PathPoint
Supporting people in living the life they choose
Apoyamos a las personas para que lleven la vida que eligen

October 6, 2022

Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814

Dear Commissioners,

Thank you for the opportunity to provide testimony for the Little Hoover Commission's study on California's Developmental Disabilities System. I serve as the President/CEO of PathPoint, a nonprofit organization that supports people with developmental disabilities and behavioral health diagnoses in living the life they choose. Established in 1964, PathPoint provides person-centered supports to over 2,400 people across five counties: Kern, Los Angeles, San Luis Obispo, Santa Barbara, and Ventura. The agency has an annual budget of just under $30M, employs 500 people when fully staffed, and provides day services, employment services, and independent and supported living services.

I am relatively new to this work having assumed my current role in 2017 after a 25-year career in nonprofit conservation corps. I made this career transition after losing my 14-year-old daughter in 2016 to a mental health condition and have found this work to be incredibly meaningful. I am indebted to the many thought leaders across the state who have supported my learning including reviewing this testimony. More than anything, I am indebted to the individuals supported by the DD system and their families; they are the center of the system and, as service providers, our purpose is to support them in living the lives of their choosing. In that light, I am pleased to share these thoughts about the developmental disabilities system.

## 1.0 Workforce

### *1.1 One of Every Five Workers is Gone*

Without a doubt, the top issue facing PathPoint is workforce. We had 497 employees on March 1, 2020, and through attrition – without any layoffs or furloughs of regular employees – we dropped to 343 employees on April 1, 2022. We increased wages on April 1, 2022, in response to the first installment of the rate model implementation and this helped stabilize attrition. However, today we have just 366 employees, 131 (26%) below what we need to provide services at the same level as prior to the pandemic.

A survey of service providers earlier this year found that providers across the state had 19.3% fewer employees than they did pre-pandemic. Nearly one out of every five workers is gone! *Replacing the 19.3% lost workforce is necessary to serve their current caseload.* Extrapolating this out to the full system would mean that providers are **currently unable to serve 74,751 people** on their caseloads. Many individuals are only receiving a fraction of their authorized services while others are unable to access some services at all. Growing to support the additional 21,000 plus people that will be added to the system in 2022-23 will **require many thousands more workers** in addition to replacing the lost 19.3%.

Even scarier is data from Open Minds showing that demand for direct care workers is projected to grow nationally by 26% by 2030. The HCBS workforce – which includes DD services – will have 4.7 million total job openings from 2020 to 2030 including one million new jobs created by increased demand, 1.7 million openings created by turnover, and another two million created by workers leaving the labor force. This type of demand shows that the DD system's workforce crisis is likely to continue to worsen and has a dramatic impact on the ability of individuals – especially in high-cost areas – to receive the critical supports they need.

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*1.2 Turnover*

The ANCOR Foundation and UCP report in [The Case for Inclusion 2022]() that the average annual turnover rate for DSPs is **43.6%.** This means that providers must replace nearly half of their workforce every year leading to service disruptions, training/orientation issues, increased costs, and overtime. Most importantly, high turnover has significant impacts on the quality and continuity of care for the people receiving services as you most likely have heard from the panel of self-advocates and their families.

*1.3 Education level*

With reimbursement rates essentially stagnant for many years, there has been an eroding of the education level of DSPs. Long tenured colleagues at PathPoint remember when all DSPs had graduate degrees. Over time, this transitioned to DSPs holding undergraduate degrees. Today, less than a quarter of PathPoint's DSPs have a college degree. Most likely, workers with higher educational credentials have migrated to jobs that provide better compensation and benefits. It would be worth further investigation to explore how this change in education level has impacted the turnover and quality of this critical workforce.

*1.4 Solutions to the workforce crisis*

*1.4.1 Rates*. Clearly, an obvious solution is to increase payment rates with requirements to ensure that rate increases translate to corresponding pay increases for DSPs and other operational staff. (This requirement wouldn't be necessary at most providers since 70-80% of a typical provider's expenses – 81% at PathPoint – are personnel. It would ensure that outliers are not benefiting without increasing direct staff pay.) Raising pay to attract and retain DSPs is not the only solution and can be combined with other innovative approaches.

*1.4.2 Technology.* Another way to address workforce shortages – as well as prioritize independence and choice – is to reduce the number of employees needed by working smarter using technology. Just as important, technology also increases access and possibilities for individuals when it is allowed, funded and promoted. Unfortunately, current regulations don't allow for the staff ratio reductions that could be achieved through technology such as having one overnight employee monitor two neighboring homes using cameras (with privacy controls), motion detectors, and wearable tech. Likewise, a ratioed day service could reduce its ratio with tech-equipped individuals achieving more independence. Smart home technology could reduce staff hours while supporting individuals to become more independent. Additionally, this would lead to the fading of support that our system has largely not been successful in achieving.

Ohio is a [Technology First]() state and other states have also embraced this direction. Requiring fewer staff would free up funds to pay the remaining staff more (thus addressing recruitment and retention) along with covering technology costs. Fixing this issue would require addressing issues around licensing and DDS regulations that are discussed below.

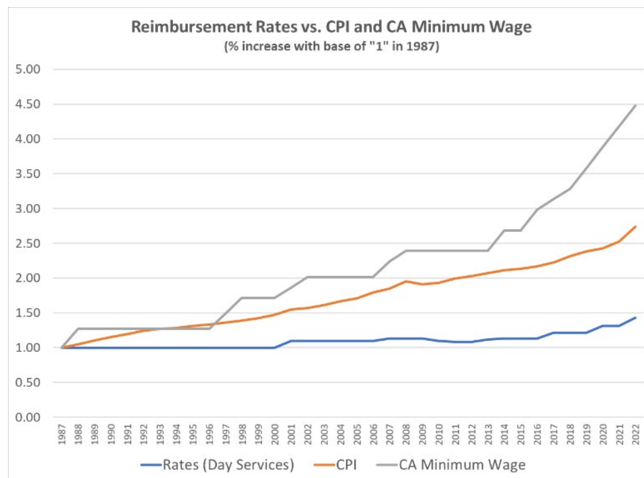
*1.4.3 Hybrid service models.* There remains a tension between the current DD system, which is operated as a fundamentally traditional medical model, versus a system that is built from the support needs of the individual and integrates community, home, technology, etc. The current menu of services is comprised of fairly rigid structures. A day service is usually five days per week, six hours per day. Job coaching must be provided in-person. Independent Living Services are no more than 20 hours per month. Allowing hybrid and remote service options – such as two days in person day service, one day individualized, and two days remote – would provide individuals with the person-centered choice they deserve while lowering the number of workers required. This will require fluidity in how service models are interpreted, flexibility and support for the transportation infrastructure, and training staff to prepare them to flow between community, facility, and home models. This approach also supports the transition from congregate settings to person-directed services and supports.

*1.4.4 Innovative payment structures.* As discussed below, transitioning from a fee-for-service structure to a value-based payment model[1] would provide the financial supports that allow providers to develop innovative service delivery models. These innovative models could address workforce challenges while promoting person-centered choice and independence.

## **2.0 Payment Structures**

### *2.1 Inadequate Rates*

While the workforce crisis was certainly exacerbated by the pandemic, it started much earlier when reimbursement rates did not keep up with inflation, increasing housing costs, and the rapid rise in state minimum wage. The recent legislation to implement the 2019 Rate Study over a multi-year ramp up will provide some relief, though still in no way addresses the full impact of inflationary and wage pressures. And the budget act that approved implementation of the rate study has no mechanism to provide on-going rate adjustments tied to inflation, thereby dooming the system to revert to the historic pattern shown in the graphic below. **The Governor and Legislature must enact a basic CPI-related adjustment to ensure the DD system is sustainable or the promise of the Lanterman Act is no longer a real promise.**




### *2.2 Rate Structure in California*

The current rate structure in California is confusing, inconsistent and, frankly, often unfair. This is not a new problem and not a problem that anyone currently involved in the system created. Rather, this rate system evolved over decades and has resulted in issues such as the following:

- *Consistency*. Rates for similar services across the state (or even within the same geographic region) have different rates. For instance, PathPoint operates the same day service in the San Fernando Valley and in Lancaster. Both are vendored through the same regional center, but one has a rate of $76.05/day while the other has a rate of $64.84/day. The reason? They were initially started at different times meaning that the arbitrary nature of when a program starts determines its rate rather than the service model, geographic region, individuals supported, etc. The rate models expect to address this issue.
- *Median Rates.* Statute requires that new services must receive the lower of the statewide or local median rate. This means that new services established in high-cost areas must receive a statewide median rate rather than a rate that reflects the costs of operating in that high-cost area. The rate models do not

[1] In contrast to traditional fee-for-service payment models that are based on the volume of care provided, value-based payment models reward providers based on achievement of quality goals and, in some cases, cost savings.

delineate a process for establishing rates for new services during the multi-year implementation phase so this will remain at least a short-term issue.

The implementation of the 2019 Rate Study is meant to address many of these issues by transitioning away from service codes to a much narrower grouping of program models with consistent rates across the state. While the implementation of the rate study is great news, there remain some significant challenges with its implementation:

- *Insufficient Rate Models.* Specific service codes have rates that are – for a variety of reasons – not reflective of current costs.
- *Missing Service Codes and Missing Services.* Specific service codes were not included in the rate study so there is not a pathway to set reasonable rates as cost structures change.
- *Innovative Services Not Included.* Some innovative services such as Project SEARCH do not have rate models so are being aligned with inappropriate service categories with insufficient rates.
- *Remote Access.* The rate models do not reflect the lessons learned through COVID, particularly the value of providing nonresidential services remotely.

*2.3 Fee-for-services versus value-based reimbursement*

The DD system in California is almost entirely structured as a fee-for-service compliance model where providers are paid for the services they provide even if a person would be more successful with less intensive supports. Essentially, providers are incentivized to maximize billing units (typically hours, days, or months) rather than incentivized to maximize quality. This is not to imply that providers don't focus on quality but rather that they are paid based on the number units of service they provide, not how well those services are provided. Here are some examples of how this plays out:

- An employment provider can only bill for job coaching when its job coach is physically with the individual at that person's job. In some cases, an individual no longer needs these intensive supports but the provider is only paid when they're provided. This can result in service provision that doesn't support independence.
- A residential provider has no incentive (and is actually disincentivized) to transition a resident to a lower level of care. Transitioning a resident who is no longer in need of a higher, more expensive home would create a vacancy in the home and a corresponding revenue loss.
- A day services provider is incentivized to maintain full enrollment and high attendance. Allowing an individual to attend only a few days a week would result in a loss of revenue, so a provider is disincentivized from providing customized services for individuals.

Job development is the only segment of the DD system that is currently an outcome-based payment structure. A provider only receives payment once an individual has been placed in a job regardless of how long the job development process took. This incentivizes placements rather than counting hours of "job development services". One downside is that the model risks providers focusing first on individuals who are easiest to place, saving for later those with more complex or challenging needs. A solution to this is to pay higher placement fees when placing those individuals with greater support needs. Additionally, placement fees should take into consideration the match between the job and the individual's hopes and dreams.

A true value-based payment model should include:

- A true "person-centered" Individual Program Plan (IPP) for every person, like an Individual Education Plan (IEP) in schools, with clear annual goals and objectives that are ambitious and lead to true quality of life outcomes. Providers should receive a fixed monthly payment for services that is augmented – or reduced – based on the individual's progress toward meeting their IPP goals.

- Payment for hours an individual works rather than hours spent job coaching. Oregon and other states use this model which incentivizes a provider to support an individual to be independent using natural supports (e.g., a friend at work), supportive supervisors, intermittent coaching, and remote supports.

*2.4 Challenges with Quality Incentive Program*

The 2021-2022 California budget called for a multi-year implementation of the 2019 DDS Rate Study along with an added quality incentive component. The goal of adding a quality incentive piece is fabulous! Unfortunately, the current design of the model has deep flaws, does not adhere to best practice, and will destabilize the support system individuals depend on. For example, it uses two different calculation methods over the implementation phase (percent of the rate increase, percentage of the total rate) that will result in many providers receiving rate cuts in 2024 below their 2021 rates. (They would have the potential to earn back the cut funds in 12-18 months after data is collected and analyzed.) This will destabilize the provider network that individuals depend on for services, especially since minimum wage increases and inflationary pressures are dramatically increasing costs.

The quality incentive program, as it's currently structured, would also result in hundreds of millions of dollars being lost to the system each year and require a complicated identification of specific incentives for each of the 40,000+ vendorizations. There are at least two potential legislative solutions that are cost neutral and would address the issues outlined above by changing the mechanism of how the quality incentive payment is calculated. A more ambitious proposal would be to scrap the current payment structure and design an innovative value-based payment structure that builds on best practices employed in other systems and other states; such an approach would most likely require pushing back the quality incentive program's start date.

## 3.0 Regulations and Flexibilities

*3.1 Updating regulations*

DD services in California fall under Title 17 of the California Code of Regulations, which was written before not only the internet age but even before the computer age. This leads to an overreliance on staffing and paper systems rather than technology. There should be a comprehensive review of Title 17 to update it for today's technologically advanced service delivery options. Such an update should consider the many flexibilities that could be embedded into the regulations around technology, remote services, and person-centered choice. The essence of the regulatory framework is to care and protect dependent adults; while health and safety is paramount, the essence of the regulations should also influence a system that helps individuals achieve socially valued roles and to retain authority and control over their services. Indeed, it is a testament to the individuals, families, providers, regional centers, and DDS that individuals are living meaningful lives often despite – rather than because of – the outdated regulations.

*3.2 Title 17 vs Title 22*

While DD services fall under Title 17 as stated above, providers that operate licensed day or residential services must also comply with Title 22 for Community Care Licensing (CCL). At times, these regulations – and the intent behind them – are in conflict. And, this conflict will continue to be accentuated by the Home and Community Based (HCBS) Settings Rule. CCL's primary interest is the health and safety of individuals under care in a licensed facility. The HCBS Settings Rule ensures that individuals have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate. Here are examples of where these rules run into conflict:

- We transport individuals from congregate day services into the community. Transportation in a vehicle with “PathPoint” on the side is not an integrated method of travel. Many people now use a ride sharing app to travel and we wanted to do likewise. CCL took many weeks of deliberation due to concerns about safety before reluctantly allowing individuals to travel by a ride sharing app.
- We desired to increase the enrollment in a licensed day service with the expectation that at least half of the individuals would be accessing the community daily. CCL required that we have a facility large enough to hold all the individuals even though we planned to have no more than half using it on any given day.

Simply put, Title 22 assumes the safest way to support individuals is to keep them inside facilities where there are back-up staff, accessible bathrooms, and climate-controlled environments. Supporting individuals to access the community involves adhering to the “dignity of risk” as a core tenant of the DD system as it transitions from a paternalistic to a person-centered system. CCL is under the Dept. of Social Services while DD services are funded through the Dept. of Developmental Services. At the risk of oversimplification, it seems that CCL and DDS should coordinate at a statewide level to address these challenges rather than individuals, providers, regional centers, and local CCL offices struggling through them on a repetitive case-by-case basis.

### *3.3 Consistency*

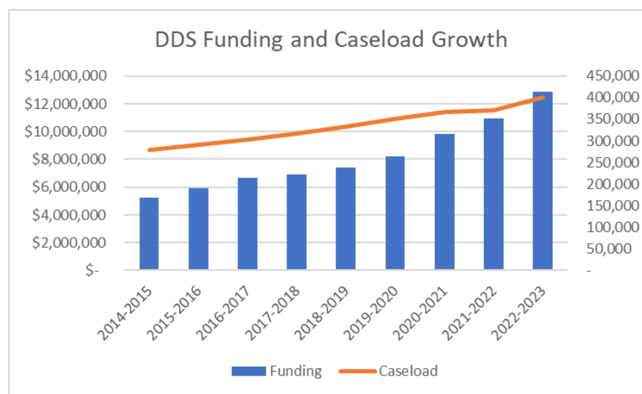
The overarching purpose of the Lanterman Act is meeting the needs of individuals, but the complexities of the system often make it convoluted and confusing. This is especially true for individuals who live near multiple regional centers and want to access services from more than one. With 21 regional centers there are often 21 different ways of performing basic functions such as completing a vendorization process, issuing service authorizations, and interpreting state regulations. PathPoint provides services in six regional center catchment areas, and we are constantly juggling our approaches to adhere to these different approaches.

The regional center system was designed to reflect local needs and there are places where customized approaches make sense. For instance, each regional center has some version of a Vendor Advisory Committee (VAC) that meets regularly with the regional center’s leadership to share updates and address issues. The VAC meetings at the very large North LA County RC are more formal than the VAC meetings at the smaller Kern RC, which has fewer vendors and a more casual approach.

Areas where consistency would be extremely beneficial are the vendorization process, the implementation of DDS directives, and service authorizations. Further, Los Angeles County has seven regional centers, and it would make sense to streamline the process of providing services across multiple regional centers. Additionally, with the advent of remote services, it’d be helpful to offer the same service across multiple regional centers or even statewide. It can be frustrating to individuals and families when services available in one regional center are not available in the neighboring regional center. Standardizing (perhaps through automation) to a much greater degree basic regional center processes and expanding the ability of individuals and vendors to receive and provide services across multiple regional center catchment areas would both support personal choice.

## **4.0 Inclusion and Sustainability**

The DD system is growing rapidly with over 400,000 individuals expected to receive services this year, an increase of 100,000 in just six years. Furthermore, the DDS budget has more than doubled in the past seven years. The CDC now estimates that one in every 44 eight-year-old children have autism – a significant increase over previous estimates – and it’s clear that the DDS system is going to continue to expand rapidly. A significant additional consideration is the important transition from congregate settings to person-centered services; without taking advantage of technology, supports that are customized to each individual require more workers – and cost more – than group services where one employee supports multiple people.




Fortunately, there is a natural alignment of what is good for individuals is also good for the financial sustainability of the system. An old credo of the disability rights movement is that people are not "disabled"; rather, society has not yet developed the supports to allow all people to live fully inclusive lives. California can take three important steps towards inclusion and all three will make the system more financially sustainable:

*4.1 Employment First*

California should prioritize employment for all working-age individuals in the DD system. Currently, just 13% of California's DD population is working. This is below the national average of 22% and far below states that have prioritized employment including MD (40%), OK (82%), OR (58%), RI (47%), and WA (84%). It is important to understand this is not purely an "apples to apples" comparison because California has an entitlement while other state systems only support a portion of the people who would have qualified for services in California. Challenges to expanding employment include reducing the impact on individual benefits, ensuring transportation is readily available, training provider staff on customized employment, and developing a value-based payment structure for employment.

*4.2 Independence*

Only 6% of individuals in the system live in Community Care Facilities (CCF). However, CCFs comprise 30% of the annual purchase of services budget. Supporting individuals to gain greater independence and person-centered choice in living situations could result in greater system-wide sustainability, especially if technology is incorporated into the supports. Additionally, supporting independence in other services like day and employment can have similar financial benefits through technology, regulations reform, value-based payment models, and hybrid services.

*4.3 Technology First*

As discussed earlier, a focus on technology could reduce the workforce demands, create greater independence and choice, and lower the costs of services. This is especially critical in the transition away from congregate settings to individualized services.

Thank you for the opportunity to share these comments and for your work to support individuals with I/DD.

Sincerely,

Harry Bruell
President/CEO