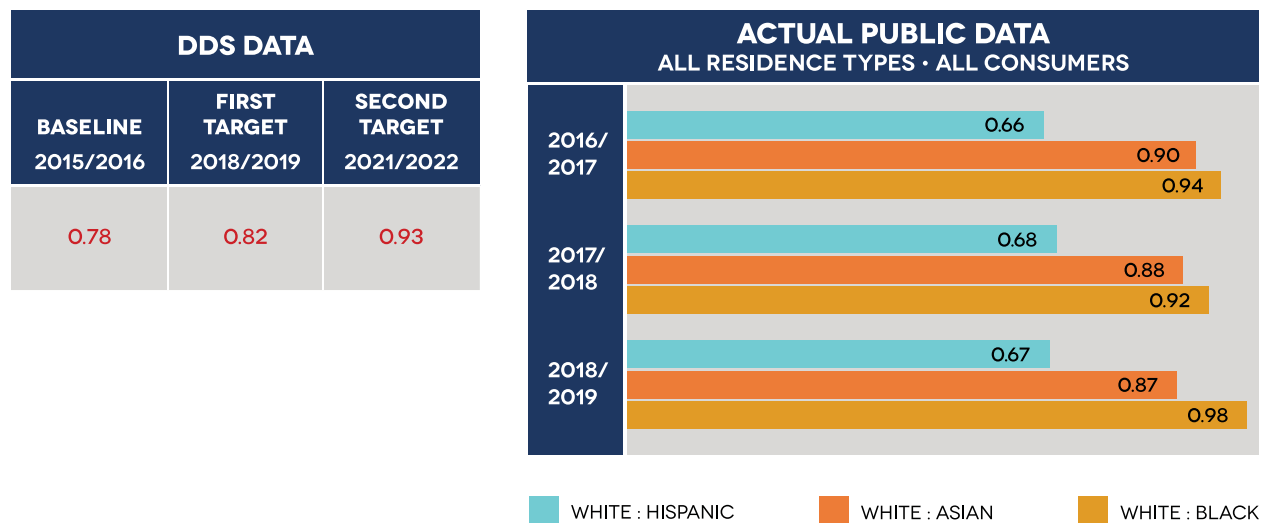
## CONCLUSION

DDS' disparity measures are intended to serve as bellwethers for system change that can be easily compared over time. However, these measures are flawed. Corrections and additional clarifying information are needed from DDS in order for these measures to achieve their intended purpose.



With the exception of Black/African-American children, DDS' improvement targets for equity in POS expenditures among its selected groups largely have not been met by the regional centers.

**FIGURE 7 • Approximating DDS' Approach for Measure #1a: High Level Comparison Between White Children and Children of All Remaining Ethnicities, Ages 3-21**  
*Comparing POS Expenditures*



### Comparing POS Expenditures Between White Children and Hispanic Children

Comparing against DDS' Measure #1a, all Hispanic children ages 3 through 21 are at 67% (.67) relative to what all White children received in FY 2018-2019, when DDS' target goal under the measure for "all combined ethnicities" relative to all White children was 82% (.82). (Figure 7).

Comparing against Measure #5, Hispanic children with some POS fell well short at 66% (.66) relative to what White children with some POS received in POS expenditures for FY 2018-2019, when DDS' target goal under the measure was 90% (.90). This disparity in POS expenditures between Hispanic and White children has not significantly changed throughout all the fiscal years. (Figure 8).

**FIGURE 8 · Approximating DDS' Approach for Measure #5:  
Comparison of Average POS Between White Children and Hispanic Children, Ages 3-21  
Comparing POS Expenditures**

DDS DATA			ACTUAL PUBLIC DATA ALL RESIDENCE TYPES · SOME POS		
BASELINE 2015/2016	FIRST TARGET 2018/2019	SECOND TARGET 2021/2022	WHITE : HISPANIC		
			2016/2017	2017/2018	2018/2019
0.85	0.90	0.97	0.65	0.66	0.66

### Comparing POS Expenditures Between White Children and Asian Children

Comparing against DDS' Measure #1a, all Asian children are at 87% (.87) relative to what all White children received in FY 2018-2019, when DDS' target goal under the measure for "all combined ethnicities" relative to all White children was 82% (.82). (Figure 7). At first glance, this seems as if progress has been made in POS expenditure disparity between Asian and White children. However, since FY 2015-2016, when Asian children received slightly more POS expenditures than White children, Asian children have progressively seen disparities worsen in relation to White children in subsequent fiscal years. In FY 2016-2017, all Asian children received 90% (.90) of what all White children received; and in FY 2017-2018, all Asian children received 88% (.88) of what all White children received. (Figure 7).

DDS' Measure #5 does not contain an improvement target for Asian children relative to White children, presumably because DDS considered Asian children's FY 2015-2016 baseline to be above the data for White children and therefore unnecessary. (Figure 9). If this is true, this is a troubling oversight on the part of DDS, given the inequitable trajectory Asian children have since faced. Furthermore, these disparity measures are dated March 12, 2019, which would have amply given DDS two fiscal years of expenditure trends to evaluate for change of status since the baseline. The reclassification of Filipinos into the Asian category may have played

a role in the emergence of Asian children now having disparities vis-a-vis White children, and DDS should explore this potential causal factor further and disclose its findings.

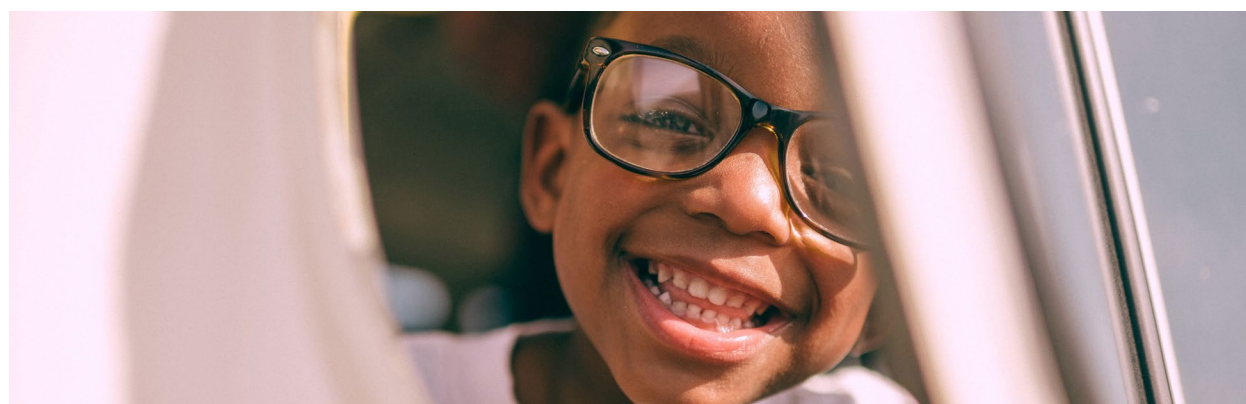
**FIGURE 9 · Approximating DDS’ Approach for Measure #5:  
Comparison of Average POS Between White Children and Asian Children, Ages 3-21  
*Comparing POS Expenditures***

DDS DATA			ACTUAL PUBLIC DATA ALL RESIDENCE TYPES · SOME POS		
BASELINE 2015/2016	FIRST TARGET 2018/2019	SECOND TARGET 2021/2022	WHITE : ASIAN		
			2016/2017	2017/2018	2018/2019
N/A	N/A	N/A	0.89	0.88	0.87

**Comparing POS Expenditures Between White Children and Black/African-American Children**

Comparing against DDS’ Measure #1a, all Black/African-American children are at 98% (.98) relative to what all White children received in FY 2018-2019, when DDS’ target goal under the measure for “all combined ethnicities” relative to all White children was 82% (.82). (Figure 7). This is one instance where considerable progress seems to have been met in reducing disparities.

Comparing against Measure #5, Black/African-American children with some POS are equal (100%, or 1.00) to what White children with some POS received in FY 2018-2019. DDS’ target goal under the measure was 90% (.90), but as noted above, this appears to be a drafting error given that the baseline was 94% (.94). (Figure 10). The improvement target for DDS now should be revised to maintain the achieved equity (1.00), instead of the next target goal of 97% (.97) for FY 2021-2022.



**FIGURE 10 · Approximating DDS' Approach for Measure #5:**  
**Comparison of Average POS Between White Children and Black Children, Ages 3-21**  
*Comparing POS Expenditures*

DDS DATA			ACTUAL PUBLIC DATA ALL RESIDENCE TYPES · SOME POS		
BASELINE 2015/2016	FIRST TARGET 2018/2019	SECOND TARGET 2021/2022	WHITE : BLACK		
			2016/2017	2017/2018	2018/2019
0.94	0.90	0.97	0.98	0.96	1.00

**Comparing POS Expenditures Between English-Speaking Children and Spanish-Speaking Children**

Comparing against DDS' Measure #1b, all Spanish-speaking children ages 3 through 21 are at 78% (.78) relative to what all English-speaking children received in FY 2018-2019, when DDS' target goal under the measure for "all remaining languages" relative to all English-speaking children was 95% (.95). (Figure 11). We can reasonably infer that this falls well short of DDS' goal as it relates to Spanish-speaking children. In FY 2018-2019, over 73% of the total consumer population for ages 3 through 21 were classified as English-speaking, while nearly 24% were classified as Spanish-speaking, accounting for almost 97% of the overall population. Given how far below the actual data is from DDS' improvement target, and with most of the population already represented, we can therefore assume that DDS' target goal for this measure generally has not been met, even if data for the ancillary languages were to be factored into the analysis.

**FIGURE 11 · Approximating DDS' Approach for Measure #1b: High Level Comparison Between English-Speaking Children and Children of All Remaining Languages, Ages 3-21**  
*Comparing POS Expenditures*

DDS DATA			ACTUAL PUBLIC DATA ALL RESIDENCE TYPES · ALL CONSUMERS		
BASELINE 2015/2016	FIRST TARGET 2018/2019	SECOND TARGET 2021/2022	ENGLISH : SPANISH		
			2016/2017	2017/2018	2018/2019
0.90	0.95	0.95	0.77	0.80	0.78

Comparing against Measure #9a, Spanish-speaking children with some POS fell well short at 72% (.72) relative to what White children with some POS received in FY 2018-2019, when DDS' target goal under the measure was 91% (.91). (Figure 12). This disparity in POS expenditures for Spanish-speaking children relative to English-speaking has not significantly changed throughout all the fiscal years.

**FIGURE 12 · Approximating DDS' Approach for Measure #9a: Comparison of Average POS between English-Speaking Children and Spanish-Speaking Children, Ages 3-21**  
*Comparing POS Expenditures*

DDS DATA			ACTUAL PUBLIC DATA ALL RESIDENCE TYPES · SOME POS		
BASELINE 2015/2016	FIRST TARGET 2018/2019	SECOND TARGET 2021/2022	ENGLISH : SPANISH		
			2016/2017	2017/2018	2018/2019
0.87	0.91	0.98	0.72	0.74	0.72

The disparity between English-speaking and Spanish-speaking children is greater when children with some POS are compared (72%) than when all children are compared (78%). (Comparing Figure 12 to Figure 11). This appears attributable to the different rates of consumers with no POS among English-speaking and Spanish-speaking children. In FY 2018-2019, 32% of English-speaking children did not receive any POS while 27% of Spanish-speaking children did not receive any POS. Here, English-speaking children see a greater increase in their per capita expenditures when total expenditures are recalculated to only apply to their consumers who received some POS, which, in turn, causes the disparity between them and Spanish-speaking children to only widen further.

## CONCLUSION

Disparities in POS expenditures are still evident and worsening for many. POS disparities in expenditures seen in the Hispanic and Spanish-speaking child populations languish at unacceptably high levels and disparity in expenditures for Asian children has greatly increased. On the other hand, funding equality in expenditures for Black/African-American children appears to have nearly been achieved.





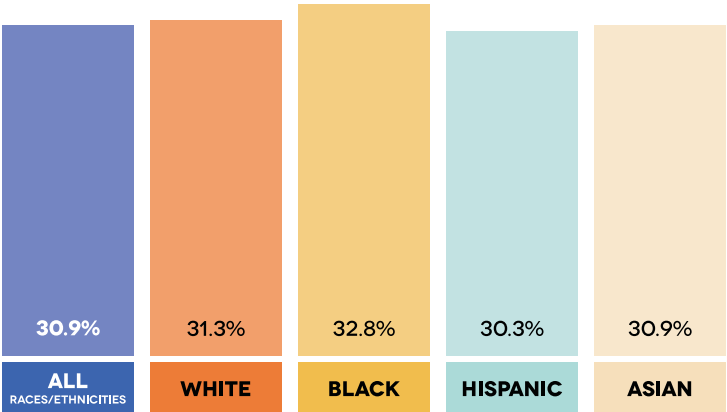
**FINDING 4:** *Deprivation of services among children in all subgroups is substantial and is not sufficiently explained.*

Regional centers calculate and report expenditures based on “all consumers,” whether the consumer received services or not. However, when per capita expenditures are recalculated based on who actually received services, the gaps are often more substantial and raise deprivation concerns—who is not being served and why.

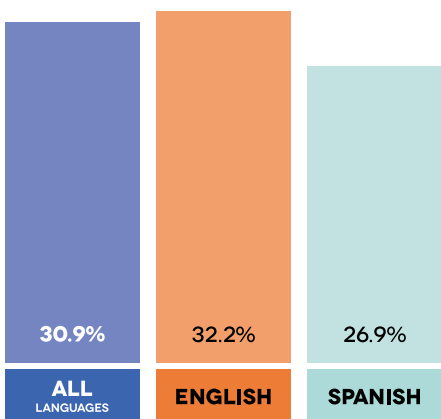
For FY 2018-2019, the statewide average for children ages 3 through 21 who received no POS by race/ethnicity ranged from 30% to 33%.<sup>15</sup> (Figure 13).

The rates of consumers with no POS for English-speaking children and for Spanish-speaking children for FY 2018-2019 were 32% and 27%, respectively.<sup>16</sup> (Figure 14).

**FIGURE 13 · Deprivation (No POS) for Ages 3-21 by Race/Ethnicity**



**FIGURE 14 · Deprivation (No POS) for Ages 3-21 by Language**



Although the statewide percentage rates of children not receiving any services vary little among race/ethnicity, there are instances where some regional centers have greatly exceeded the statewide rates, either on the whole or, perhaps even more concerning, with respect to just one or two of their subgroups. For FY 2018-2019, the average percentage rate of deprivation among the regional centers for all consumers ages 3 through 21 ranged

15 The rates of consumers with no POS based on race/ethnicity for prior fiscal years are similar. For the sake of brevity, data tables pertaining to consumers with no POS for prior years are not included in this report but are available by request.

16 The rates of English-speaking and Spanish-speaking consumers with no POS for prior fiscal years are similar. For the sake of brevity, data tables pertaining to these consumers with no POS for prior years are not included in this report but are available by request.

from 19% (Tri-Counties Regional Center) to 44% (Regional Center of the East Bay). At Regional Center of Orange County, the range in its deprivation rates in FY 2018–2019 for White children and Hispanic children respectively was 23% and 41% and its deprivation rates for English-speaking children and Spanish-speaking children respectively was 27% and 43%.<sup>17</sup>

In its background material for its disparity measures, DDS attempts to help justify differences seen in per capita expenditures between Hispanic and White children under the following premise:

“A larger share of Hispanic consumers are age 3 through 21 years than is true for White consumers, for example; those younger consumers *likely* receive many services through the school system rather than through POS, reducing average POS for Hispanic consumers as a group.” (emphasis added).<sup>18</sup>

The regional centers have also attempted to explain disparities between White consumers and consumers from communities of color similarly.<sup>19</sup> However, suggesting that disconcerting data reflecting large percentages of certain consumers without any services and lower per capita expenditures is due to their service needs being met elsewhere, or because consumers have declined POS and only want case management services from the regional center, is insufficient without evidence to substantiate those unfounded assertions.

## CONCLUSION

By excluding the nearly 31% of the pediatric consumer population that did not receive services when calculating per capita expenditures, a more accurate and starker picture of existing disparities emerges. These hidden disparities especially impact communities of color because inequities reflected in the data reported by regional centers are actually muted and do not tell the whole story.

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17 For the sake of brevity, data tables for consumers with no POS by regional center are not included in this report but are available by request.

18 See page 1 of DDS’ Background and Process for Developing Disparity Measures here: [dds.ca.gov/wp-content/uploads/2019/03/Disparities\\_BgProcessDevelopingDisparityMeasures\\_20190329.pdf](https://dds.ca.gov/wp-content/uploads/2019/03/Disparities_BgProcessDevelopingDisparityMeasures_20190329.pdf).

19 During a legislative hearing before the Senate Human Services Committee on March 14, 2017, the executive director of the Association of Regional Center Agencies (ARCA) testified that services disparities exist not just in the regional center system, but throughout health and human services’ programs, including special education, in-home supportive services, Medi-Cal, SSI and mental health. Yet, the ARCA director then suggested some of the disparities seen in regional center services may be attributable to consumers having their needs met elsewhere by these other agencies. This testimony occurred at approximately 25:30–30:00 minutes into the hearing, which can be viewed or heard on the California State Senate’s website at: [senate.ca.gov/media-archive](https://senate.ca.gov/media-archive).



**FINDING 5:** *DDS and most regional centers have consistently failed to follow requirements under statutory data reporting law.*

DDS and the regional centers are required to annually compile and post specific data on their respective websites relating to the regional centers' POS authorizations, utilizations, and expenditures. Regional centers must post this data by the end of the year each year and maintain all previous years' data on their websites. DDS has a similar obligation under the law.

Our review of all 21 regional centers' current and prior data reports indicates that they, and thus DDS, are noncompliant with the law.<sup>20</sup> The regional centers' reports lack uniformity and many reports are missing, incomplete, inaccurate, and inaccessible.<sup>21</sup> These failures to report as legally required were also reported in our previous reports and much remains the same. Erroneous data are suspected in some reports, some data reports contain only partial information, not all of the fiscal years are being reported online, and there still is significant lack of uniformity and accessibility to many of the reports that have been posted. (See Appendix D).

## CONCLUSION

Statutory data reporting requirements are not being met by most regional centers. Incomplete and inaccurate data obscure evidence of disparities in service authorization and spending.



<sup>20</sup> California Welfare and Institutions Code § 4519.5.

<sup>21</sup> As detailed in Appendix C, all the data necessary for the findings of this report are available online.



## RECOMMENDATIONS

As the governor’s revised state budget for 2020-2021 projects, the coronavirus pandemic that began escalating in California in March 2020 will have a fundamental effect on California’s economy over the next several years. To partially address needs created or exacerbated by the coronavirus pandemic, the governor has proposed a \$300 million budget reduction to the developmental services system. Yet, this crisis has only further exposed long-standing inequities in access to basic necessities, health care, and services and supports for children and families of color.

We urge the executive administration and legislature to spare the developmental services system any program cuts that will disproportionately and adversely impact communities of color. Significant budget cuts made to this system during the Great Recession of 2008 compounded pre-existing funding disparities.<sup>22</sup> The state must not repeat this mistake, especially since these funding disparities largely remain and the consumer population served through this system continues to become more culturally and linguistically diverse each year.<sup>23</sup>

To effectively address funding disparities, we recommend that the state undertake the following actions. These recommendations should be considered now in order to mitigate against further exacerbation of inequities in the wake of the coronavirus crisis.

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22 On March 14, 2017, the Senate Human Services Committee held a legislative oversight hearing on POS disparities and determined that very little improvement had been made in reducing disparities in the five years since a prior legislative committee hearing was held on this issue on April 30, 2012. The background paper for the March 14, 2017 hearing: “Moving Toward Equity: Addressing Disparities In Services Provided By The Regional Center System,” described the disproportionate affect that the budget cuts from the Great Recession of 2008 had on communities of color and is available for review here: [shum.senate.ca.gov/content/hearings](http://shum.senate.ca.gov/content/hearings). The March 14, 2017 hearing can be viewed or heard on the California State Senate’s website at: [senate.ca.gov/media-archive](http://senate.ca.gov/media-archive).

23 In our May 2019 disparity report, we detailed how the restoration of suspended services, such as camping and social recreation services, and the repealing of other statutes restricting service access imposed during the Great Recession of 2008, would improve equity for communities of color. See Public Counsel, Addressing Funding Disparities in Services for Children with Developmental Disabilities, (2019), available at: [publiccounsel.org/tools/assets/files/1173.pdf](http://publiccounsel.org/tools/assets/files/1173.pdf). ARCA agrees that reinstating the suspended services would assist in the efforts towards more equitable spending: [arcaneet.org/wp-content/uploads/2018/01/suspended-services.pdf](http://arcaneet.org/wp-content/uploads/2018/01/suspended-services.pdf). These recommendations still stand and should be revisited by the legislative and executive administration leadership once the state’s economic condition improves.

## REVISE DDS' BUDGET AND ALLOCATION METHODOLOGY TO A CLIENT-NEEDS BASED MODEL

DDS' current budgeting formula allocates funding to regional centers not according to their consumers' needs but based on what the regional centers spent the prior year. Under prior leadership, DDS acknowledged that such a formula is flawed and DDS previously initiated a process, since abandoned, to reform the methodology that would be more equitable, established by client characteristics.<sup>24</sup>

The state should enact legislation to impanel a legislative task force consisting of DDS and stakeholders to develop a client-needs-based POS budget and allocation methodology that is based on objective criteria. The process for creating the new methodology should be transparent and provide opportunities for consumer and public input.

## REQUIRE REGIONAL CENTERS TO DEVELOP, MAINTAIN, AND PUBLISH LANGUAGE ACCESS PLANS

AB 959 passed in 2017 requiring regional centers to provide information to consumers and their families in a manner that is culturally and linguistically appropriate, including through the provision of alternative communication services, pursuant to state law prohibiting discrimination on the basis of national origin.<sup>25</sup> But the regional centers still have not developed specific language access plans on their own initiative in response to implementing this Lanterman Act mandate.

To ensure that AB 959 is fully operationalized as intended, legislation should be enacted to prescriptively require the regional centers to develop language access plans, utilizing census data to identify languages spoken in their catchment areas. Regional centers must evaluate their internal language capacity and develop a plan to ensure non-discriminatory processes in intake, assessment, and the purchase and provision of services.<sup>26</sup> The language access plans should include a complaint process for persons who believe their rights to meaningful language access have not been met by the regional center.

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24 At the Senate Select Committee on Autism and Related Disorders hearing on April 30, 2012, former DDS Director Terri Delgadillo testified that regional centers' POS budgets are based on what the regional centers spent the prior year, and that any additional money is distributed based on caseload ratios and growth in service utilization. Director Delgadillo acknowledged that DDS' budget and allocation methodology was inequitable and that DDS planned to put in place a "bridge" methodology as a step towards a client-needs-based budget and allocation methodology that "would be blind to ethnicity" and serve as a "starting point" in addressing POS disparities. The transcript and ability to view this hearing is available on the California Senate Select Committee on Autism and Related Disorders' website at: [autism.senate.ca.gov/informationalbearings](http://autism.senate.ca.gov/informationalbearings); see also Zarembo, A. (2012, May 1) Activists criticize state over unequal autism aid; Advocates testify that families with fewest resources get the least help for their children. Los Angeles Times. Retrieved from: [autism.senate.ca.gov/sites/autism.senate.ca.gov/files/LOS%20ANGELES%20TIMES.pdf](http://autism.senate.ca.gov/sites/autism.senate.ca.gov/files/LOS%20ANGELES%20TIMES.pdf)

25 California Welfare and Institutions Code § 4502.1(b).

26 The state has enacted such legislation to ensure other private agencies adhere to federal and state language access laws, such as AB 389 of 2015 pertaining to licensed general acute hospitals and SB 853 of 2003 and SB 223 of 2017 pertaining to licensed health care plans and health care insurers.

The regional centers should be required to consult with California’s Department of Fair Employment and Housing (DFEH) for technical assistance and final approval in developing comprehensive language access plans that comport with state and federal antidiscrimination law. In turn, these language access plans should be posted online as part of the regional centers’ public disclosure requirements.

## **REVIEW THE EFFICACY OF DDS’ DISPARITY REDUCTION PROJECTS THROUGH A TRANSPARENT AND INCLUSIVE PROCESS**

After four years of DDS’ funding of various disparity reduction projects, it is unclear what impact these efforts have had in reducing disparities or at least mitigating growth in disparities. Progress appears to have been made in narrowing the gaps in POS funding between White and Black/African-American children and a study should be undertaken to determine whether certain disparity reduction projects contributed toward this improvement. If so, best practices from those projects perhaps could be applied to projects where targeted populations have not realized improvement. Likewise, as noted above, a few regional centers have made improvement in reducing disparities in POS authorizations for their Hispanic and Spanish-speaking children. What role any disparity reduction projects may have played in these improvements should also be explored for establishing and replicating potential best practice models.

While there has been no improvement in reducing POS disparities for Hispanic, Asian, and Spanish-speaking children overall on a statewide basis, it is possible that DDS’ disparity reduction projects may have curbed the growth of disparities for some or all of these groups. Additionally, the community based organizations (CBOs) executing many of these disparity reduction projects are also currently serving a critical role as conduits for DDS and the regional centers into accessing underserved communities during the coronavirus crisis and funding for these projects should therefore remain.



DDS should be required to study, with inclusive and transparent stakeholder participation, the efficacy of its disparity reduction efforts. Stakeholder participation should include one or more outside community members with expertise in data analysis. DDS should publish the study's findings and redirect funds towards programs that have demonstrated the capability to make remedial impact on POS disparities.

## **REVISE DDS' DISPARITY MEASURES AND PUBLISH SPECIFIC DATA USED FOR THESE MEASURES**

As detailed above, DDS' disparity measures lack transparency, and are confusing and misleading in their current state. These measures should be pulled from DDS' website and revised and republished. The revised measures should contain all of the fiscal years' data since 2015-2016. The terms and data used for each measure should be consistent with one another, and free of any possible copying errors. DDS should provide improvement targets for Asian children given that they too face significant inequities. DDS should also clarify what impact the incorporation of the data for Filipinos into the larger Asian data in 2015-2016 may have had on the emergence of disparities for this racial group. Lastly, DDS should post on its website the specific data that it is using to measure the regional centers' improvement towards these measures so that the public can independently assess for improvement.

## **ENFORCE COMPLIANCE WITH DATA REPORTING AND OTHER PUBLIC DISCLOSURE MANDATES**

The regional centers' contracts with DDS must maintain annual performance objectives and steps for contract compliance, including incentives for regional centers to meet or exceed performance standards and levels of probationary status for regional centers that do not meet, or are at risk of not meeting, performance standards.<sup>27</sup> The legislature should enact law to ensure that the regional centers comply with their data reporting and other public disclosure requirements by tying compliance of these requirements to their performance contracts with DDS.

DDS should thoroughly review and enforce the regional centers' compliance with the data reporting requirements and other public disclosure mandates, particularly those that have an inextricable relation to disparity issues. For instance, all regional centers should now have a link on their websites to the list and description of services that DDS developed and posted pursuant to AB 959.<sup>28</sup> The law also requires regional centers to post online their revised respite policies in light of changes in the law as well as their respite assessment tools and protocols so that families can better understand the eligibility criteria for those services.<sup>29</sup> Regional centers should also have all approved minutes and agendas of their board of directors' meetings and

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27 California Welfare and Institutions Code § 4629(c) and (d).

28 California Welfare and Institutions Code § 4629.5(b)(14).

29 California Welfare and Institutions Code § 4690.2(c).

their boards' committee meetings contemporaneously posted online.<sup>30</sup> These meetings' minutes often have disparity issues and other relevant service access information, and online access may be the only means for some families unable to attend board meetings to review this important information.

## **REQUIRE REGIONAL CENTERS TO ASSESS AND REPORT ON CASES WHERE CONSUMERS HAVE NO POS**

DDS and the regional centers have a duty to account for the needs of all their consumers.<sup>31</sup> Regional centers are contractually obligated to measure progress in reducing disparities and improving equity in purchase of service expenditures.<sup>32</sup> Under this contractual obligation, DDS should require regional centers to assess all their cases with no POS to determine the cause for the lack of POS receipt and report their findings to DDS for public dissemination. In the course of this assessment, categories should be created to help clarify the basis for the consumer not receiving any services, including:

- the consumer's needs have been overlooked or neglected by the regional center;
- the consumer has a pending appeal with a generic agency over a service that the regional center may also fund but is not funding;
- the consumer does not meet or has not fulfilled the regional center's criteria under its purchase of services guidelines, protocols, and/or assessment tools used to determine service needs;
- barriers to the consumer's utilization of authorized services exist, such as conflicts in schedules of availability, transportation needs, or lack of bilingual and/or culturally appropriate providers;
- no services have been offered to the consumer by the regional center;
- significant amount of tracked time has lapsed between the consumer's request for the service to the provision of the service;
- all of the consumer's needs are being met elsewhere by generic agencies;
- consumer has declined services and wishes to retain case management services only.

These assessment reports should be done at least quarterly to measure progress towards alleviating cases where lack of POS receipt was avoidable and to better identify barriers attributable to lack of resources. DDS should make these reports publicly available.

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30 California Welfare and Institutions Code § 4629.5(b)(7).

31 California Welfare and Institutions Code § 4501.

32 California Welfare and Institutions Code § 4629(c)(1)(A)(iv).



## CONCLUSION AND NEXT STEPS

DDS has stated it anticipates the regional centers, working within existing resources, will substantially reduce disparities.<sup>33</sup> Our findings indicate that the opposite has primarily happened, as many disparities have only gotten worse over time.

It is past time for the state to adopt more fundamental changes to address funding inequities that are only increasing as the consumer population served by regional centers continues to diversify. During these times, reducing disparities in the funding of critical, life-altering developmental services is now more important than ever. We strongly urge the state's legislative and executive administration leadership to pursue the recommendations in this report.



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33 See page 2 of DDS' Background and Process for Developing Disparity Measures here: [dds.ca.gov/wp-content/uploads/2019/03/Disparities\\_BgProcessDevelopingDisparityMeasures\\_20190329.pdf](https://dds.ca.gov/wp-content/uploads/2019/03/Disparities_BgProcessDevelopingDisparityMeasures_20190329.pdf).

# ACRONYMS

ARCA .....	Association of Regional Center Agencies
CBO .....	Community-Based Organization
DDS .....	Department of Developmental Services
DFEH.....	Department of Fair Employment and Housing
IPP .....	Individual Program Plan
POS .....	Purchase of Services

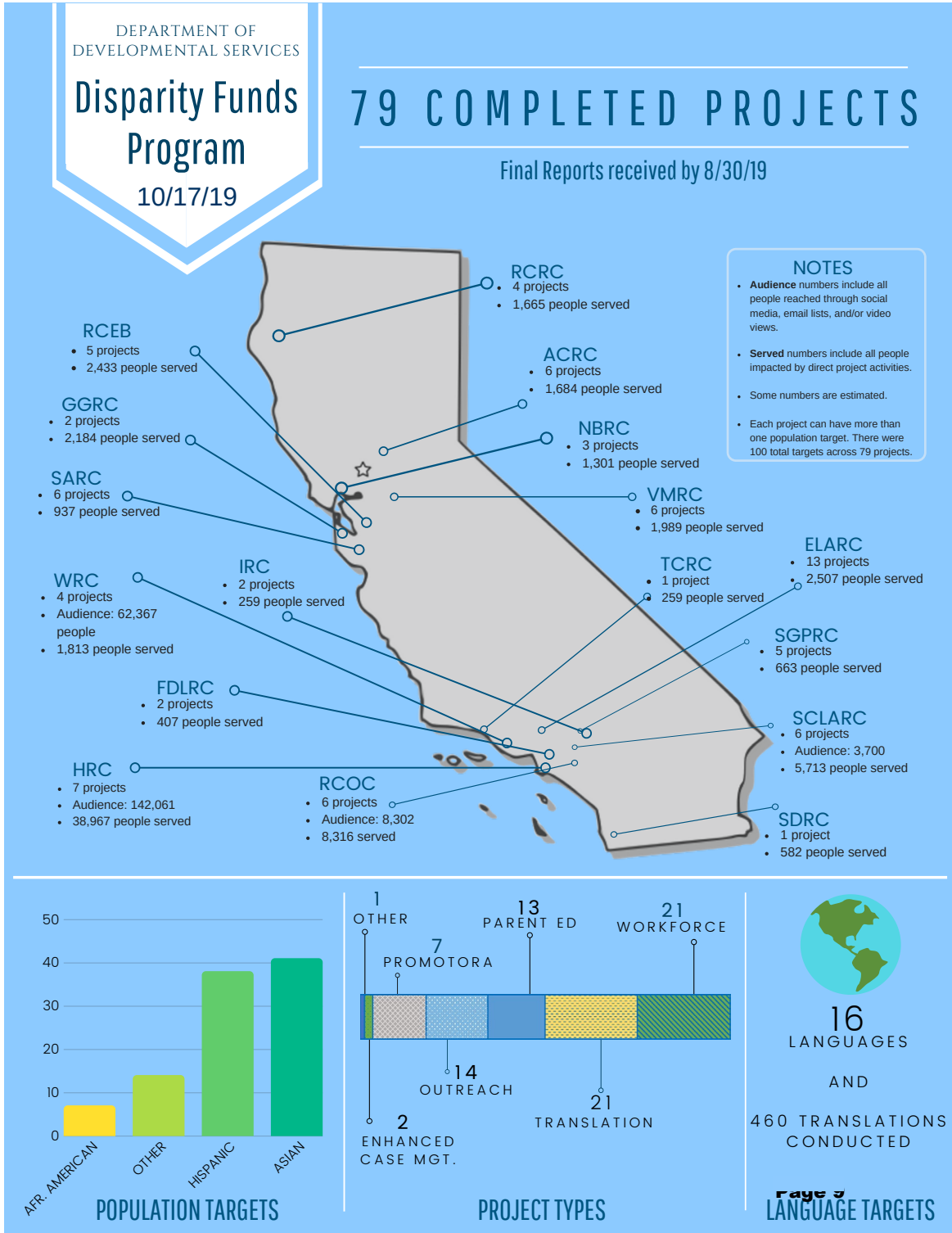
## REGIONAL CENTERS

ACRC .....	Alta California Regional Center
CVRC .....	Central Valley Regional Center
ELARC.....	Eastern Los Angeles Regional Center
FNRC .....	Far Northern Regional Center
GGRC .....	Golden Gate Regional Center
HRC .....	Harbor Regional Center
IRC.....	Inland Regional Center
KRC.....	Kern Regional Center
LRC.....	Frank D. Lanterman Regional Center
NBRC.....	North Bay Regional Center
NLACRC.....	North Los Angeles County Regional Center
RCEB .....	Regional Center of the East Bay
RCOC.....	Regional Center of Orange County
RCRC .....	Redwood Coast Regional Center
SARC.....	San Andreas Regional Center
SDRC .....	San Diego Regional Center
SCLARC.....	South Central Los Angeles Regional Center
SGPRC.....	San Gabriel Pomona Regional Center
TCRC .....	Tri-Counties Regional Center
VMRC .....	Valley Mountain Regional Center
WRC.....	Westside Regional Center

# APPENDIX A

## DDS' DISPARITY REDUCTION PROJECTS

APPENDIX A, FIGURE 1



# PROJECT OUTCOME HIGHLIGHTS

## WORKFORCE

(Bilingual Staff)




**97 FAMILIES**  
Served by new bilingual staff

### SUCCESS STORIES

"Having Spanish translators helped her understand her son and she is very grateful for the program."

## TRANSLATION

**16**  **LANGUAGES**

**1,613 PEOPLE**   
USED NEW TRANSLATION EQUIPMENT


 **35,303 COPIES**  
DISTRIBUTED


655 DOWNLOADED OR POSTED ONLINE

### SUCCESS STORIES

"Families have consistently reported to us that they appreciate having this information available to them in their own written language."

## PARENT EDUCATION

 **2,075** PARENTS TRAINED  
69 WORKSHOPS

 **977**  
USED OR VIEWED MATERIALS ONLINE

Armenian, Cambodian, Cantonese, Japanese, Korean, Mandarin, Spanish, Vietnamese

## WORKFORCE

(Training)



**133 WORKSHOPS**  
**6,675 ATTENDEES**  
**4,077 RC STAFF**

 **10**  
DIFFERENT TOPICS RELATED TO CULTURAL SENSITIVITY

### SUCCESS STORIES


"The training motivated me to improve the quality of my meetings and relationships with clients and their families."

## OUTREACH

  
**18,179 REACHED**  
**140 EVENTS**

Chinese, Filipino, Hispanic, Native American, Korean, Vietnamese

## PROMOTORA

 **12**  
COMMUNITY COLLABORATIONS

**725** FAMILIES RECEIVING INTENSIVE SUPPORT

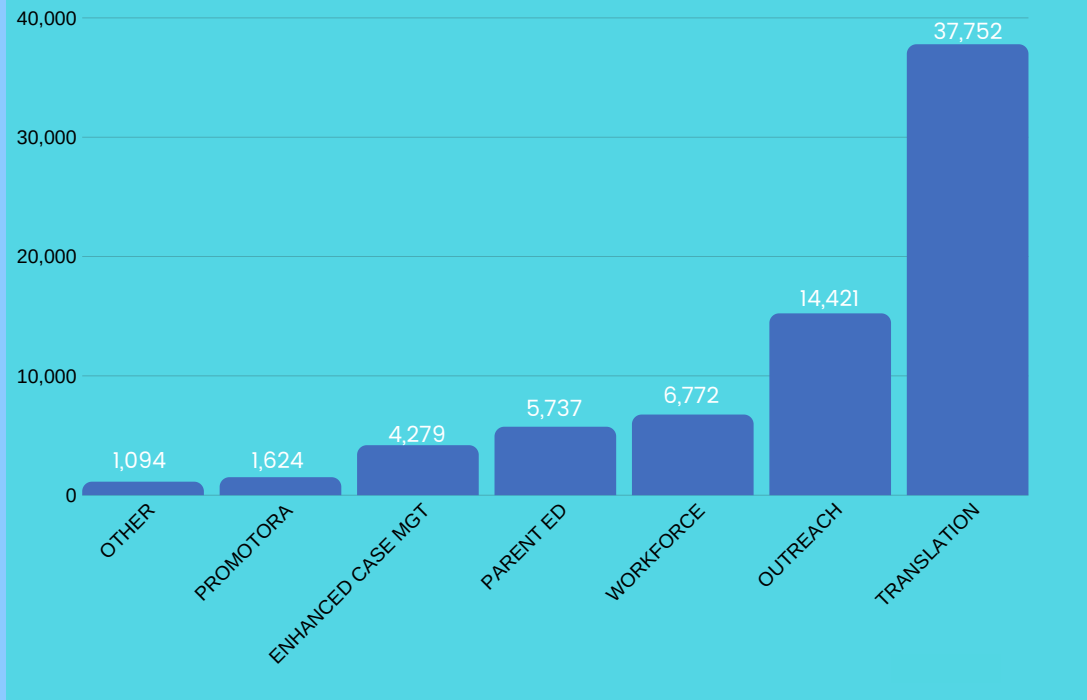
 **113** PARENTS ATTENDING SUPPORT GROUPS

  
**SUCCESS STORIES**  
"It's amazing to ask for help and have someone respond without so much bureaucracy."

## STATEWIDE HIGHLIGHTS



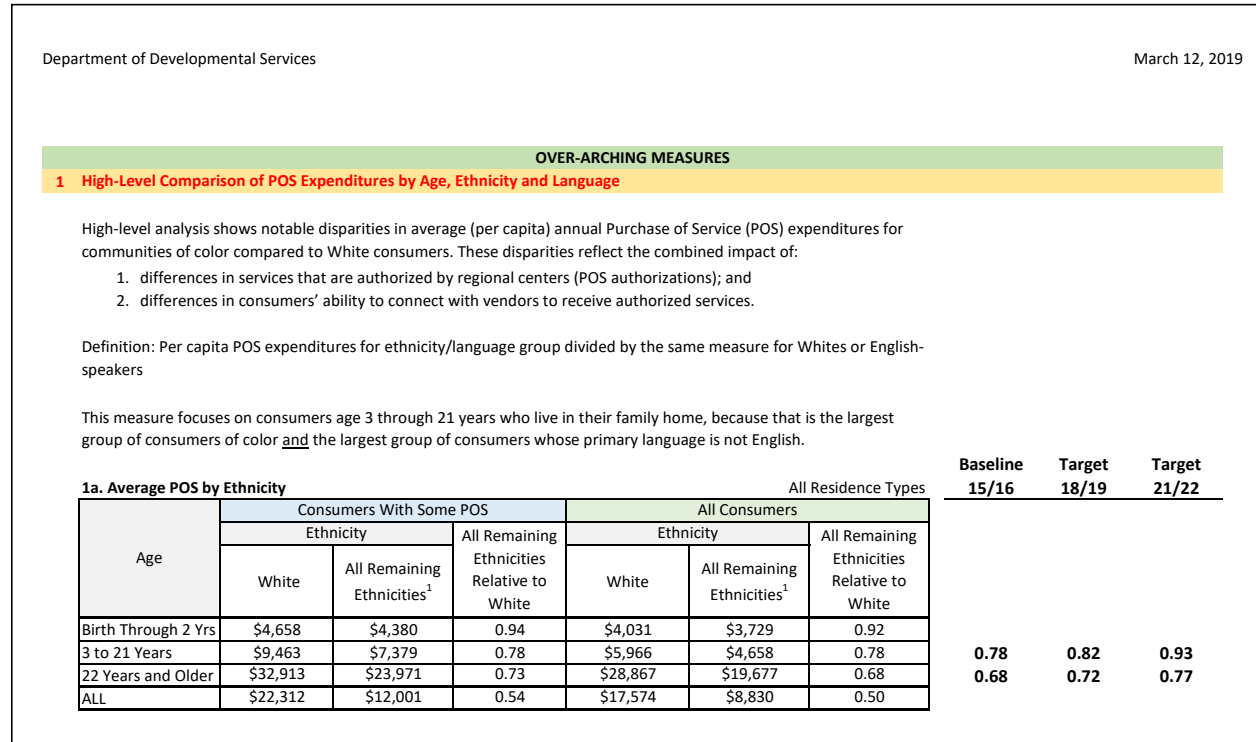
### NUMBER OF PEOPLE SERVED (EXCLUDES ELECTRONIC OUTREACH)



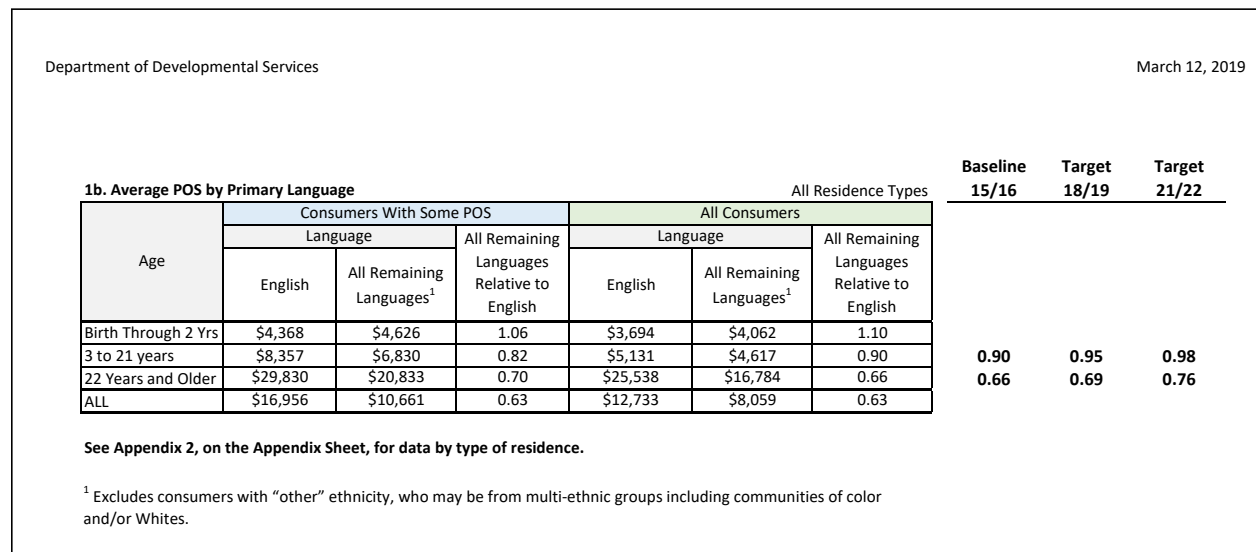
# APPENDIX B

## DDS' DISPARITY REDUCTION MEASURES (EXCERPTED)

APPENDIX B, FIGURE 1



APPENDIX B, FIGURE 2



## APPENDIX B, FIGURE 3

Department of Developmental Services

March 12, 2019

### YOUTH

#### 5 POS Equity FOR DISCUSSION PURPOSES

Youth in the RC system may access most of their services through generic resources such as the school system; their average POS expenditures may be low compared to those of adults. However, significant differences exist among ethnic groups even in this age population. Disparities that begin among youth may compound as consumers age.

Definition: Average POS expenditures for Hispanic youth divided by the same measure for White youth.

Among consumers age 3 to 21 years who live in their family home, Hispanics have the largest gap in average POS expenditures compared to Whites. Hispanics have lower POS expenditures than Whites for nearly all service categories.

#### 5. Average POS

Ethnicity	Average POS		Each Ethnicity Relative to Whites	
	Youth With Some POS	All Youth	Youth With Some POS	All Youth
African American	\$8,041	\$4,851	0.94	0.87
Asian	\$8,775	\$5,794	1.02	1.04
Hispanic	\$7,329	\$4,765	0.85	0.86
Other	\$8,128	\$5,151	0.95	0.93
White	\$8,579	\$5,548	--	--
ALL	\$7,948	\$5,125	--	--

Baseline 15/16	Target 18/19	Target 21/22
0.94	0.90	0.97
0.85	0.90	0.97

## APPENDIX B, FIGURE 4

Department of Developmental Services

March 12, 2019

### AGES 3 YEARS AND OLDER

#### 9 Equity for Language Diversity

Families who do not speak, read and write English may have difficulty learning about RC services, providing required information, advocating for needed services that have not been authorized or finding service providers they can communicate with easily. This may reduce their access to services. POS data show that consumers whose primary language is not English access fewer services than English-speaking consumers.

Definition: Per capita POS expenditures for the three most common language groups other than English divided by the same measure for English-speakers

Target population: Consumers with active status of all ages in all residence types

This measure compares consumers in the four largest language groups among RC consumers: Chinese, English, Spanish and Vietnamese.

#### Per capita POS by Language

##### 9a. Age 3 to 21 years

Primary Language	Living in family home			
	Consumers With Some POS		All Consumers	
	Average POS	Each Language Relative to English	Average POS	Each Language Relative to English
Chinese	\$9,974	1.22	\$7,149	1.39
English	\$8,191	--	\$5,157	--
Spanish	\$7,095	0.87	\$4,859	0.94
Vietnamese	\$9,155	1.12	\$6,521	1.26
ALL	\$7,934	--	\$5,116	--

Baseline 15/16	Target 18/19	Target 21/22
0.87	0.91	0.98

# APPENDIX C

## METHODOLOGY AND APPROACH

The data analyzed for this report was taken from the following regional centers' sub-reports:

- Total Annual Expenditures and Authorized Services by Ethnicity or Race
  - Fiscal Years 2015-2016 through 2018-2019
- Total Annual Expenditures and Authorized Services by Language
  - Fiscal Years 2015-2016 through 2018-2019
- Total Annual Expenditures and Authorized Services by Ethnicity or Race for Residence Type: Home
  - Fiscal Years 2015-2016 through 2018-2019<sup>34</sup>
- Total Annual Expenditures and Authorized Services by Language for Residence Type: Home
  - Fiscal Years 2015-2016 through 2018-2019
- Consumers with No Services by Ethnicity or Race
  - Fiscal Years 2015-2016 through 2018-2019
- Consumers with No Services by Language
  - Fiscal Years 2015-2016 through 2018-2019

Data taken from the online reports were placed onto Excel spreadsheets and checked multiple times for input accuracy. Percentages derived from the regional centers' data reports through Excel computations were rounded up or down to the nearest whole number.

The main sets of analyses included in this report are:

- Per capita POS authorizations by race/ethnicity for children ages 3 through 21 living in their home, for Fiscal Years 2015-2016 through 2018-2019
- Per capita POS authorizations for English-speaking and Spanish-speaking children ages 3 through 21 living in their home, for Fiscal Years 2015-2016 through 2018-2019
- Per capita POS expenditures by race/ethnicity and language for children ages 3 through 21, for all children and for just those children who received some POS, for Fiscal Years 2015-2016 through 2018-2019
- No POS by race/ethnicity and language for children ages 3 through 21, for Fiscal Years 2015-2016 to 2018-2019

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<sup>34</sup> WRC's report for 2018-2019 is missing the sub-report entitled: "Total Annual Expenditures and Authorized Services by Ethnicity or Race for Resident Type: Home." Instead, WRC provided a different sub-report entitled: "Total Annual and Authorized Services for Consumers Living at Home by Ethnicity or Race." The data from this latter sub-report is slightly different and the organization of the data differs on how race/ethnicity is listed.



### **Analyzing Per Capita Authorizations by Race and Language**

We compiled the regional centers' per capita authorizations by race and language for ages 3 through 21 and compared them among the four main race/ethnicity groups: White, Black/African-American, Hispanic, and Asian, and between English-speaking and Spanish-speaking consumers. Additionally, we compared the regional centers' per capita authorizations with statewide averages to determine whether each regional center fell above or below the statewide averages for these categories. For the statewide averages, we divided the relevant total POS authorization amounts for all regional centers by the relevant total consumer counts, for all fiscal years.

### **Analyzing Per Capita Expenditures by Race and Language According to Actual Receipt of Services**

In analyzing per capita expenditures according to actual receipt of services, we used the consumer data from the regional centers' "Total Annual Expenditures and Authorized Services by Ethnicity or Race" and "Total Annual Expenditures and Authorized Services by Language" sub-reports for Fiscal Years 2015-2016 through 2018-2019, not the more discrete sub-reports reporting according to the residence type of home. This is because when recalculating the total expenditures, we excluded consumers with no POS, as reflected in the regional centers' "Consumers with No Services by Ethnicity or Race" sub-reports, and thus we needed to have matching total consumer counts between the sub-reports.

We divided the total expenditures amounts for the race/ethnicity and language subgroups by only those consumers within these subgroups who received some POS to produce our findings. We compared the difference between our derived per capita expenditures amounts with the per capita expenditures amounts being attributed to all consumers, as reported in the regional centers' reports.

### **Analyzing Deprivation of Services**

We compiled the regional centers' percentages of consumers with no POS by race and language for ages 3 through 21 and compared them among the four main race/ethnicity groups: White, Black/African-American, Hispanic, and Asian, and between English-speaking and Spanish-speaking consumers. Additionally, we compared the regional centers' percentages of consumers with no POS with statewide averages to determine whether each regional center fell above or below the statewide averages for these categories. For the statewide averages, we divided the relevant total percentages of consumers with no POS for all regional centers by the relevant total consumer counts, for all fiscal years.

## APPENDIX D

### DATA REPORTING REQUIREMENTS AND COMPLIANCE

DDS and the regional centers are statutorily required to annually collaborate to compile data in a uniform manner relating to purchase of service authorization, utilization, and expenditure by each regional center.<sup>35</sup> Regional centers must post this data on their websites by December 31 each year, disaggregated by race/ethnicity, language, age, disability and residence type, and regional centers must maintain all their previous years' data on their websites. The data must also include the number and percentiles of individuals, categorized by age, race or ethnicity, and disability, and by residence type, who have been determined to be eligible for regional center services, but are not receiving purchase of service funds.

DDS is also required to maintain all previous years' data from each regional center on its Internet Web site.

### DDS AND THE REGIONAL CENTERS' ARE OUT OF COMPLIANCE WITH THE DATA REPORTING REQUIREMENTS

Review of all 21 regional centers' online data reports indicates that DDS and the regional centers are not in compliance with the statute's uniformity requirement and that certain reports are missing, incomplete, inaccurate and inaccessible.<sup>36</sup> The following issues were identified:

#### Missing Reports

- For FY 2011-2012, 2012-2013, and 2013-2014, SDRC has substituted the data reports for its own inter-agency reports to DDS, summarizing just excerpts of certain data from its data reports. Reports to DDS are not substitutes for the data reports themselves, which are required to be posted online. SDRC should either post its full data reports for these years or post a statement online acknowledging their omissions if it does not have these reports.
- Fiscal Year 2011-2012 data reports are not online for GGRC, IRC, and SARC. These regional centers should either post their full data reports for these years or post a statement online acknowledging their omissions if they do not have these reports.

#### Incomplete Reports

- WRC's report for 2018-2019 is missing the sub-report entitled: "Total Annual Expenditures and Authorized Services by Ethnicity or Race for Resident Type: Home." Instead, WRC provided a different

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35 California Welfare and Institutions Code § 4519.5

36 The regional centers' websites were last visited on May 25, 2020 to review data reporting compliance.

sub-report entitled: “Total Annual and Authorized Services for Consumers Living at Home by Ethnicity or Race.” The data from this latter sub-report is slightly different and the organization of the data differs on how race/ethnicity is listed. WRC should provide the “Total Annual Expenditures and Authorized Services by Ethnicity or Race for Resident Type: Home” report to ensure uniformity among all regional center reports.

- In 2018-2019, only SGPRC is in compliance under the Lanterman Act in reporting the number of instances where a request for a written copy of the individual program plan was not translated into a non-threshold language within 60 days, as required by California Welfare and Institutions Code § 4519.5(a) (6). SGPRC reported this data for Fiscal Years 2015-2016 and 2017-2018, but the 2017-2018 report can only be accessed if one creates an account. Although TCRC has a link for this report for its 2014-2015 data, the link is inactive. All regional centers must post a report similar to SGPRC’s 2018-2019 report to be in compliance with the statute.
- IRC’s report for 2014-2015 only has eight pages of data. IRC should post the full report.
- GGRC’s 2014-2015 report is missing the sub-report: “Total Annual Expenditures and Authorized Services by Language for Residence Type: Home.”
- The 2012-2013 reports by ACRC and NBRC are missing “Consumers with No Services by Language” and these regional centers should repost their reports containing this information.

### **Inaccurate Reports**

- VMRC’s 2018-2019 report (and its prior reports) contains apparent erroneous classifications for its “For ages 22 years and older” and “For All Ages” categories in its sub-reports for race/ethnicity and language. The columns for the per capita expenditures and per capita authorizations data appear to be reversed, with the per capita expenditures being reported greater than the per capita authorizations, thus producing utilization rates exceeding 100% for the over 22 years old and all ages groups. VMRC should make the corrections and resubmit its reports online to ensure accuracy and uniformity with other regional center reports.
- IRC is reporting “Other” under Ethnicity and Race for its 0 through 2 population at a much higher rate than all the other regional centers, currently at 73% in 2018-2019 and up from 65% in 2017-2018. In contrast, LRC only has 4% of its 0 through 2 population classified as “Other” for Fiscal Year 2018-2019. IRC’s “Other” population reporting calls into question the validity of IRC’s data according to ethnicity or race for its 0 through 2 population. DDS should review the manner in which IRC is classifying its 0 through 2 population to determine why IRC’s numbers are so high compared to the other regional centers
- SDRC still has a large percentage of its population classified as “Other,” and this category increased by five percentage points to 31% for ages 0 through 2 in the past fiscal year, which was the largest spike in “Other” aside from IRC noted above. SDRC claims that it is working to reclassify its “Other” consumers into the

other main ethnic subgroups. DDS should review the manner in which SDRC continues to classify its 0 through 2 population to determine why SDRC's numbers have increased again.

- The 2012-2013 report by KRC mislabels its sub-report "Consumers with No Services by Language" with "Consumers with No Services by Residence" instead (pages 18-21 in PDF). KRC should resubmit this report online reflecting the accurate title for this sub-report.

### **Inaccessible Reports**

- DDS' current (as of March 31, 2020) "Regional Center Purchase of Service Data" webpage states: "You may view each regional center's data by selecting from the list on the left." However, DDS' linkage system to the regional centers' websites is inconsistent. Some links provide links to some regional center's web pages containing links to multiple years of reports and some provide links to general transparency and accountability webpages where one must then continue to search to find the data reports.
- DDS' website includes a link to the general "transparency" portal for SDRC. SDRC's reports are not contained on DDS' link to SDRC's general transparency and accountability webpage; rather, one must go to "About SDRC" to access SDRC's POS data. The problem with linking directly to just the current year report or linking to the wrong page is that one must then go separately to the regional center's own website to try to find its purchase of service data, which can be a daunting task, as most regional centers classify the data reports under various categories. Most data reports are maintained under "Transparency", "Accountability" or "Governance" pages that are one or two links removed from the regional center's home page, via intermediary links such as "About Us" or "Information." For example, TCRC's data reports are accessed through an inconspicuously placed "Transparency & Public Info" link in small print at the bottom left of its home page which requires scrolling down to find.
- All of NBRC's reports, with the exception of its 2018-2019 report, suffer from the inability to search within the document itself through the "Control F" function. The reason, unlike the other 20 regional centers, is that NBRC has placed its logo on the upper right hand side and then scanned (poorly) its report for the link. NBRC should pull its reports from prior years and resubmit them without its logo so that they are more easily searchable like their most recent report and all the other regional centers' reports.
- CVRC's 2016-2017 report is also not searchable in PDF through the "Control F" function and CVRC should correct the inaccessibility of this report.

### **Reports Lacking Uniformity**

- For Fiscal Years 2011-2012, 2012-2013, 2013-2014, and 2014-2015, VMRC has created spreadsheets that do not correspond uniformly with the data reports from all the other regional centers. VMRC should reformat its prior reports to be consistent with the format of all the other regional centers and repost them.

- RCEB's report for 2011-2012 contains aggregated data in a different format that is difficult to understand and to make meaningful comparisons with other reports, including its own subsequent reports. RCEB should reformat its 2011-2012 report and repost it.
- If reports continue to be posted as one full document, they should not begin with the regional centers' Total Annual Insurance-Related reports. These reports are ancillary and do not pertain to all consumers generally. Total Annual Insurance-Related reports should be at the end of the full report document so that the public reviewing these reports do not have to sift through documents that may not pertain to them.

## CONCLUSION

DDS' own compliance with the Lanterman Act's data reporting requirements is largely dependent on whether the regional centers themselves are in compliance, because DDS is simply providing direct links to the regional centers' webpages instead of maintaining its own online repository for these reports. DDS should carefully review its linkage system and collaborate further with the regional centers to ensure their statutory compliance with the data reporting requirements. Further, DDS should develop a manner for the public to access all of the regional centers' reports in a more consistent and accessible way, per the above observations and recommendations.