



Developing Cost-Efficiency Standards in California's Self-Determination Program

An Evidence-Based Policy Framework

Balancing Program Integrity with Participant Choice and Self-Direction

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Executive Summary

The California Department of Developmental Services (DDS) has expressed concern about outlier hourly rates within certain SDP service codes and is considering a cost-efficiency standard for California's Regional Centers, including the Self-Determination Program. This paper proposes a structured, evidence-based framework for evaluating and developing that standard.

This paper recommends that DDS finalize the required cost-effectiveness definition on schedule, then develop cost efficiency separately, grounded in program data, stakeholder engagement, and evaluation of alternatives. The goal: a framework that strengthens accountability without compromising SDP's foundational principles, participant choice, Budget Authority, and Employer Authority.

Key Findings

- Existing oversight mechanisms already generate substantial auditable data that could support a cost-efficiency evaluation.
- No published analysis has quantified the scope or causes of any statewide cost-efficiency concern.
- Defining cost-effectiveness is a statutory requirement due August 1, 2026; cost efficiency is a separate policy concept without a statutory deadline.
- Rate-based cost-efficiency standards may affect SDP's statutory participant authorities and workforce availability.
- A policy analysis should precede adoption of any statewide cost-efficiency framework.
- Existing oversight data can support targeted review of statistical outliers while broader policy analysis is completed.
- Measuring whether a standard works requires baseline data collected before implementation, so outcomes can be compared before and after.

Background

The Self-Determination Program

In October 2013, Governor Edmund G. Brown Jr. signed SB 468 (Emmerson), creating the Self-Determination Program (SDP) as an alternative to California's traditional, vendor-based regional center model. SDP gives participants and families more freedom, control, and responsibility in choosing services to meet their Individual Program Plan (IPP) goals. Capped at 2,500 participants during its three-year rollout, SDP has been available statewide, voluntarily, to any eligible regional center consumer since July 1, 2021.

Each participant's individual budget is set by their IPP team, generally based on purchase-of-service funds authorized for the prior twelve months or, absent that history, the regional center's identified cost for the service. By statute, spending cannot exceed the certified budget.

SDP within California's Regional Center System

SDP is not separate from the regional center system; it is one of two service-delivery models California's 21 regional centers administer under the Lanterman Act. SDP participants remain regional center consumers, retain all rights under WIC §§ 4502 and 4646–4648, and go through the same person-centered IPP process as the traditional vendored model. They are subject to the same program-integrity requirements, abuse and Special Incident Reporting, background checks, and DDS/regional center audit authority. Neither SB 468 nor WIC § 4685.8 exempts SDP from these safeguards; the statute changes how services are selected and delivered, not the oversight governing them.

SDP differs from the traditional model by granting decision-making authority absent from the vendored system. Under WIC § 4685.8(a)–(b) and California's approved 1915(c) HCBS waiver, participants exercise **Budget Authority** to direct an individualized service budget and may exercise **Employer Authority** to recruit, hire, and manage their own support workers. These authorities are SDP's defining statutory features, operating within, not in place of, existing oversight.

This matters when evaluating proposals to measure SDP cost efficiency against vendored rates. WIC § 4685.8(t) exempts all SDP providers except Financial Management Services (FMS) from Title 17's vendorization requirements, but not from oversight. Nonvendored providers must still meet statutory certification requirements, including licensure, exclusion screening, and DDS-established qualifications. Those delivering direct personal care, and other nonvendored providers when requested by the participant or FMS, must also complete criminal background checks before providing services (WIC § 4685.8(v)).

California's approved HCBS waiver confirms participants aren't limited to vendored providers and may select any qualified provider through the IPP process. A policy measuring SDP cost efficiency

solely against vendored rates therefore compares two different models: one built on standardized, state-set reimbursement, and another the Legislature designed for individualized purchasing authority within its own oversight framework.

Rate Reform and the Vendored System

Separately, DDS has been implementing system-wide “rate reform,” a multi-year effort to restructure vendored-provider reimbursement so the payment system is fair, supports quality care, and helps people access services. DDS's own guidance states that rate reform “is not automatically applied” to SDP budgets, since IPP teams set those individually rather than through the vendored schedule. SDP operates on a fundamentally different budgeting logic than the system rate reform governs.

Existing Program Integrity Framework

Before considering a new cost-efficiency standard, it is worth inventorying the safeguards already in place. SDP is not an unmonitored spending mechanism, it sits inside an extensive, largely federally required system of financial and program-integrity controls, summarized below.

Safeguard	How It Works Today
Mandatory Financial Management Services (FMS)	The only vendored service required of every SDP participant. FMS pays providers and employees directly and issues monthly reports itemizing funds allocated, spent, and remaining.
Individual budget ceiling	A participant's budget is based on what would have been allocated in the traditional system. Without a 12-month authorization history, it defaults to the regional center's average cost unless a documented unique need justifies otherwise. The regional center certifies this budget.
IPP team oversight & spending-plan certification	Every spending plan must align with the IPP's goals. The regional center certifies each plan for federal eligibility, non-duplication of generic resources (e.g., Medi-Cal, IHSS), and alignment to individualized needs before releasing funds.
Appeals and fair hearing rights	SDP participants retain the same appeal, fair-hearing, and due-process rights as consumers in the traditional service model, creating a check on improper budget or service denials in either direction.

Safeguard	How It Works Today
Criminal background checks	Any non-family employee or non-vendored provider furnishing direct personal care must obtain a criminal background check and clearance before beginning work.
Mandated abuse reporting & Special Incident Reports (SIRs)	Vendored providers and FMS entities must file SIRs on incidents they know of or that are reported to them; certain professionals are separately mandated reporters to regional centers and law enforcement.
Independent audits for high-volume vendors	Vendored providers billing a regional center \$500,000 or more annually must submit an independent audit or review (Welfare and Institutions Code § 4652.5).
Electronic Visit Verification (EVV)	Applicable in-home services are subject to EVV, which confirms the time, date, and location that a service was actually delivered.
HCBS Settings Final Rule compliance	All SDP-funded settings must meet federal Home and Community-Based Services quality and integration criteria, reviewed by the regional center.
Quality Incentive Program (QIP)	Ties provider incentive payments to measured performance (health and wellness, employment, participant satisfaction, provider capacity) and requires HCBS, EVV, and audit compliance as eligibility gates.

These mechanisms generate substantial auditable data, FMS reports, Special Incident Reports, independent audits, and appeals records, that could support a cost-efficiency evaluation.

Nor are these safeguards new: the Legislature already directed DDS to develop fraud, waste, and abuse detection practices (WIC § 4620.3(b)), and SDP operates within that framework. The question is not whether SDP lacks accountability, but whether a new rate-based standard responds proportionately to demonstrated need.

Defining Waste, Fraud, and Abuse

This paper uses “waste, fraud, and abuse” per standard Medicaid program-integrity usage, not as a synonym for any expenditure higher than a comparable vendored rate. Fraud is intentional misrepresentation to obtain an unauthorized benefit. Abuse is practice inconsistent with sound fiscal or program practice that produces unnecessary cost, without necessarily involving intent.

Waste is inefficient resource use, without even abuse's impropriety element. None turns on rate deviation alone.

SDP is designed to produce individualized variation from the vendored norm, reflecting its statutory participant authorities. WIC § 4685.8(m)(1)(A)(ii) already permits a budget adjustment where the IPP team documents changed circumstances, needs, or resources. This paper follows that logic: a rate is a concern only when it lacks a needs-based justification, not because it deviates from a statistical norm.

Measured against that standard, Section 2.4's safeguards are strong on scope, eligibility, and budget control, but lack a point-of-sale check on rate reasonableness: independent audits under WIC § 4652.5 apply only to vendors billing \$500,000 or more annually. That gap is narrow; DDS's proposal would apply far more broadly.

The Policy Problem

Understanding DDS's Cost-Efficiency Standard

DDS has expressed concern about outlier hourly rates within certain SDP service codes and has proposed a framework to address those rates. Protecting public resources and maintaining confidence in state administration are core DDS responsibilities, and this paper treats that concern as a legitimate starting point. No published analysis, however, currently quantifies its scope, frequency, or causes. Publishing an analysis drawing on Section 2.4's safeguards would strengthen that evidentiary foundation and help ensure any resulting standard is well-targeted.

As a relatively new statewide program (2021), SDP may include isolated expenditures warranting review, and existing oversight is designed to catch such cases through established processes. Determining the scope, frequency, and causes of any concern would let DDS calibrate a standard to the actual problem.

DDS's Proposed Cost-Efficiency Standard

Cost-effectiveness and **cost efficiency** are distinct concepts, and that distinction is central to this paper's recommendation. Cost-effectiveness has an established statutory basis: WIC § 4685.8(b)(2)(H)(i) requires IPP teams to consider it, as defined by cross-reference to WIC § 4648(a)(6)(D), when developing a participant's budget. DDS must finalize this definition by August 1, 2026.

Cost efficiency, by contrast, has no independent statutory definition or deadline. DDS has proposed folding it into the cost-effectiveness definition by setting SDP rates it characterizes as reasonable, based on comparable vendored reimbursement rates. This would effectively link participant-negotiated SDP rates to the vendored system's standardized fee schedules, the model SB 468 designed SDP to be an alternative to.

Accordingly, a data-driven framework would finalize cost-effectiveness on schedule while developing any cost-efficiency standard separately, through the structured, evidence-based process outlined in Sections 5 and 6.

It's also important to distinguish an **individual budget** from a **service rate**. A participant's budget, the total amount available to implement the IPP, is determined under WIC § 4685.8(m), based on prior expenditures or the regional center's average cost for comparable services. DDS's proposal doesn't modify this budgeting methodology; it would instead regulate rates paid within an already-established budget. It would not change how much funding participants get, only how they may spend it.

The Case for a Standardized Rate Benchmark

Before evaluating alternatives to DDS's proposal, it's worth taking seriously the administrative logic likely behind it. A standardized, vendored-rate benchmark offers three practical advantages a case-by-case standard cannot easily replicate.

Administrative consistency. Tying SDP rates to the existing vendored fee schedule would let DDS and the 21 regional centers apply one already-audited rate table across both models, rather than evaluating each SDP rate individually, simpler to administer, easier to defend in audit, less dependent on individual judgment.

Statewide equity. Because SDP rates are negotiated at the participant level, comparable services can cost differently across regional centers, or between SDP and vendored participants receiving the same support. A standardized benchmark would narrow that variation and answer the concern that similar participants shouldn't receive materially different public funding.

Predictability. A known rate ceiling gives DDS, regional centers, and the Legislature a stable basis for budgeting and oversight, and gives participants and providers advance notice of the rate to expect.

These are legitimate objectives, and DDS's interest in them is reasonable on its face. The question is not whether they're worth pursuing, but whether linking SDP rates to the vendored schedule is the best tool for achieving them, given SDP's distinct, individualized budgeting logic (Section 2.2). The structured analysis proposed below lets DDS capture these benefits while confirming the standard fits problems the data actually show.

Why a Structured Policy Analysis is Needed

This paper's central recommendation is procedural as much as substantive: completing the analytic steps that typically precede standard-setting, defining the concern's scope, establishing a baseline against vendored services, completing a comparative analysis, calibrating the remedy to SDP's design, and documenting the evidentiary basis for intervention, would strengthen DDS's proposal. Section 4 develops this framework.

Policy Analysis Framework

A cost-efficiency framework should be evaluated against the fundamental questions that guide effective policy development. Table 1 summarizes current evidence, key gaps, and the actions needed to support an evidence-based approach.

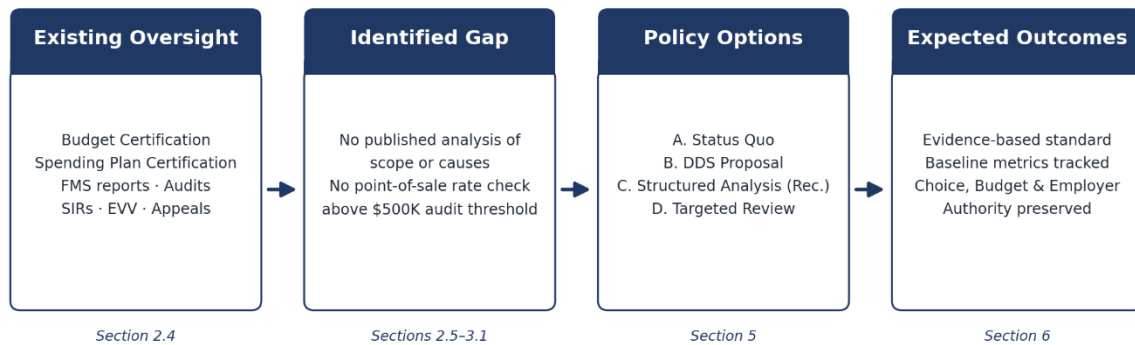


Figure 1. Conceptual framework: existing oversight, the identified evidentiary gap, the policy options in Section 5, and the expected outcomes tracked under Section 6.

Policy Area	Current Findings	Evidence Gap	Recommended Actions
Problem Definition	DDS has expressed concerns for rate outliers regarding program integrity and cost efficiency.	The scope, frequency, and causes of any rate outliers have not been quantified.	Define the problem using statewide expenditure and utilization data before selecting a policy solution.
Program Integrity	SDP already operates under the oversight framework described in Section 2.4.	Existing oversight data hasn't been systematically analyzed to determine whether additional measures are necessary.	Analyze existing oversight data to determine whether current safeguards adequately address identified concerns.
Participant Impact	A statewide cost-efficiency standard could affect participant choice, workforce recruitment, provider availability, and access to individualized supports.	The magnitude of these impacts has not been evaluated.	Conduct a participant and workforce impact assessment before implementation.

Fiscal Impact	Administrative implementation costs are identifiable. Potential savings remain uncertain because participant budgets will remain unchanged.	No formal cost-benefit or economic analysis has been completed.	Conduct a fiscal analysis comparing implementation costs, projected savings, and participant outcomes.
Legal and Policy Alignment	The proposal intersects with statutory provisions governing Budget Authority, Employer Authority, and individualized budgeting under the Lanterman Act.	No formal legal analysis has evaluated compatibility with existing statutory authority.	Complete a legal and policy review before adopting a statewide cost-efficiency standard.
Baseline Measurement	No baseline metrics exist against which any adopted standard's effect could be measured.	Without a pre-implementation benchmark, DDS cannot determine whether a new standard actually improves program integrity or cost efficiency once adopted.	Establish baseline metrics (expenditure patterns, rate variation, appeals volume, participant outcomes) from existing data before implementation, and track them afterward.

Problem Definition

The first step in developing a cost-efficiency framework is clearly defining the problem. While DDS has identified program integrity and fiscal sustainability as important objectives, no published analysis currently quantifies the scope, frequency, or causes of that concern (Section 3.1). Without that baseline, it's difficult to assess whether a statewide change is warranted, what form it should take, or whether existing safeguards could already address it.

Developing an evidence base before selecting a solution ensures future actions respond to documented issues, not perceived ones.

Understanding the scope and characteristics of expenditures of concern is an important step in evaluating whether changes to existing safeguards or a broader statewide policy response are appropriate.

Current Oversight

As detailed in Section 2.4, SDP already operates within a comprehensive oversight system spanning FMS, spending-plan certification, budget limits, background checks, incident reporting, independent audits, EVV, and HCBS compliance monitoring. These mechanisms generate data suitable for evaluating spending patterns and identifying outliers; DDS should use it to confirm current safeguards leave a demonstrated gap before adopting a new standard.

Evaluating a Cost-Efficiency Framework

Any cost-efficiency framework should advance two objectives: strengthening program integrity and preserving self-directed services' foundational principles. Section 4.6 sets out the principles used to evaluate Section 5's alternatives.

Because the evidence gap identified in Section 3.1 remains unresolved, a statewide rate-setting standard's impacts on participants, providers, workforce availability, and administrative burden cannot yet be assessed. A policy analysis provides a stronger foundation for decisions than implementing a standard before the problem is fully defined.

Evaluation Criteria

The policy alternatives in Section 5 were evaluated using a consistent set of criteria, consistent with the CDC POLARIS framework and generally accepted policy-analysis practice. These criteria include:

- Program integrity
- Fiscal accountability
- Participant outcomes
- Administrative feasibility
- Legal consistency
- Equity
- Stakeholder impact
- Implementation cost

Guiding Policy Principles

Consistent with the evidence and framework described above, any cost-efficiency framework DDS ultimately adopts should:

1. Strengthen program integrity.
2. Prevent waste, fraud, and abuse.
3. Preserve participant choice.
4. Maintain Budget and Employer Authority.
5. Protect access to individualized services.
6. Be evidence-based.
7. Be administratively feasible.
8. Be legally consistent with the Lanterman Act and HCBS waiver.

These principles, rather than any single preferred remedy, are the standard against which the policy alternatives in Section 5 are evaluated below.

Policy Alternatives

Consistent with CDC POLARIS guidance to research, describe, and rank multiple options rather than adopting the first proposal, this section presents four alternatives, compared against program impact, feasibility, and budgetary/economic criteria.

Policy Option	Program / Participant Impact	Feasibility (Political / Operational)	Budget Impact	Economic Impact / Data Gap
A. Status Quo (no change)	Low disruption; preserves choice, but concern is unaddressed	High feasibility; no new action required	No new cost	No data generated to resolve DDS's concern either way
B. DDS Proposal (link SDP rates to vendored rates)	Could affect access for above-schedule, individualized needs even paired with an accommodation mechanism	Moderate feasibility; potential impacts on administrative workload and equitable access warrant further evaluation.	Hourly rate caps do not reduce participant budgets but may increase administrative costs.	Addresses rate outliers and unjustified rates; may affect service availability, and administrative costs without reducing participant budgets.
C. Structured Policy Analysis First (Recommended)	Neutral to positive; Protects choice and builds evidence but requires additional time.	High feasibility; mirrors DDS's own rate-reform stakeholder process	Moderate, one-time analytic cost	Enables a defensible cost-benefit case before any rate action

Policy Option	Program / Participant Impact	Feasibility (Political / Operational)	Budget Impact	Economic Impact / Data Gap
D. Targeted Program-Integrity Review (Interim)	Low disruption; targets actual outliers using data already available	High feasibility; uses existing FMS/audit infrastructure	Low; leverages required reporting already in place	Produces real evidence quickly, at low cost

The table below evaluates each alternative against the principles established in Section 4.6, so the option selected is judged against a consistent framework.

Policy Principle	A. Status Quo	B. DDS Proposal	C. Structured Analysis (Recommended)	D. Targeted Review (Interim)
Strengthen program integrity	Not directly advanced; concern remains unaddressed	Directly responsive to DDS's stated concern	Builds the evidentiary foundation for a durable standard	Adds a point-of-sale check using existing infrastructure
Prevent waste, fraud, and abuse	Existing safeguards continue unchanged	Targets cost outliers via a rate ceiling	Uses existing oversight data to target actual concerns	Flags statistical outliers for case-level review
Preserve participant choice	Fully preserved	At risk for above-schedule needs even with an accommodation mechanism	Fully preserved during the analysis period	Fully preserved; review applies only to flagged cases
Maintain Budget and Employer Authority	Fully preserved	Directly setting service code rates reduces participant	Fully preserved during the analysis period	Fully preserved; no system-wide rate change

Policy Principle	A. Status Quo	B. DDS Proposal	C. Structured Analysis (Recommended)	D. Targeted Review (Interim)
		discretion over spending plan funds.		
Protect access to individualized services	Fully preserved	Could narrow access even with an accommodation mechanism	Fully preserved during the analysis period	Preserved; targets anomalies, not the whole program
Be evidence-based	Generates no new evidence	Not yet grounded in a published cost-efficiency analysis	Directly designed to generate the missing evidence	Uses data already collected; produces real-time evidence
Be administratively feasible	High; no new action required	High; leverages the existing rate structure	Moderate; requires a one-time analytic effort	High; uses existing FMS/audit infrastructure
Be legally consistent with the Lanterman Act and HCBS waiver	Fully consistent; no change	Requires confirming alignment with WIC § 4685.8's individualized-budget mandate	Fully consistent; mirrors DDS's own rate-reform stakeholder process	Consistent; operates within existing statutory oversight authority

Option A: Status Quo

DDS takes no action on cost efficiency, continuing to administer SDP budgets under the current IPP-team methodology while finalizing its required cost-effectiveness definition by August 1, 2026. This preserves participant choice but leaves DDS's cited rate outliers unaddressed.

Option B: Folding Cost Efficiency Into the Cost-Effectiveness Definition

This option folds cost efficiency into the cost-effectiveness definition DDS must finalize by August 1, 2026, by linking SDP rates to comparable vendored rates. It's administratively straightforward and directly responsive to DDS's concerns, but has three gaps. First, it lacks an evidentiary basis showing the standard targets a demonstrated need. Second, many Employer Authority services have no comparable vendored rate, requiring a proxy-pricing methodology. Third, participants whose needs exceed standardized rates, particularly in rural areas or for specialized supports, would need an accommodation mechanism to preserve access. Because budgets are determined independently under WIC § 4685.8(m), rate limitations wouldn't reduce budgets but would shape how funds may be used; the rulemaking record should say so explicitly.

Option C: Finalize Cost-Effectiveness on Schedule; Analyze Cost Efficiency Separately (Recommended)

DDS finalizes the cost-effectiveness definition by August 1, 2026 and evaluate cost efficiency separately. The CDC POLARIS framework, or a comparable methodology, would let DDS analyze existing data, FMS records, independent audits, appeals, to define and quantify any concerns, evaluate alternatives on effectiveness, feasibility, and cost, and engage stakeholders before adopting any new standard.

Option D: Targeted Program-Integrity Review (Interim Measure)

Without folding cost efficiency into the definition system-wide, DDS directs existing oversight, FMS monthly reports, independent audits, regional center reviews, to flag statistical outliers for case-level review, while finalizing cost-effectiveness separately and on schedule. Per Section 2.5, a flagged rate is a prompt for documentation, not proof of waste, fraud, or abuse; only one lacking a needs-based justification, once requested, substantiates DDS's concern. This measure can begin immediately, uses existing infrastructure, and targets actual anomalies while a fuller Option C analysis proceeds.

Recommendation & Implementation Roadmap

This paper recommends a phased path toward the objective DDS has articulated through Option B: complete the structured analysis in Option C, paired with the interim safeguard in Option D, so any resulting standard rests on documented evidence. Baseline data is built into every phase, so efficacy can be measured, not assumed. The roadmap follows.

Phase 1: Data Collection and Sequencing

- Finalize the required cost-effectiveness definition under WIC § 4685.8(b)(2)(H)(i) and § 4648(a)(6)(D) by August 1, 2026. Sequence any rulemaking folding cost efficiency into that definition to follow Phase 2's structured analysis, so the resulting standard is informed by evidence.

- Compile existing monthly expenditure reports, and independent audits, required under current law.
- Convene stakeholders.
- Establish baseline metrics from the compiled data (expenditure patterns, rate variation, appeals volume, participant outcomes) before any policy change, creating the benchmark needed to later measure the standard's effect.

Phase 2: Policy Analysis

- Quantify the scope and magnitude of any substantiated cost-efficiency issue using the assembled data.
- Identify breakdowns in current safeguards.
- Determine if established safeguards are adequate to address the issue or if further remedies are required.
- Score candidate remedies against program impact, political and operational feasibility, and budgetary/economic criteria, using a policy analysis table consistent with CDC POLARIS guidance.

Phase 3: Evidence-Based Rulemaking

- If the analysis substantiates a material gap, propose a narrowly tailored remedy, for example, a rate-reasonableness band anchored to labor-market or SDP peer-wage data rather than the vendored fee schedule, paired with a documented, needs-based justification requirement enforced through existing FMS and spending-plan checkpoints, rather than a blanket rate-linking rule.
- Publish findings and any proposed standard for public comment, consistent with DDS's existing rate-reform stakeholder process.

Phases 4: Monitoring and Evaluation

- Track outcomes through DDS's existing Quality Incentive Program and Data Dashboard infrastructure, measured against the Phase 1 baseline to determine whether the adopted standard is achieving its intended program-integrity and cost-efficiency objectives.
- Revisit findings annually, or sooner if new data indicates a need for adjustment.

Limitations

This analysis is limited by the absence of public expenditure-level data, outcome comparisons between SDP and traditional services, and completed DDS cost-efficiency analyses. Recommendations rest on statutory analysis, existing oversight mechanisms, policy-analysis methodology, and public administrative information.

Conclusion

A cost-efficiency policy analysis gives DDS a chance to strengthen accountability while preserving participant choice, individualized budgeting, and self-direction. Sequencing development this way positions DDS as a model for evidence-based innovation, balancing fiscal stewardship, participant autonomy, and long-term sustainability.

References

Statutory Authority

- Welfare and Institutions Code (WIC) § 4501 (legislative findings; consumer and family empowerment and choice).
- Welfare and Institutions Code § 4502, Persons with Developmental Disabilities Bill of Rights, including subdivision (b)(10) (right to make choices in program planning and implementation).
- Welfare and Institutions Code § 4519.5 (purchase-of-service authorization, utilization, and expenditure data collection; disparity reporting by race, ethnicity, and language).
- Welfare and Institutions Code § 4620.3 (regional center administrative best practices, including detection and prevention of fraud, waste, and abuse).
- Welfare and Institutions Code § 4648(a)(6)(D) (cost-effectiveness standard, incorporated by reference into § 4685.8(b)(2)(H)(i)).
- Welfare and Institutions Code § 4652.5 (independent audit requirement for vendored providers billing \$500,000 or more annually).
- Welfare and Institutions Code § 4685.8 (Self-Determination Program), including subdivisions (a), (b)(2)(H)(i), (m), (m)(1)(A)(ii), (t), and (v).
- Social Security Act §§ 1915(c) and 1915(k) (federal Medicaid home- and community-based services waiver authority).

Legislation

- SB 468 (Emmerson, Ch. 683, Stats. 2013) (establishing the Self-Determination Program).

Program and Regulatory Documents

- California Department of Developmental Services, Application for a §1915(c) Home and Community-Based Services Waiver: California Self-Determination Program Waiver for Individuals with Developmental Disabilities (Waiver Control No. CA-1166, Draft ID CA.001.02.00).
- California Department of Developmental Services, Self-Determination Program guidance on the applicability of system-wide rate reform to individual budgets.

Methodology and Framework

- Centers for Disease Control and Prevention, POLARIS Policy Analysis Framework.
- Stanford Law School Policy Lab, Policy Writing Guidance.