Evaluating California's System for Serving Infants and Toddlers With Special Needs

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Executive Summary

California Serves More Than 40,000 Infants and Toddlers With Special Needs. In 2015-16, California provided early intervention services to about 41,000 infants and toddlers with special needs. These infants and toddlers either have a disability (such as a visual or hearing impairment) or a significant developmental delay (such as not beginning to speak or walk when expected). The state's early intervention system provides these infants and toddlers with services such as speech therapy and home visits focused on helping parents promote their child's development. Parts of California's early intervention system date back more than 35 years. During this time, the state has not regularly, or even periodically, evaluated this system. In this report, we provide a comprehensive assessment of the system.

Background

Services Are Provided Through Three Programs. California's plan for serving infants and toddlers with special needs involves three programs operated by two types of local agencies.

- ***Regional Centers' Early Start Program.*** Regional centers are the main provider of early intervention services in California. These centers are nonprofit agencies overseen by the Department of Developmental Services. In addition to their original mission—coordinating community-based services for adults and school-aged children with developmental disabilities—regional centers coordinate services for about 33,500 infants and toddlers with special needs.
- ***Schools' Legacy Program.*** The state also provides early intervention funding for 97 schools that have a long legacy of providing early intervention services. The state funds these schools to serve the same number of infants and toddlers as they served when they first received state funding back in the 1980s—about 5,000.
- ***Schools' Hearing, Visual, and Orthopedic Impairments (HVO) Program.*** Although regional centers are required to serve most infants and toddlers not served in the school legacy program, schools are required to serve infants and toddlers who have solely HVO impairments and no other eligible condition. Schools currently serve about 2,500 infants and toddlers with HVO impairments, of which about 1,500 are served in the school HVO program and 1,000 are served in the legacy program.

State Provides Most Funding for Early Intervention Services. Although services are required as a condition for receiving a federal early intervention grant, this grant covers a relatively small portion (about $50 million, or 10 percent) of associated service costs. State funding covers the bulk of service costs (about $370 million, or 77 percent), with other fund sources (such as health insurance billing) covering the remainder of costs (about $60 million, or 13 percent).

Schools and Regional Centers Provide Similar Services Using Different Delivery Models. Although federal law outlines a general process both schools and regional centers must follow in serving infants and toddlers with special needs, the two types of agencies use notably different service delivery models. Specifically, schools tend to employ their own service providers (such as speech therapists), whereas regional centers coordinate services offered by independent service providers.

Assessment

Important Differences Between Schools and Regional Centers. Although considerable overlap likely exists in the populations served by the two types of agencies, schools spend much more per child than regional centers (about $16,000 as compared to about $10,000). Additionally, regional centers tend to offer parents more choice among service providers. Finally, regional centers are better equipped to help parents access public or private insurance coverage.

California's Bifurcated System Likely Causes Service Delays. Because California's system is divided between three programs and two types of agencies, parents and agency staff are frequently confused as to which program is responsible for serving each child. Moreover, California lags nearly all states in providing timely services. Many infants and toddlers wait weeks or even months before being placed in the appropriate program, during which time they do not receive services. California also performs worse than other states in facilitating transition from early intervention services to preschool special education. Based upon our conversations with stakeholders, we believe these preschool delays likely result from some regional centers struggling to coordinate with schools.

Recommendations

Unify All Services Under Regional Centers. Given the shortcomings of California's bifurcated system, we recommend the state unify the system under one lead agency. Compared to California's existing system, a unified system likely would provide more timely services and provide more equal funding for each child served. Given how the state's early intervention system has evolved over the past 35 years, we believe regional centers currently are better positioned than schools to serve in this lead capacity. Specifically, regional centers already serve the vast majority of infants and toddlers with special needs, provide more parental choice, and are better equipped to access public and private insurance billing.

Establish a Transition Plan. We recommend the state develop a plan to help ensure continuity of services for families during the transition to a unified system. As part of the transition plan, we recommend the state allow regional centers some flexibility in contracting with schools to continue serving some infants and toddlers. We also recommend the regional centers develop transition plans for serving infants and toddlers who are deaf or hard of hearing. In addition, we recommend the state require regional centers to follow established best practices to ensure smooth transitions to preschool.

New System Would Produce State Savings. Though we recommend transitioning to a new system for the direct benefits it would have for infants and toddlers with special needs, a unified system under the regional centers also would generate state savings. We estimate savings in the range of $5 million to $35 million. The state could repurpose these savings for any budget priority or use them to expand or enhance early intervention services (for example, by conducting more outreach or raising associated reimbursement rates).

INTRODUCTION

In 2015-16, California provided early intervention services to about 41,000 infants and toddlers with special needs. These infants and toddlers either have a disability (such as a visual or hearing impairment) or a significant developmental delay (such as not beginning to speak or walk when expected). California's early intervention system consists of three programs administered by two types of local agencies—schools and regional centers for persons with developmental disabilities. This report provides the first comprehensive analysis of this system since it was established in 1993. The report has three main sections. We first provide background on California's early intervention system, then assess this system, and conclude by recommending several ways to improve the system.

BACKGROUND

Below, we describe the history of early intervention programs in California, the state's current approach to placing infants and toddlers into each of its three programs, what types of services these three programs provide, and how these programs are funded.

Origins of System

Some Schools Have a Long Legacy of Serving Infants and Toddlers With Special Needs. Immediately prior to Proposition 13 (1978), 61 schools were providing services to a small number of infants and toddlers with special needs. (Throughout this paper, we use the term "schools" to refer to both school districts and county offices of education. "Infants and toddlers" refer to children from birth until their third birthday.) These 61 programs were funded by local property tax revenue and established at the discretion of local school administrators. Following the passage of Proposition 13, schools across the state experienced significant reductions in property tax revenue and began eliminating some locally funded programs. To backfill for lost property tax revenue, California in 1980 began providing state funding to the 61 schools already operating early intervention programs. Between 1985 and 1987, California expanded this state funding to an additional 36 schools. The state continues to fund these 97 schools for serving the same number of infants and toddlers they each served when they first received state funding—a total of about 5,000 infants and toddlers statewide. We refer to this state funding for these 97 schools as the school "legacy program" throughout the remainder of this report.

Regional Centers Also Have a Long History of Serving Some Infants and Toddlers With Special Needs. In 1965, the state began developing a network of regional centers to coordinate services for individuals with developmental disabilities. The centers—nonprofit agencies overseen by the Department of Developmental Services (DDS)—were designed as a community-based alternative to state institutions. Originally serving adults and school-aged children with developmental disabilities, regional centers began receiving state funding in 1983 to serve infants and toddlers deemed "at risk" of becoming lifelong consumers of community-based services. Throughout the 1980s, the state provided several rounds of one-time funding to expand these early intervention services. By 1988, regional centers were serving about 6,000 infants and toddlers per year.

In 1993, the State Developed a Plan to Serve All Infants and Toddlers With Special Needs. Starting in the mid-1980s, the federal Individuals with Disabilities Education Act (IDEA) authorized annual grants to states that agreed to identify and serve all infants and toddlers with special needs. California was the last state to apply for this federal program (now known as IDEA Part C), submitting a comprehensive early intervention plan in 1993. Relative to California's early intervention programs before 1993, this comprehensive plan significantly expanded the role of regional centers but required all schools to serve infants and toddlers who had only a hearing, visual, or orthopedic (HVO) impairment. In the first year under this comprehensive plan, regional centers served about 11,000 infants and toddlers with special needs, compared to 6,000 infants

and toddlers being served by schools (5,000 in the legacy program and 1,000 in the new HVO program).

Current System

Under State's Plan, Regional Centers Serve Most Infants and Toddlers With Special Needs. Since 1993, California's early intervention plan has made regional centers the default agency for serving most infants and toddlers with special needs. In 2015-16, the state's 21 regional centers served about 33,500 (82 percent) of the 41,000 infants and toddlers receiving early intervention. Most infants and toddlers served by regional centers have developmental delays, meaning they are significantly behind most children in developing important abilities such as speech or motor skills. A smaller number of infants and toddlers served by regional centers have disabilities such as autism or Down syndrome. The regional centers' early intervention program is called Early Start.

Infants and Toddlers With Only HVO Impairments Are Served by Schools. Although California requires schools to serve infants and toddlers who have only HVO impairments, it does not require schools to serve infants and toddlers who have HVO impairments in combination with any other eligible condition. For example, the state requires schools to serve infants and toddlers who are deaf and have no other eligible condition but requires regional centers to serve infants and toddlers who are both deaf and have a developmental delay. Nearly 25 years after the state developed its early intervention system, the original rationale for this division of responsibilities is somewhat unclear. In conversations with stakeholders, we heard many suggest that schools have a long history of serving older children with HVO impairments and thus were well positioned in 1993 to serve infants and toddlers with similar impairments. Schools currently serve about 2,500 infants and toddlers with only HVO impairments, comprising 8 percent of all infants and toddlers receiving early intervention services. About 1,000 of these 2,500 infants and toddlers are served in the school legacy program, whereas the other 1,500 are served in the school HVO program.

Schools in the Legacy Program Continue to Serve Any Eligible Child. The state continues to fund the 97 schools that have a long legacy of serving infants and toddlers with special needs. Schools in this legacy program can serve any eligible infant or toddler and must serve at least as many infants and toddlers as they served in the mid-1980s (5,000, or 12 percent of all existing infants and toddlers receiving early intervention services). In 2015-16, in addition to serving approximately 1,000 infants and toddlers with only HVO impairments, the legacy program served 4,000 infants and toddlers with other disabilities. Figure 1 summarizes the history of California's three early intervention programs, and Figure 2 illustrates the relative proportions of infants and toddlers currently served in each program.

Schools and Regional Centers Use the Same Process to Develop Individual Service Plans. Both schools and regional centers follow a five-step process outlined in federal law for serving infants and toddlers.

- ***Referral.*** Infants and toddlers typically are referred to a school or regional center by primary care physicians following routine check-ups.
- ***Evaluation.*** Following each referral, school or regional center staff evaluate the child to determine eligibility for early intervention.
- ***Individualized Family Service Plan.*** For each child deemed eligible for services, his or her family meets with staff to develop an individualized family service plan. These plans are reviewed at least once every six months. Typically, these plans include targeted services like weekly speech therapy sessions and regular home visits from an early education specialist who provides support on a wide range of developmental issues.
- ***Identification of Providers.*** Staff identify appropriate providers for the services listed in the plan.
- ***Service Provision.*** Direct service providers travel to each child's home whenever possible, generally providing services alongside the child's parents (or other primary caregiver). This final requirement is intended to ensure parents learn how to promote their child's development as part of their daily routines.

Schools and Regional Centers Use Different Service Delivery Models. Schools typically employ their own early intervention service providers (such as speech therapists), whereas regional centers coordinate services from independent providers. Before directly paying for services, regional centers are required by

Figure 1

California's Early Intervention System Developed Over Many Years

		Before 1980	1980	1983	1985 - 1987	1993 - Current
Schools	Legacy Program	61 districts fund early intervention with local property tax revenues.	State backfills 61 districts for revenue lost due to Proposition 13.		State funds additional 36 districts to provide early intervention.	State continues funding 97 districts to serve any eligible child.
Schools	HVO Program					State requires schools to serve all children with only HVO impairments.
Regional Centers	Early Start			State funds regional centers to serve "at-risk" infants and toddlers.		State requires regional centers to serve all eligible infants and toddlers not served by schools.

HVO = hearing, visual, or orthopedic impairments.

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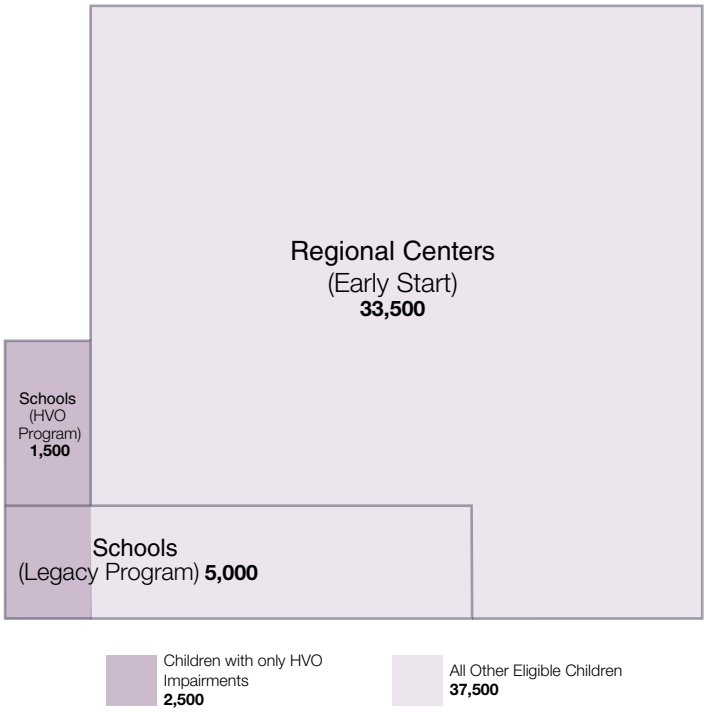
law to first access services paid for by families' health insurance plans, including Medi-Cal and private insurance. Regional center service coordinators typically help families navigate the health insurance system to get early intervention services covered. When a family's insurance network does not provide easy access to a specified early intervention provider (as is frequently the case), regional centers pay for these services with state funding.

In Some Cases, Schools Provide Services Under Regional Center Contracts. Regional centers can contract with any qualified provider of early intervention services. Typically, these providers are either nonprofit organizations specializing in early intervention or independent clinics offering speech therapy, physical therapy, or other specialized services. Regional centers also sometimes contract with schools to provide early intervention services. These schools typically provide the same

Figure 2

Regional Centers Serve Most Infants and Toddlers With Special Needs

2015-16



HVO = hearing, visual, or orthopedic impairments.

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services to infants and toddlers served under regional center contracts as they provide to infants and toddlers served in the legacy program. In 2015-16, regional centers contracted with a total of 18 schools to provide $13 million of early intervention services.

Federal Law Requires Administering Agencies to Initiate Services Soon After Referral. Under IDEA, schools and regional centers must develop an initial individualized family service plan no later than 45 days after each child's referral. They must begin services no later than 45 days after development of the initial service plan. These requirements are intended to ensure eligible children do not fall even further behind their peers while waiting to receive early intervention. All states must annually report their compliance with these deadlines to the federal government, which uses such data to evaluate the performance of each state's early intervention system.

Some Children Transition to Preschool Special Education Upon Turning Three. Many children receiving early intervention show significant progress and are determined to no longer require special supports at age three. For example, some infants who have not spoken their first words by 18 months and are diagnosed with initial communication delays overcome those issues by age three. Some three year olds, however, have more serious and lingering disabilities (such as visual impairments or autism). About 45 percent of children served by California's early intervention system qualify for special education at age three. To ensure a seamless transition from early intervention to preschool services, the federal government requires early intervention providers to work with each child's school to develop a transition plan no later than 90 days before his or her third birthday. As with the deadlines for initial service delivery, all states must annually report their compliance with this transition deadline.

Some Children Become Lifelong Consumers of Regional Center Services. At age three, regional centers assess children to determine if they are eligible for ongoing services through DDS (unless parents do not want their child assessed). To be eligible, children must have a developmental disability that is substantial in nature and expected to continue indefinitely. Qualifying disabilities are autism, epilepsy, cerebral palsy, intellectual disability, or other disabling condition similar to intellectual disability or that requires similar treatment. Statewide data show about 20 percent of children who receive early intervention go on to become active DDS consumers. (Most of these children also qualify for preschool special education.)

Funding

State Funds Most Early Intervention Services. Figure 3 shows state and federal funding in 2015-16 for early intervention services in California. Across the three early intervention programs, the state provided $367 million (88 percent), whereas the federal government provided $50 million (12 percent).

Most Early Start Provider Rates Are Determined by State Policy. Prior to 2003, DDS set a range of allowable rates for providers of most Early Start services. Within the allowable range, regional centers set a specific provider's rate based on that provider's documented costs. (Although schools providing Early Start services under regional center contracts were

Figure 3

State Funds Most Early Intervention Services[a]

LAO Estimates for 2015-16 (In Millions)

Program	Amount
Regional Centers: Early Start	
State Non-Proposition 98 General Fund	$289.8
Federal IDEA Part C Grant	35.9
Subtotal	($325.7)
Schools: Legacy Program	
State Proposition 98 General Fund	$74.8
Subtotal	($74.8)
Schools: HVO Program	
Federal IDEA Part C Grant	$14.2
State Proposition 98 General Fund	2.4
Subtotal	($16.6)
Total	**$417.1**

[a] Does not include (1) Early Start services billed to Medi-Cal and private insurance; (2) Early Start services reimbursed by federal Early Periodic Screening, Diagnosis, and Treatment funding; or (3) general purpose K-12 funds locally repurposed to support school-based early intervention.

HVO = hearing, visual, or orthopedic impairments and IDEA = Individuals with Disabilities Education Act.

not subject to these allowable ranges, their rates were similarly based on each school's documented costs.) Starting in 2003, the Legislature effectively froze rates for existing providers and capped rates for new providers at the statewide average rate for existing providers. Since 2003, most Early Start rate increases have been due to increases in the statewide minimum wage. These rate policies do not apply to speech, physical, or occupational therapists, each of which receive a uniform statewide rate equal to the Medi-Cal rate for such services. Since 2003, Medi-Cal rates for these types of therapists have been largely unchanged.

Before Using Early Start Funds, Regional Centers Determine if Insurance Coverage Is Available. State law requires regional centers to help families access services covered by their private or government-sponsored health insurance plans before using state funding to pay for early intervention services. Despite this requirement, we estimate relatively few early intervention services are paid for by insurance. Specifically, we estimate Medi-Cal provides about $40 million annually for early intervention, and private health insurance provides less than $20 million annually. By comparison, regional centers provide about $325 million annually from state and federal funding for Early Start.

State Funds School-Based Programs Using Two Funding Formulas. As detailed in the nearby box, the state maintains one formula to fund the legacy program and another to fund the HVO program. Compared to Early Start, neither program receives notable reimbursements from third-party insurance. Though state law does not prohibit schools from accessing such funding, available data indicate insurance covers less than 1 percent of school-based early intervention costs.

Schools Supplement Early Intervention Funding With Locally Repurposed K-12 Funding. School expenditure data show that state and federal early intervention funding is insufficient to cover the full cost of school-based programs. Consequently, schools cover some early intervention costs with a combination of K-12 general education funding (mostly from the Local Control Funding Formula) and K-12 special education funding. We estimate schools cover between $5 million and $10 million annually in early intervention costs with repurposed K-12 funding.

Funding for School Programs

Legacy Program Funded Through Complicated Formula. Since 1980, schools in the legacy program have been funded using a formula originally developed for K-12 special education. The formula is linked to the estimated cost of specific K-12 special education services. For example, schools receive one rate for special day classrooms serving only students with special needs and another rate for serving students with special needs in mainstream classrooms. Each district receives a unique rate per special education service based on a statewide survey of special education costs conducted in 1979-80, with cost-of-living adjustments. Importantly, the state no longer uses this formula to fund K-12 special education, having adopted a simpler and more flexible funding formula in 1998. Though the state continues to use the more dated and complicated formula to fund early intervention, stakeholders have long argued the formula is a poor proxy for the cost of these services. More than 30 years have passed and the formula remains unaltered.

HVO Program Has Been Flat-Funded for Two Decades. School hearing, visual, or orthopedic (HVO) programs have received no funding increases since 1996-97. Rather, state and federal funding has remained constant at $16.6 million even as the total number of infants and toddlers with only HVO impairments has increased from about 1,500 in 1996-97 to about 2,500 today. Because state and federal funding has not kept pace with increasing service costs, HVO programs likely rely more heavily on locally repurposed K-12 funding than legacy programs.

ASSESSMENT

Below, we compare the programs run by schools and regional centers, assess the timeliness of service planning and delivery, and examine how smooth the transition is from early intervention services to preschool special education services.

Comparing the Two Types of Agencies

Likely Considerable Overlap in Populations Served by Schools and Regional Centers. In theory, the state intended schools to serve mostly infants and toddlers with HVO impairments, whereas regional centers would serve most other types of infants and toddlers. In practice, we think the populations served by each agency overlap notably. Specifically, based on available school data, we extrapolate that regional centers serve as many as 45 percent of all infants and toddlers with HVO impairments. Regional centers likely serve such a high share of these children because the state plan requires them to serve infants and toddlers who have HVO impairments in combination with any other eligible condition. At the same time, because schools in the legacy program can serve any eligible child, statewide school data indicate nearly 60 percent of all infants and toddlers served by schools do not have HVO impairments. Though we suspect considerable overlap in the types of children served by regional centers and schools, the regional centers do not compile information on infants and toddlers served by type of disability. Due to this data limitation, whether regional centers, on average, have more or less severe caseload is unknown.

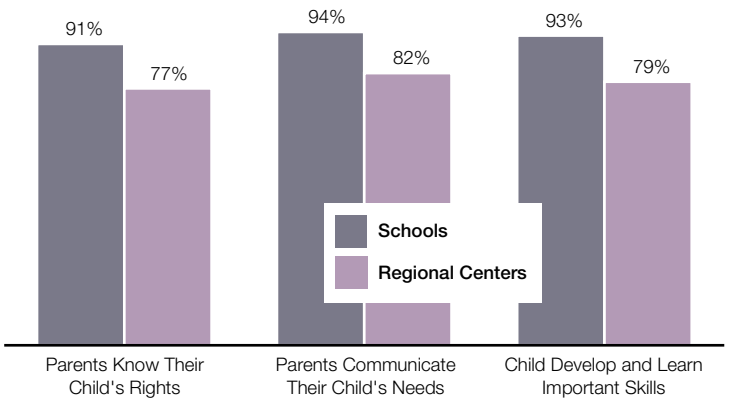
Regional Centers Provide Same Types of Services at Much Lower Cost. To help assess relative cost-effectiveness, we compared the per-child expenditures on early intervention services at schools and regional centers in 2015-16. After accounting for all fund sources, we estimate schools spent 60 percent more than regional centers per child served. Specifically, we estimate schools spent about $16,000 per child whereas regional centers spent about $10,000 per child. Based on conversations with local stakeholders and a review of the available data, we believe at least two factors contribute to this large cost difference. First, schools typically pay service providers for travel time and cancelled appointments whereas regional centers do not. Second, schools are more likely to provide services through credentialed teachers, who tend to be better compensated than other early education specialists. The available data do not allow us to determine what share, if any, of the cost difference is due to schools possibly serving infants and toddlers with more severe disabilities. Comparative data on the number of services provided per child are also unavailable, so we could not determine the extent to which that factor might be driving cost differences.

Parents Largely Satisfied With Both Agencies. Figure 4 shows the results of a parental satisfaction survey conducted in 2011-12. Large majorities of parents reported being satisfied along three different service dimensions, regardless of which agency served them. A somewhat larger share of parents served by schools, however, expressed satisfaction than those served by regional centers.

Figure 4

Parents Largely Satisfied With Both Schools and Regional Centers

2011-12[a], Percentage Reporting Early Intervention Agency Helped . . .



[a] The only year for which these data are disaggregated for parents served by each type of agency.

Regional Centers Offer More Parental Choice Than Schools. Parents served in school programs typically cannot choose their early intervention service providers. They must accept services from the school's own employees. By contrast, parents served by regional centers often have a choice of several providers. This could be one reason parents served by regional centers are nearly as satisfied with their services as parents served by schools, despite schools spending notably more per child.

Regional Centers Are Better Equipped to Help Parents Access Medi-Cal and Private Insurance. Parents served by schools rarely bill Medi-Cal and almost never bill private insurance for early intervention, meaning the state must pick up nearly the entire cost of school-based programs. By comparison, regional centers are more accustomed to working with families to access third-party insurers, which produces state savings.

Service Deadlines

Timely Service Delivery Is Crucial in Early Intervention. Children develop rapidly during their first three years, such that babies developing just a few days behind their peers can quickly grow into toddlers several months or even a year behind. Concerned that such widening gaps might result in long-run academic challenges, the federal government sets deadlines for providing early intervention services.

California's Bifurcated System Likely Causes Service Delays. Families and early intervention staff often have difficulty determining whether schools or regional centers are responsible for serving a particular infant or toddler. For example, a toddler who is orthopedically impaired will typically be served in the school HVO program, unless he or she also has a developmental delay, in which case he or she will typically be served by a regional center. However, if this toddler resides near a school receiving legacy program funding, he or she typically receives school services, unless the school has already filled its legacy program capacity, in which case he or she can only be served by a regional center. Determining an infant or toddler's placement can sometimes take days or even weeks, thereby delaying services.

California Lags Other States in Providing Timely Services. Figure 5 compares California's performance in meeting federal early intervention service deadlines with other states. Though most states comply with these deadlines more than 95 percent of the time, California complies less than 85 percent of the time. One of the few states to perform worse than California on these measures, South Carolina, is also the only other state we could identify that divides its early intervention system between two state agencies. (South Carolina ranks last nationally in meeting both deadlines.)

Preschool Transition

California Performs Worse Than Other States in Facilitating Transition to Preschool. Figure 6 (see next page) compares California's performance to that of other states with regard to meeting federal deadlines for transitioning children from early intervention to preschool special education. As with the deadlines for initial service delivery, California lags behind the large majority of states at key transition phases. In particular, California lags far behind other states in notifying schools of children who are receiving early intervention services and soon to turn three. When schools are not notified ahead of time, they cannot participate in developing transition plans (which are then developed solely by the regional centers), likely resulting in less seamless transitions.

Transition Challenges Likely Due to Poor Regional Center Practices. Unlike with early intervention, agencies have no confusion over who is

Figure 5

California Does Poorly in Meeting Federal Deadlines

Percentage of Children for Which State Completed Activities on Time, 2013-14[a]

	Develop Initial Service Plan	Begin Services
25th ranked state	97.9%	98.3%
40th ranked state	95.1	94.6
California[b]	82.1	82.1

[a] An initial service plan is to be developed within 45 days of referral. Services are to begin within 45 days of developing an initial service plan.

[b] California ranks 46th among the 50 states in meeting the initial service plan deadline and 47th in meeting the begin services deadline.

responsible for serving children in preschool special education—schools always have this responsibility. Consequently, regional centers must coordinate with schools to ensure a smooth transition. Many stakeholders indicate regional centers do not always follow best practices in coordinating these transitions, which likely explains California's weak results relative to other states in meeting federal deadlines.

Figure 6

California Does Poorly in Planning Preschool Transitions

Percentage of Children for Which State Completed Activities on Time, 2013-14[a]

	Notify School	Hold Planning Conference	Develop Transition Plan
25th ranked state	99.7%	98.0%	99.3%
40th ranked state	94.3	90.7	94.4
California[b]	74.5	86.2	91.4

[a] Deadline for all activities is 90 days before child's third birthday.
[b] California ranked 47th among the 50 states in notifying schools about impending transitions, 44th in holding planning conferences, and 47th in developing transition plans.

RECOMMENDATIONS

Below, we make a series of recommendations that if taken together would substantially address the concerns highlighted in the previous section. First, we recommend unifying the state's early intervention system under a single agency. Second, we recommend the state make several changes to ensure a smooth transition to a unified system. Finally, because we anticipate the new system would result in state savings, we briefly discuss options for using these savings to either expand or improve early intervention.

Unify System

Unify System Under a Single Agency. We recommend shifting all major program responsibilities (along with all state and federal early intervention funding) to a single agency. We believe such a unified system would provide families more timely services. A unified system also would simplify state funding allocations and eliminate the current funding differences among the state's three early intervention programs. Additionally, a unified system could offer some families more choice among service providers.

Make Regional Centers Responsible for Serving All Infants and Toddlers With Special Needs. Given how California's system has evolved over the years, we believe regional centers currently are better positioned than schools to run an early intervention system. Regional centers already serve the vast majority of infants and toddlers with special needs. Whereas shifting the approximately 6,500 infants and toddlers currently served by schools to regional centers would increase the regional center Early Start caseload by 19 percent, shifting the approximately 33,500 infants and toddlers served by regional centers to schools would increase the school early intervention caseload by more than 500 percent. Because schools spend notably more than regional centers per child served, shifting all infants and toddlers from schools to regional centers also likely would produce state savings. By contrast, we estimate it could cost as much as $200 million to shift all infants and toddlers from regional centers to schools. Finally, we believe the state can continue to enjoy the benefits of school-based programs (for example, expertise in serving children with HVO impairments) even after shifting all infants and toddlers to regional centers by encouraging more schools to provide services under regional center contracts. Shifting all infants and toddlers to schools, however, likely would undermine the existing benefits of regional center programs, including greater parental choice and third-party billing.

Establish Transition Plan

Encourage Schools to Continue Serving Infants and Toddlers Under Regional Center Contracts. Although we believe regional centers generally are better positioned to oversee a unified early intervention system, schools currently are the only early intervention providers in some rural counties. Moreover, schools tend to have more expertise in serving children with

HVO impairments than other providers. To ensure infants and toddlers who live in rural areas or have HVO impairments continue to receive services, we recommend requiring regional centers during the transition period to contract with schools that currently participate in the legacy and HVO school programs. We further recommend funding regional centers such that they can negotiate higher reimbursement rates for these schools during the transition, as these schools currently receive funding rates that are higher than regional center rates. In the long run, however, we recommend any further rate increases apply equally to both schools and other types of Early Start providers.

Require Regional Centers to Develop Transition Plans for Serving Infants and Toddlers Who Are Deaf or Hard of Hearing. Among disabilities and developmental delays, deaf or hard of hearing seems to arouse the greatest policy controversy regarding appropriate early intervention services. In response to potential concerns about how deaf or hard of hearing infants and toddlers may fare under a unified system, we recommend the Legislature require regional centers to develop specific transition plans for this group. Specifically, we recommend these regional center plans specify the providers they have lined up to serve these children and outline the approach they will use to ensure each child receives appropriate support. We recommend subjecting these plans to review and approval by the California Department of Education's Office for Deaf and Hard of Hearing Students. Such an approach would leverage the department's existing expertise in serving these children.

Establish Best Practices to Improve Preschool Transition. To improve preschool transitions, we recommend the Legislature adopt statute requiring regional centers to exercise a series of best practices. These best practices would include having regional centers develop annual interagency agreements with each school in their service area to specify the general process for handling preschool transitions, identify a specific point of contact at each school for coordinating all transitions, and implement shared data systems to allow both agencies to track children nearing their third birthdays. We believe these recommendations could be accomplished either by reprioritizing existing resources or with a relatively modest increase in regional center funding of no more than $1.5 million.

Repurpose State Savings

Unified System Likely Would Result in State Savings. Though we recommend transitioning to a unified system for the direct benefits it likely would have for infants and toddlers with special needs, such a shift likely also would result in state savings. This is because regional centers are both better equipped than schools to help parents access third-party insurance coverage and tend to pay less than schools for each child served. We estimate shifting all infants and toddlers with special needs from schools to regional centers would save the state between $5 million and $35 million annually. The exact savings would depend on many factors, including how many infants and toddlers continue to be served by schools under relatively generous interim regional center contracts and how many early intervention therapies are billed to third-party insurers. (These savings are contingent upon the state removing current funding from the Proposition 98 minimum guarantee. Precedent exists for rebenching the guarantee in such cases.)

State Could Repurpose Savings to Expand or Improve Early Intervention. The Legislature would have many options for repurposing state savings, ranging from redirecting the savings to other parts of the state budget to putting the savings back into schools or regional centers. If the Legislature wanted to keep the savings within the area of early intervention, it, in turn, would have many options. For example, the state could conduct targeted outreach aimed at identifying and serving more infants and toddlers with special needs or it could raise reimbursements rates. Raising rates likely would help retain existing providers in the system and encourage more providers to participate, which, in turn, would increase parental choice. The Legislature would face difficult trade-offs as they weighed these options. For example, many DDS programs, as well as other state programs, desire higher reimbursement rates.

CONCLUSION

California's early intervention program has notable weaknesses. In particular, its bifurcated design results in service delays and large differences in the amount of funding and parental choice offered to families served by schools and regional centers. We recommend unifying the system and serving all infants and toddlers through regional centers. We believe this unified system would address the system's major weaknesses while generating state savings that could be used to expand or improve early intervention services.

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This report was prepared by Ryan Anderson and Sonja Petek, and reviewed by Jennifer Kuhn and Mark C. Newton. The Legislative Analyst's Office (LAO) is a nonpartisan office that provides fiscal and policy information and advice to the Legislature.

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