LAO

May 1, 2019

Hon. Eloise Gómez Reyes, Acting Chair
Assembly Budget Subcommittee No. 1 on Health and Human Services
Room 2175, State Capitol
Sacramento, California 95814

Dear Assembly Member Reyes:

Purpose and Outline of This Letter. This letter responds to a request made by the Chair of the Assembly Budget Subcommittee No. 1 on Health and Human Services at the March 6 budget subcommittee hearing. The Chair requested that our office develop a few options for actions that could be taken by the Legislature in the 2019-20 budget based on the intelligence of a contracted study of service provider rates in the Department of Developmental Services (DDS) system. (Throughout this letter, we refer to these options as the rate study implementation options.) This statutorily required rate study—conducted by Burns and Associates (hereafter Burns)—was submitted to the Legislature on March 15, 2019 in draft form (as public comment was still being collected). Consequently, we submit this letter to the Subcommittee without the benefit of having seen the final version of the rate study and associated rate models. The deadline for submitting public comment was April 5. DDS indicates that Burns will likely release revised rate models within the month of May and the final report at a date to be determined.

This letter has five sections. First, we discuss the budgetary and practical/administrative constraints that make unlikely the full implementation of the rate study's proposed rate models in 2019-20. We next identify and describe two main rate study implementation options for beginning the process of rate reform in 2019-20. In the third section, we describe what we are calling "status quo funding increase options" for increasing funding in 2019-20 under the current rate-setting framework (for the service providers who would not benefit from the first round of implementation under our two rate study implementation options). As the status quo funding increase options would be in addition to and combined with a chosen rate study implementation option, the fourth section discusses ways to package these options and the associated fiscal impact of each combination. In the final section, we raise other important issues for the Legislature to consider as it deliberates on rate reform for the longer term, including identifying some of the high-level benefits and trade-offs of the proposed rate models themselves.

An important backdrop to DDS rate reform is the recent federal rule about home- and community-based services (HCBS). Continued receipt of federal Medicaid HCBS waiver funding (which currently comprises nearly $2.2 billion of the DDS budget) requires services to be in compliance with the final rule by March of 2022. The HCBS rule seeks to increase consumer integration into the wider community and promote consumer choice and

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independence. As the DDS system thus continues to evolve in that direction, it requires a rate-setting framework that will support it.

Real Opportunity to Take Substantive Action. We recognize that the Legislature has placed a significant priority on reforming the rate-setting process in the DDS system; it funded the rate study for this purpose and requested this letter to that end. In light of this preference and the release of the rate study, there is an opportunity to take substantive action this year to begin reforming the system. We note that anything less than full implementation of the proposed rate models has risks. If, for example, the fiscal condition of the state deteriorates in the coming years or the priorities of the Legislature and administration shift, DDS could end up in the position of having dual rate-setting systems, one based on the logic of the rate study and one based on the current methods. We suggest doing as much as reasonably possible—both fiscally and administratively—in 2019-20, based on the proposed rate models in the rate study.

LAO Bottom Line

Although it is the Legislature's intent to fully reform the rate-setting process in the DDS system, the estimated cost ($1.9 billion total funds, $1.2 billion General Fund) and significant administrative challenges associated with the proposed rate models make it unlikely the state could achieve full implementation in 2019-20. Our office offers two options for substantively beginning rate reform in 2019-20, however. Because of interest in providing a measure of fiscal relief to all providers in 2019-20, we also list options for increasing funding under the status quo rate-setting framework as an interim measure for those providers not benefitting from the first round of implementation of the rate study.

Rate Study Implementation Options. One option we offer to begin rate reform is a staged rollout, beginning in 2019-20 with the proposed rate models in up to four targeted service categories—residential, employment, respite, and independent living services (ILS). Among all of the proposed rate models, the rate models for these particular service categories would be the most feasible to implement from an administrative and policy perspective. A second option we offer is to combine the staged rollout option with pilot projects in the service categories that are not included in the first round of the staged rollout. The pilot projects could be relatively small and low-cost in scope with the goal of gaining a better understanding of the implementation challenges associated with the rate models and ways to address them. Simultaneously to either option, DDS could develop a plan for the ultimate full implementation of rate models, which could be submitted for legislative review and approval as part of the 2020-21 budget process.

Status Quo Funding Increase Options. Given expressed legislative interest in providing some level of fiscal relief to all service providers in 2019-20, we list options that are not dependent on the implementation of the rate models proposed in the rate study and that have been discussed at budget hearings. We also provide their associated costs. The cost of each status quo option would be lower in most cases to the extent it is combined with a rate study implementation option (as the status quo option would be structured to benefit only those providers not benefitting from the implementation of the rate study in 2019-20). Figure 1 (see next page) summarizes the estimated cost of the staged rollout rate study implementation option and the status quo funding increase options that we offer for legislative consideration. (If pilot

projects were included, the cost—which could be determined by the Legislature—would be in addition to the cost of the staged rollout.)

Figure 1

Estimated Costs of Various Options, Relative to the Governor's Proposed 2019-20 Budget

2019-20 Cost (In Millions)

Rate Study Implementation Options—Staged Rollout[a]			Status Quo Funding Increase Options		
Service Category	Total Funds	General Fund	Option	Total Funds	General Fund
Residential services (not including shared supported living services)	$948	$607	Fix state minimum wage quirk	$16.1	$8.0
Supported employment (group and individual)	24	15	Cover local minimum wage	Unknown	Unknown
Respite (including agency- and participant-directed)	50	32	Repeal uniform holiday schedule	50.3	30.1
Independent living services (including specialists)	-1	-1	Repeal half-day billing policy	2.7	1.6
			Restore social recreation and camp services	23.2	14.8
			Increase rates across the board: 8%	464.0	296.5
			Increase rates across the board: 4%	232.0	148.3

[a] Options reflect implementation of rate study's proposed rate model for one to four of the listed service categories. If pilot projects in other service categories were also included, there would be an additional cost as determined by the Legislature.

Packaging Options. Should the Legislature wish to package rate study implementation options with status quo funding increase options, the cost could range from less than $50 million to more than $1.4 billion total funds ($25 million to $900 million General Fund).

Additional Considerations. As the Legislature and the administration embark on efforts to reform the rate-setting process in the DDS system over the longer term, we identify several high-level issues to consider. For example, we suggest the Legislature ask DDS to be more transparent about which services it does not consider compliant under new federal rules set to take effect in 2022 and how it intends to phase those services out while ensuring consumer access to good alternatives.

Why Achieving Full Implementation of Rate Models in 2019-20 Is Likely Not Feasible

Even if the rate study's proposed rate models were finalized, requiring no additional discussion or refinement, certain constraints would nevertheless prevent full implementation in 2019-20. Our recognition of these constraints helped to guide our development of the rate study implementation options for 2019-20.

Fiscal Constraints

Full implementation of the rate models as designed by Burns would require increased funding for regional center (RC) purchase of service (POS) budgets of $1.9 billion total funds ongoing ($1.2 billion General Fund) in 2019-20. This additional funding would increase the total proposed 2019-20 DDS budget by 25 percent, from $7.8 billion to $9.7 billion. General Fund spending would also increase 25 percent from $4.8 billion to $6 billion. Given competing legislative priorities for discretionary state resources available for allocation in the 2019-20 budget, an increase of this magnitude would unlikely be accommodated, at least not right away in 2019-20.

Implementation and Administrative Constraints

Implementation of the rate models as designed will involve significant and consequential adjustments at every level of the DDS system. Even if the state were prepared to increase total funding by the requisite $1.9 billion in 2019-20, it would be near impossible from a practical standpoint to implement the rate models that quickly. Implementation and administrative challenges include:

Enacting Required Policy Changes. Implementing the rate models as designed will require changes—some very significant—to statute and/or regulations. In some cases, promulgation of regulations can take one to two years after they are drafted. Burns and DDS are still in the process of identifying all of the aspects of the rate models that would require policy changes in order to implement them. Among others, these changes range from new rules about staffing ratios and new requirements about direct care worker qualifications to new billing procedures and changes in the number and use of service codes.

Furthermore, when a change of policy (or practice) occurs in the DDS system, DDS typically issues guidance to RCs and service providers about how to implement the changes. For example, it currently issues instructions about how to request rate increases associated with increases in the state minimum wage and how to request health and safety waivers to get an exemption from current rate freezes. Implementation of the rate models will require such guidance and instructions—the full extent of what guidance will be necessary has yet to be determined.

Attaining Required Federal Approvals. To maximize the amount of federal Medicaid waiver funding available to the DDS system (currently about $2.2 billion), DDS must seek approval of any rate changes from the federal Centers for Medicare and Medicaid Services (CMS) following a public comment period. This process can take some time depending on how long it takes to prepare the request, the extent of the public comment, how much clarification CMS needs from DDS, and whether stakeholders express concerns to CMS directly. Turnaround times typically range from six months to three years. Given the complexity of the changes associated with the proposed rate models, we expect it will be an involved and potentially lengthy process, both for preparation of the request and for CMS approval.

Making Necessary Day-to-Day Operational Changes. Numerous changes would be needed at the DDS, RC, service provider, and consumer levels to successfully implement the rate models and it could take some time to get all of these changes in place. Below, we provide a number of examples.

It may be necessary to change the service authorization, billing, and payment processes and information technology systems used by providers, RCs, and DDS. Some direct care workers, known as direct support professionals (DSPs), will now require certification; the process for implementing and enforcing such requirements has not been developed yet. Currently, some groups of services are bundled together under one rate; the proposed rate models would instead bill these services separately. This process also has not yet been developed. DSPs, RC employees, and DDS staff may need training on certain aspects of the new rate system to ensure compliance with rules and practices. Some providers would need to work with their RCs to revisit their program design and assigned service code to reflect requirements in the new system. Finally, and perhaps most importantly, RCs would have to carefully review consumers' individual program plans to ensure consumers are authorized to receive the services they need under the new system. This would likely require individual meetings with consumers and their families.

How We Developed Rate Study Implementation Options for 2019-20

Given that it does not appear feasible—fiscally or practically—to fully implement the proposed rate models in 2019-20, we considered several potential approaches for beginning the process of rate reform. To arrive at our two main approaches for legislative consideration, we considered the following:

Implementation Feasibility. Could the practical implementation challenges associated with the approach be realistically addressed in 2019-20?

Efficacy. Would the approach lead to the outcomes the state hopes to achieve through rate reform? For example, would it help to increase consumer access to services, improve the quality of services, and achieve rate parity across similar providers (which can help facilitate consumer choice and access to services)? Would the approach effectively lay the groundwork for full implementation of rate models in the future?

Rate Model Readiness. Are the particular rate models associated with the approach refined enough to begin implementation? This is a separate question from implementation feasibility and concerns the actual model used to develop the rate. For example, are the assumptions on which the model is based sound? Are any changes needed to the inputs? How serious are the problems associated with the assumptions or inputs? Does the rate model require additional discussion and refinement?

In the following two sections, we provide details on our two rate study implementation options for 2019-20. In addition to providing information on the fiscal impact of the options, we assess the option's implementation feasibility, efficacy, and rate model readiness.

Rate Study Implementation Option #1—Staged Rollout

Description of Option

One main option is to roll out the rate models in stages. In 2019-20, it may be feasible to implement new rate models for a select set of service categories while DDS simultaneously develops a plan, including a time line, for the subsequent rollout of other rate models. (This plan

could be submitted for legislative review and approval as part of the 2020-21 budget process.) Based on conversations with DDS and our review of the rate study, there are only a few service categories for which the associated rate models could realistically be rolled out in 2019-20, namely residential services, supported employment, ILS, and respite. To put these services into context, among the 330,000 DDS consumers, about 9 percent of consumers receive residential services (not including supported living services), while this service category currently accounts for more than a quarter of POS expenditures. About 4 percent of consumers receive group or individual supported employment and these services comprise less than 3 percent of POS spending. ILS are accessed by about 6 percent of consumers and make up less than 3 percent of the POS budget. About 20,000 consumers access in-home respite services and these services make up about 8 percent of POS spending.

Fiscal Impact

According to the fiscal estimate in the draft rate study and additional information from DDS, the cost for each of the four service categories noted above is as follows (see Figure 2).

Figure 2

Estimated Cost to Roll Out Rate Models for Select Service Categories in 2019-20

2019-20 Costs (In Millions)

Service Category	Increased Costs, Relative to Proposed 2019-20 Budget	
	Total Funds	General Fund
Residential services (not including shared supported living services)	$948	$607
Supported employment (group and individual)	24	15
Respite (including agency- and participant-directed)	50	32
Independent living services (including specialists)	-1	-1
Totals (if All Four Categories Were Implemented)	**$1,021**	**$653**

Assessment

Implementation Feasibility. According to DDS, the rate models for the four service categories above could be feasibly rolled out in 2019-20 because the way that these services would be delivered and billed under the rate models would not change significantly. The state could decide to begin rate study implementation in 2019-20 with one or more of these services. Changes to the way a service is delivered—including a basic rate change—requires federal approval from CMS for the state to continue receiving matching funds through Medicaid waivers for Medicaid-eligible recipients. Consequently, even if the rate models for these services were relatively easy to implement from a practical standpoint, it would likely take at least six months to obtain the necessary federal approval. This means that DDS, RCs, and service providers could spend the first six months of 2019-20 resolving any minor implementation issues while DDS seeks federal approval. We would suggest allowing DDS to issue emergency regulations while it

goes through the more time-intensive process of promulgating final regulations. In terms of funding, there are options for the Legislature. For example, the Legislature could provide full-year funding, retroactively applying the rate changes to July 1, 2019 once federal approval is obtained. Alternatively, it could provide half-year funding beginning January 1, 2020 to roughly correspond to the earliest date federal approval might be obtained.

Efficacy. When it comes to effectiveness goals, such as improving access and quality of services, assessing potential outcomes from rate reform is somewhat difficult. DDS and the RCs do not currently collect data in a way that allows the state to systematically quantify gaps in access to services or unmet consumer need. Nevertheless, DDS has indicated that rates for residential services are especially outdated. To the extent that outdated rates have caused residential providers to exit the market or have discouraged new providers from entering the market, a rate increase in this service category could potentially improve access to services.

Regarding supported employment services, state legislation enacted in 2013—"Employment First"—created an ambitious goal of providing competitive integrated employment (CIE) for DDS consumers who want to work. According to the most recently available data, however, the rate of employment among consumers remains low. The proposed rate models for group and individual supported employment might improve employment outcomes. However, improvements in individual supported employment (which facilitates CIE) might be relatively modest given the rate changes (up for some and down for others) and the number of hours assumed under the rate model for job development (40 hours per individual per year).

Regarding respite services, we have not heard that this service is experiencing access or quality issues. However, this does not mean that access/quality problems do not exist that could be potentially addressed by rate reform.

ILS actually receives an aggregate rate *decrease* under the proposed rate model. This implies that ILS is potentially overfunded. However, we also know that ILS will be a particularly important service as more consumers hope to live on their own and the state must come into compliance with HCBS rules. If a rate decrease has the effect of reducing access to, or the quality of, ILS services, this could work against the state's ultimate goals.

In terms of laying the groundwork for full implementation, staging the rollout by first implementing the proposed rate models for one or more of the four service categories discussed above allows DDS to meanwhile identify and resolve implementation issues associated with the service categories that would be rolled out later.

Rate Model Readiness. Relative to other service categories, the proposed rate models associated with each of these four service categories are fairly refined. Two issues stand out, however, that suggest the need for further refinement. First, for participant-directed respite (as opposed to agency-directed respite), the models will likely need to add administrative costs (to cover employment supports for the respite provider). This could increase total costs for respite by about $20 million total funds. Second, the wage assumptions for ILS (as well as other service categories) are based on Bureau of Labor Statistics occupation codes and wages for personal care aides (weighted at 55 percent), and home health aides, psychiatric aides, and recreation workers (each weighted at 15 percent). However, since ILS services focus more on functional skills

training than personal care, the wage assumptions underlying the rate model for ILS may need to be adjusted upwards if the desire is to more accurately reflect actual costs, potentially resulting in a rate increase rather than decrease.

Rate Study Implementation Option #2— Staged Rollout With Pilot Projects in Other Service Categories

Description of Option

A second option for 2019-20 is to conduct the staged rollout described above along with pilot projects in other service categories—such as day programs and early intervention—whose rate models are more complicated to implement. The purpose of the pilot projects would be to gain a better understanding of the overall implementation, programmatic, and administrative challenges associated with implementing the new rate models, in respect of services/providers covered under the pilots.

This option includes conducting pilot projects simultaneously with the staged rollout given our overall suggestion that the state do as much as reasonably possible towards full implementation of rate reform in this first year. Only conducting pilot projects creates the risk of the state losing the momentum to reform the rate-setting process as state conditions and priorities change in the coming years.

Pilot projects should include a small number of RCs (perhaps no more than three) to keep the effort administratively efficient, but include as many of the service categories as feasible to gain as much insight as possible from the pilots. Within each of the service categories under study, the pilot should include a small handful of providers, perhaps along a number of dimensions, such as size, level of consumer need, and location. Although RCs and DDS would collect information and make implementation adjustments throughout the course of the pilot projects, the Legislature should require DDS to compile a final set of lessons learned at the end of the pilot process about whether the rate models themselves need revision, approaches for handling implementation challenges, and best practices overall.

Fiscal Impact

The cost estimates for the staged rollout would be the same as those listed in option #1. The added cost to conduct pilot projects would be relatively low. The Legislature could appropriate a fixed amount it wishes to spend on pilot projects and DDS could design them accordingly, based on the fixed amount and with consideration to the following factors:

- How many RCs, service categories, and service providers to include.
- How many consumers are served by each of those providers.
- The administrative resources DDS and RCs would need to implement and manage the pilot.

Assessment of the Pilot Projects

Implementation Feasibility. Pilot projects have a number of potential feasibility challenges and they raise other issues, but ones we expect could be largely resolved.

- ***Whether to Seek Federal Funding.*** Seeking federal CMS approval for the pilot may be time consuming and necessitate a greater understanding of how the rate models will be implemented than is known right now. While it is normally important to draw down whatever federal resources are available, the cost to secure these funds for pilot projects (in terms of delays) may outweigh the benefit. It is also the case that the amount of foregone federal funding may be relatively modest in the context of pilot projects. Accordingly, we suggest that the Legislature consider funding pilots with General Fund dollars and not awaiting federal approval for the pilot-tested rate/service changes.
- ***Ensuring Widespread Participation of Service Providers.*** Among providers, there may be little incentive to participate in a pilot if their rate is actually reduced. For example, the rates for work activity programs face a net reduction under the rate study's proposed rate models. Even within service categories that would receive a net increase (such as individual supported employment), some providers (such as those in the San Francisco Bay Area) will face a reduction. This issue may be difficult to resolve. Providing participation incentives to these providers, for example, would compromise the integrity of the pilot.
- ***How Much Flexibility to Grant DDS, RCs, and Providers.*** We suggest providing DDS and the participating RCs and providers as much flexibility as possible under the pilots to see what works. The primary objective of the pilot projects is to understand and work through the implementation challenges, identify and develop appropriate policies (via statute, regulations, and guidance), and ultimately to submit a request for federal CMS approval to roll out the rate models on a statewide basis in 2020-21 or later. Rather than expecting DDS or RCs to anticipate all potential issues or prepare guidance in advance, the pilots should instead give the participating RCs a reasonable amount of discretion to implement the models with their participating providers. DDS could provide basic technical assistance and oversight. There is a precedent for using a pilot project to test rate methodologies. In 1987, a pilot was conducted with three RCs to test an alternative residential model (ARM) rate structure for residential facilities. After the pilot, DDS phased in the ARM rates with other RCs. ARM rates are still in use today.

DDS has noted several concerns and potential challenges associated with a pilot program, and we address these below.

- ***Inappropriate Use of Services and Service Codes.*** If a select set of service categories were included in the pilot, DDS notes that it could create an incentive to overuse those categories if the rates were higher than the rates in other categories. We are less concerned about this potential outcome given that only a few providers within a given service category would be included, and because the Legislature may also wish to

provide other forms of fiscal relief to nonparticipating providers (discussed in the next section of this letter).

- ***Significant Amount of Administrative Work for DDS and Participating RCs.*** DDS notes that it may be as much work administratively for DDS and the participating RCs to implement a pilot project as it would be to implement rate models fully, and that they would need additional resources for this administrative work. Although we agree that additional resources would be needed, we believe a pilot is likely to require fewer administrative resources than full implementation would. For example, the administrative workload under a pilot should be less given that: (1) funding pilots fully with General Fund dollars eliminates the need to seek federal approval, (2) new regulations or even emergency regulations may not be necessary to implement the pilot, and (3) the limited number of participating RCs and service providers would necessarily limit the amount of technical assistance needed.
- ***Results at One or Two RCs May Not Be Generalizable to All RCs.*** DDS raises an important point that because of differences in wages and real estate costs across the state, the pilot results for one RC may not be applicable to other RCs. One way to mitigate this concern is to select three RCs for participation, representing three different major cost areas. This would allow DDS to test rate models with differing regional rate adjustments. In addition, a number of the implementation challenges are more process-oriented than rate-oriented and would provide important lessons for a statewide rollout.

Efficacy. Given the small number of participating service providers (and thus consumers) in a pilot project, the impact on access to services or service quality would be limited. In terms of laying the groundwork for full implementation, however, a pilot program could be a rich source of information for how the more complicated rate models would actually work in practice and would reveal the areas in need of greater refinement. Ideally, a pilot could shed light on how rate models affect service provision and whether they could potentially lead to improved consumer outcomes.

Rate Model Readiness. The proposed rate models for a number of service categories appear to need greater refinement. For example, day programs, transportation, and early intervention/infant development stand out. An important purpose of the pilot projects, however, is to shed light on whether the rate models themselves need adjustment. We would thus suggest allowing the participating RCs and service providers to move forward with implementing the rate models even in cases where greater refinement appears needed, and provide regular feedback to DDS (and the Legislature) on known and emerging implementation issues as well as approaches they have taken, if any, to resolve them.

Status Quo Options for Increasing Funding for the Providers Not Benefitting From Rate Reform in 2019-20

Recognizing the Legislature's interest in providing fiscal relief for all service providers in 2019-20, regardless of whether the rate models are fully implemented, we list numerous options below for doing so within the existing status quo rate framework. The options listed have

generally been suggested previously by Members and/or the advocacy community at budget hearings. These options are listed for informational purposes and do not necessarily reflect our office's support of them.

The fiscal estimates provided for individual status quo options in Figure 3 were provided by DDS (except the General Fund estimate to fix the state minimum wage quirk) and account for the cost to effect the change across *all* providers. Accordingly, if the intent is to apply the status quo option only to those providers that are not part of the staged rollout of the rate models in 2019-20, the incremental cost of the status quo option would be less than if it were applied to all providers. In the next section, we provide fiscal estimates if one or more of these options were packaged with the staged rollout rate study implementation option described above.

Figure 3

Summary of the Added 2019-20 Costs to Implement Status Quo Options Under the Current Rate Framework

(In Millions)

Option	Total Funds	General Fund
Fix the state minimum wage quirk	$16.1	$8.0
Cover local minimum wage	Unknown	Unknown
Repeal uniform holiday schedule	50.3	30.1
Repeal half-day billing policy	2.7	1.6
Restore social recreation and camp services[a]	23.2	14.8
Increase rates across the board: 8%	464.0	296.5
Increase rates across the board: 4%	232.0	148.3

[a] The cost to restore social recreation and camp services in 2019-20 would reflect a ramp-up period. The Department of Developmental Services estimates the full-year cost at $42.9 million total funds ($27.3 million General Fund).

Note: These amounts reflect the cost to apply the increase to *all* service providers and would likely be lower if packaged in combination with a staged rollout of the proposed rate models.

Option—Fix State Minimum Wage Quirk

In our recent analysis of the Governor's 2019-20 budget proposal, *The 2019-20 Budget Analysis of the Department of Developmental Services Budget*, we highlighted a quirk in the current rate-setting process that allows certain providers to request rate adjustments when the state minimum wage increases (to cover the added staffing costs for minimum wage employees). Current law—as interpreted by the administration—does not enable providers in areas with local minimum wages (exceeding the state's) to request any rate adjustment associated with the *state* minimum wage increases. This results in these providers not being able to seek rate adjustments for either the local minimum wage increases or the state minimum wage increases, despite higher staffing costs. We suggest in this earlier analysis that the Legislature could conduct statutory cleanup to allow these providers to request increases associated with the state minimum wage increases taking effect January 1, 2020. Our office assumes the cost for this ($16.1 million total funds as estimated by DDS and $8 million General Fund as estimated by our office based on DDS' estimate of total funds) is above the $83 million ($42 million General Fund) for state minimum wage increases already in the Governor's proposed 2019-20 budget.

Option—Cover Local Minimum Wage

Another option for the Legislature to consider is fully covering the cost of local minimum wages. There is no precedent for doing this in the context of the DDS system, however, so such an action would represent a significant policy shift. The cost to cover local minimum wages is unknown, but would likely be in the low hundreds of millions of dollars from the General Fund. If the Legislature wanted to pursue this option, the administration would need additional time to prepare a refined fiscal estimate.

Option—Repeal the Uniform Holiday Schedule

The Governor's 2019-20 budget proposes enforcement of the "14-day uniform holiday schedule," which prohibits service providers in certain nonresidential service categories from billing for services on 14 set days per year. It was originally enacted as a cost-savings measure during the recession. DDS estimates that if this policy was repealed and RCs instead had their own policies that averaged eight days annually, it would cost $50.3 million in 2019-20 ($30.1 million General Fund).

Option—Repeal the Half-Day Billing Policy

A current policy requires day program and work activity providers to bill for a half-day of service (rather than a full day) when a consumer attends the program for less than 65 percent of the day. This policy was originally enacted as a cost-savings measure during the recession. DDS estimates repealing this policy would cost $2.7 million in 2019-20 ($1.6 million General Fund).

Option—Restore Social Recreation and Camp Services

During the recession, the state suspended social recreation and camp services as a cost savings measure. DDS estimates that restoring social recreation and camp services would cost $23.2 million in 2019-20 ($14.8 million General Fund). DDS expects it would take some time to fully restore these services, meaning that estimated costs in 2019-20 reflect partial-year costs. DDS estimates the full-year cost at $42.9 million ($27.3 million General Fund).

Option—Increase Rates Across the Board

Assembly Members Holden and Frazier and various advocates have called for an across-the-board rate increase for DDS service providers in 2019-20. Although an across-the-board increase would not be the most cost-efficient method for increasing rates (because some providers may need more or less funding than others to remain sustainable), it would be relatively simple to implement administratively and all providers would receive some fiscal relief. One trade-off with an across-the-board increase is that some of the providers that would receive rate increases in 2019-20 could face subsequent rate reductions once the rate study's proposed rate models are fully implemented. Although this outcome could be addressed with hold-harmless provisions, such provisions would represent a deviation from the logical structure of the proposed rate models. The advocates indicate they are requesting an 8 percent across-the-board increase because it reflects corresponding changes in the consumer price index since the last rate increase in 2016. If the Legislature pursued this option, it could choose the 8 percent amount or some other potentially lower amount. We provide the example of both a 4 percent and 8 percent rate

increase in Figure 3. DDS estimates that an 8 percent increase would cost $464 million in 2019-20 ($296.5 million General Fund). We then estimate that a 4 percent increase would cost half that—$232 million in 2019-20 ($148.3 million General Fund).

Packaging Options

The Legislature might wish to package one of the rate study implementation options (staged rollout or staged rollout along with pilot projects) with one or more of the status quo funding increase options. This would provide some measure of fiscal relief to providers whose service categories are not included in the first stage of rollout or who are not participating in the pilot program.

Below, we have provided some examples of the cost to package the individual status quo funding increase options with rate models under the staged rollout rate study implementation option. (It is important to note that the cost estimates of the packages reflect that providers whose rates are set by one of the proposed rate models in 2019-20 would not receive additional funding under the status quo option.) The last two rows provide estimates for the cost to package more than one status quo option with the staged rollout. The final column represents the cost to include all four service categories in the staged rollout with the various individual status quo options. These fiscal estimates were developed by our office based on the information provided by DDS about the individual costs of rate models and status quo options. Figure 4 (see next page) is the cost in total funds, while Figure 5 (see next page) is the General Fund cost. Please note that for both figures, estimated costs are *relative* to the Governor's 2019-20 budget proposal. Also, to the extent a staged rollout is combined with pilot projects, the cost of the pilot projects—at whatever level chosen by the Legislature—would be added to the estimated package cost (as shown in the figures) to arrive at a grand total cost.

Other High-Level Considerations for Long-Term Implementation of Rate Reform

This letter operates under the assumption that the rate models developed and proposed by Burns are sound and represent the right direction for the DDS system. Overall, our office believes the rate models could ameliorate some of the rate-setting and service provision challenges in the DDS system, such as rates that are outdated, not transparent, and not equitable across similar providers or similar consumers. At the same time, a number of issues associated with the rate models warrant further discussion.

Proposed Rate Models Take a "Fee Schedule Approach" for All Services

The statute calling for the rate study required it to include consideration of alternative rate-setting methodologies. In its report, Burns notes five methods for setting rates that were presented by CMS in 2016 and 2017 and comply with Medicaid requirements: (1) fee schedules akin to a fee-for-service system, (2) negotiation within a range of permissible market rates, (3) cost reconciliation based on actual costs, (4) tiered rates based on the characteristics of the individual served and/or the provider, and (5) bundled rates for more than one service. Based on the potential risks, benefits, and disadvantages of the various methods, Burns concluded that a fee schedule system makes the most sense. It noted that this method is transparent, supports equity across providers and consumers, and simplifies rate setting. Burns notes that it also

Figure 4

Cost to Package Staged Rollout With Individual "Status Quo" Funding Increase Options

2019-20 Estimated Cost[a], All Funds (In Millions)

Status Quo Funding Increase Options	Staged Rollout of Rate Study Models				Example Combinations . . .	
	Residential Services	Employment Services	Respite Services	ILS	Employment, Respite, ILS	All Four Services
Fix state minimum wage quirk	$965	$39	$64	$15	$86	$1,035
Repeal UHS	999	74	100	49	122	1,071
Repeal half-day billing policy	951	26	52	2	75	1,023
Restore social recreation and camp services	972	47	73	22	95	1,044
Increase rates across the board: 8%	1,276	475	481	451	480	1,428
Increase rates across the board: 4%	1,112	250	265	225	276	1,224
Example Combinations . . .						
Fix state minimum wage quirk and repeal UHS	1,015	90	115	65	137	1,085
Repeal UHS and half-day billing policy, restore social recreation and camp services	1,025	100	126	75	148	1,097

[a] Cost is relative to the Governor's 2019-20 budget proposal.

Note: We do not include the status quo funding increase option of fully covering local minimum wages because the cost is unknown.

ILS = independent living services and UHS = uniform holiday schedule.

Figure 5

Cost to Package Staged Rollout With Individual "Status Quo" Funding Increase Options

2019-20 Estimated General Fund Cost[a] (In Millions)

Status Quo Funding Increase Options	Staged Rollout of Rate Study Models				Example Combinations . . .	
	Residential Services	Employment Services	Respite Services	ILS	Employment, Respite, ILS	All Four Services
Fix state minimum wage quirk	$615	$23	$39	$7	$53	$660
Repeal UHS	637	45	62	29	76	683
Repeal half-day billing policy	609	17	33	1	48	655
Restore social recreation and camp services	622	30	46	14	61	668
Increase rates across the board: 8%	816	304	308	288	307	914
Increase rates across the board: 4%	712	160	170	144	176	784
Example Combinations . . .						
Fix state minimum wage quirk and repeal UHS	645	53	69	37	83	690
Repeal UHS and half-day billing policy, restore social recreation and camp services	654	62	78	46	93	700

[a] Cost is relative to the Governor's 2019-20 budget proposal.

Note: We do not include the status quo funding increase option of fully covering local minimum wages because the cost is unknown.

ILS = independent living services and UHS = uniform holiday schedule.

provides the ability to account for variation in the cost of service delivery, such as across regions. Although we agree that a fee schedule method may make sense in many cases, it is unclear whether this is necessarily the best or most appropriate approach in all cases. For example, we could imagine a scenario in which a bundled-service approach might make sense, such as in the provision of Early Start services for infants and toddlers. We make this point to raise awareness about the range of possible rate-setting methodologies and to note that a fee schedule approach is just one method of many. The Legislature may wish to consider the proposed rate models in this context as it makes decisions about how to handle short- and long-term rate reform.

We now turn to a high-level evaluation of the benefits and trade-offs of the rate models proposed in the Burns study.

Benefits and Trade-Offs of Proposed Rate Models

The proposed rate models offer a number of benefits that would likely improve significantly upon the current system, yet in some cases, they appear to need refinement and further discussion with RCs, providers, and DDS consumers and their families to understand how they would be operationalized and to understand the potential impacts and unintended consequences.

Rate Models Are Logical and Transparent. Each of the proposed rate models is built on several key factors—the wages, benefits, and productivity of direct care workers (the DSPs); program operations expenses; and administrative expenses. Each of these factors is based on accessible data and information, such as wage data from the Bureau of Labor Statistics (BLS). The rate study also applies adjustment factors for regional variation in cost, based on the geographic service area of each RC.

Rate Models Could Be Updated at Regular Intervals. A benefit of having logical rate models built on transparent and accessible data and information is that the individual components can be updated at regular intervals. For example, wage data could be updated when BLS releases new datasets. Additional components that should be revisited on a regular basis (even if not as frequently as the wage data) include the regional adjustment factors and worker productivity assumptions (which were based on a survey Burns conducted with service providers in 2018). If the proposed rate models are ultimately adopted, we recommend the Legislature require DDS to prepare updates to the rate models when the state minimum wage increases and at other regular intervals to reflect increases in the costs of doing business, and to provide a clear description of its methods. Even if the state is not in a position at the time to absorb the additional costs associated with these updates, it will be important to use this process to understand costs and to maintain fidelity to the design of the rate models.

Some Providers Will Receive Rate Reductions. If fully implemented, the proposed rate models will result in rate reductions for a number of providers. While in some cases this could mean that services are currently overfunded, in other cases a reduced rate could lead to problems with consumer access to services or with the quality of services.

Local Minimum Wages Are Not Considered Explicitly. Although Burns specifically made an adjustment to wage assumptions in the base rate models to account for increases in the state minimum wage, it did not do the same to account for local minimum wages. The rate study notes that applying the proposed regional adjustment factors (which reflect BLS regional data and

consequently end up capturing these higher labor costs to some extent) leads to wages that end up exceeding local minimum wages. Burns acknowledges that this does not work in all locations for long, however. Once the local minimum wage reaches $15 per hour in 2020 in Los Angeles, the DSP wage built into many of the rates for Los Angeles providers—$14.89—will fall short. Although other factors, such as administrative, operations, and supervisory costs, are components of the final rate (meaning the final rate exceeds $14.89), this approach does not appear to support equity across providers, one of the benefits of fee schedules cited by Burns. For example, the DSP wage built into the models in many other regions fully covers the cost of the minimum wage, giving those providers more cushion for other expenses (or to even pay DSPs a wage several dollars above the minimum wage).

Rate Models Add Administrative Complexity in Some Cases. The rate study assumes that service providers will spend the same dollar amount for administrative costs that they do currently, yet in some cases, the proposed rate models add administrative complexity. For example, day program providers would transition from billing a daily rate to an hourly rate and the rate could vary throughout the day based on whether the consumer is out in the community or at the day program facility.

Rate Models in Certain Service Categories Could Benefit From Additional Deliberation. Some of the rate models require more complex changes to providers' program designs and business processes. We note this appears especially true for early intervention/infant development (and associated therapies), day programs, and consumer transportation. In the area of infant development, for example, the reconfiguration of the service code and requirement that any needed therapies be billed at Medi-Cal rates (with the possibility of a 39.7 percent supplemental payment) appears to reduce flexibility and potentially reduce net rates overall for some providers. To the extent that early intervention can improve later life outcomes for children and their families and potentially save the state money in the long run because a child no longer needs special education or lifelong DDS services, we suggest revisiting the assumptions that were used to build the proposed rate model in this area (even if this service category is part of pilot projects).

Other Considerations

Compliance With HCBS Rules. Although the rate study includes consideration of compliance with the HCBS rules that will take effect in 2022, it does not specifically address or explain DDS' plans for how it will handle rates for services that may not be HCBS-compliant. In the rate study, there is at least one example of how the new rate models signal DDS preferences, yet this preference is not addressed directly. Specifically, residences that serve seven or more consumers were not provided a new rate model in the rate study, yet there is no written explanation for why that is. We learned in conversations with Burns and DDS that because homes serving seven or more residents will not be compliant with HCBS rules, they did not develop a rate model for them (the rationale being that limiting rate increases for these providers could provide a disincentive to operate such homes). We suggest a more transparent process. DDS should specifically identify the services it hopes to phase out by 2022 and develop a plan for how these services will be phased out, one that would ensure consumers have access to good alternative services. An important example in this regard is work activity programs, or "sheltered

workshops." Based on the various cost inputs, the rates for these programs will decline under the new rate model (reflecting that these programs may have been overfunded). DDS has not yet indicated whether these programs will be allowed after HCBS rules take effect (if they are allowed, they will likely not be eligible for federal funding, meaning the state would have to fully fund them), nor has it developed a plan for how to offer alternative services, including CIE, to consumers currently participating in these workshops.

Considering Quality and Innovation in Service Provision. The rate study notes that it is difficult to directly affect the quality of service through the rate-setting process. More indirectly, the rate study adds a rate premium for non-English speaking DSPs and it makes assumptions about the number of hours of training that DSPs should receive. The rate study offers future options for greater professionalization of DSPs, including the establishment of three levels of DSP, each with a greater degree of required qualifications and competence. The rate tied to each DSP level would be adjusted to reflect higher DSP wages as the DSP level increases. The fiscal estimate provided in the rate study does not yet include this option, therefore the full cost to implement rate models, including the three tiers of DSPs, is uncertain.

In addition, we note that the rate study does not discuss how innovation in service delivery will be supported by rates or how to adjust and use rate models to provide customized services to consumers. The rate study appears to support the ability to add services as needed. For example, a consumer may live in a home where a residential service provider tends to the consumer's basic needs, while a behaviorist is brought in to provide intensive supports. Although this method of authorizing additional supports and services could be used to provide a customized service design for an individual consumer, it is not clear how this would work in practice or the degree to which such approaches would receive support from DDS. Given that RCs are expected to coordinate services in an ever more integrated and person-centered way, it will be important to ensure enough flexibility in the rate-setting process to support an evolving system.

Reconciling the Rate Study With Self Determination. DDS is in the process of implementing its Self Determination Program (SDP), which gives a consumer and his or her family discretion over which providers to work with and how to spend the consumer's DDS-funded "individual budget" to secure the services he or she needs. The program includes certain requirements—the services must be HCBS-compliant and the consumer must work with a financial management service to pay providers and ensure proper payments—but the provider does not have to be "vendored" in the RC system and the rate paid is negotiated with the provider by the consumer and his or her family. SDP will be phased in with 2,500 individuals over the next several years and then offered to everyone in the system. It is unclear at this point how DDS intends to run two parallel systems with differing rules, whether it intends to standardize certain aspects across SDP and traditional service delivery, and what this means in terms of rate setting. While there are no easy answers, these are important questions to keep in mind as rate reform and SDP are considered and implemented simultaneously.

In closing, this letter offers two options to begin the process of rate reform in the DDS system in 2019-20—a staged rollout of proposed rate models starting with select service categories or a staged rollout along with pilot programs for other service categories. We also provide a list of options under the status quo rate-setting framework that could each provide a

measure of near-term fiscal relief to the providers not benefitting from the staged rollout or pilot projects.

Please do not hesitate to reach out to Sonja Petek in our office should you have any questions or if you would like an in-person briefing on the options offered in this letter for legislative consideration. Sonja may be reached at (916) 319-8340 or at Sonja.Petek@lao.ca.gov.

Sincerely,

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cc: Members of the Assembly Budget Subcommittee No. 1 on Health and Human Services
Hon. Joaquin Arambula