New Grievance Rights for Regional Center Services Under the HCBS Access Rule

A brief guide for families, self-advocates, and service coordinators

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A new federal rule gives people who get regional center services through California's home- and community-based services (HCBS) system a formal way to complain if their plan or their services aren't truly person-centered. It's a real expansion of rights — but as of this writing, California is still finishing the details of how it will work. This article briefly describes what's settled, what isn't, and how it fits alongside the advocacy tools service coordinators already use.

The short version

- The federal Medicaid "Access Rule" requires every state to set up a grievance process for people receiving HCBS through fee-for-service Medicaid — including California's regional center system.
- It lets a person (or their representative) formally object if their Individual Program Plan (IPP) wasn't built around their own preferences, if approved services aren't being delivered that way in practice, or if a residential provider isn't meeting federal HCBS setting requirements.
- California's 2026-27 budget sets aside $2.4 million and nine new positions to handle tis change.

What's Actually Changing

Under the Access Rule, states must let HCBS recipients file a grievance about how a plan or service is carried out, separate from decisions about whether a specific service is approved. In California, the federal right technically takes effect for grievances filed after July 9, 2026, but CMS has said it will not take enforcement action against states through December 31, 2027, while systems are built out.

California's own proposal would fold two existing complaint pathways — the Welfare & Institutions Code Section 4731 provider-complaint process and the separate "citizen complaint" process — into this one new process, with a target start around February 2027. In short: the right is real and coming, but the exact form, filing address, and procedures are not yet final.

Who Can File, and About What

Who: Any regional center consumer, or someone acting on their behalf (a parent, conservator, or other authorized representative).

What qualifies: Grievances can cover things like a plan that was written without input from the person, a provider who consistently unresponsive, a group home that restricts community outings or visitors without an individualized reason, or a residential setting that otherwise falls short of federal person-centered requirements.

What doesn't qualify: A dispute over whether a specific service should be authorized, increased, reduced, or terminated is a different kind of decision — a Notice of Action — and is handled through the existing fair hearing process, not this new grievance route.

Grievance vs. fair hearing — not the same thing

- Grievance (new): about HOW a plan or service is carried out — was it person-centered in practice? No Notice of Action is required to file. Expected to be resolved administratively on a timeline up to 90 days. No judge involved.
- Fair hearing (existing, unchanged): about a formal decision to deny, reduce, or end a specific service (a Notice of Action). Must be requested within 90 days of that notice. Decided by an administrative law judge.
- The two are not mutually exclusive, and filing one is not expected to require finishing the other first — though California hasn't yet published the fine print on how the two will interact in practice.

How This Fits With What Service Coordinators Already Do

This process is a formal backstop, not a replacement for the day-to-day advocacy a good service coordinator already provides — using the IPP process, documenting concerns, coordinating assessments, and negotiating directly with providers and regional centers.

Families and self-advocates should still raise concerns with their coordinator first. The new grievance right matters most when that informal path stalls or when the concern is about whether the planning process itself was person-centered.

Fair to all sides: what's still unsettled

- Timelines have already moved once — the federal deadline slipped from July 2026 to a 2027 enforcement window, and California's own plan targets roughly the same period. Nothing here is locked in yet.
- Regional centers and providers are adjusting too. Merging two existing complaint tracks into one is meant to reduce confusion for everyone, but the intake process, response timelines, and a provider's right to respond haven't been fully published.
- Until final guidance is issued, this as an emerging right to watch for — not yet a fully operational process with a known form, address, or point of contact.

What to do now: If you have a concern, keep documenting it in writing with your service coordinator. Ask your regional center whether it has interim grievance procedures in place. And watch for the directive that finalizes this process.

Sources

- National Health Law Program – Strengthening the HCBS Grievance Process (slide brief, June 2026)
- National Health Law Program – Strengthening the HCBS Grievance Process (policy brief)
- CMS Informational Bulletin – HCBS Grievance Enforcement Discretion
- CA Department of Developmental Services – 2026 May Revision Highlights
- CA Department of Developmental Services – Ensuring Access to Medicaid Services Final Rule (Access Rule)
- CA Department of Health Care Services – Medi-Cal Fair Hearing
- Disability Rights California – Medi-Cal Managed Care: Appeals and Grievances