

## PROPOSED RESIDENTIAL RATE MODEL

### INTRODUCTION

Residential services provided by licensed Community Care Facilities (CCFs) to persons with developmental disabilities are an essential element in California's system of community services. Today there are approximately 4,500 CCFs statewide serving about 21,000 children and adults with developmental disabilities. The Alternative Residential Model (ARM) is a system of residential facility service levels developed in the late 1980s and implemented fully statewide by 1991 to determine the reimbursement for residential services.

In 1998, the California Legislature, by enacting Senate Bill (SB) 1038, substantially revised the Lanterman Developmental Disabilities Act and required the developmental disabilities service delivery system be updated so that the structure of the entire service system, as well as rates, adequately support the provision of services and supports to individuals with developmental disabilities. One of the community services impacted by the Lanterman Act was residential services.

In late January 2000, the Department of Developmental Services (DDS) contracted with the Center for Health Policy Studies (CHPS Consulting) to develop a cost model to be used for setting rates to be paid to providers of services and supports to individuals with developmental disabilities that have been vendorized by regional centers. The first phase of that project was to develop a cost model to be used for setting rates for services provided to persons residing in CCFs.

There were three factors that impacted and shaped the development of a cost model.

1. The purpose of the model was to better align the payment system for services and supports with the current philosophy of a consumer centered, individualized system of services and supports where services are tailored to the changing needs of adults and children with developmental disabilities. The ARM system of levels and rates is based upon defining the kinds of services that a CCF will provide and matching consumer needs to those defined services. The shift from one service delivery model to another required fundamental changes in the way that the system operates. For a number of years DDS has been involved in an intensive ongoing process of service delivery reform, defining consumer outcomes, services requirements and personnel requirements and performance based systems. The products from the various committees served as a framework for the cost model. CHPS also made periodic presentations and engaged in dialogue with several of the sub-committees throughout the development of the cost model.

2. The cost model that was to be built for implementation of the new residential services rate system was to be based on a “model” rather than on specific costs of providers of residential services.
3. There appears to be consensus that there is a link between improved quality service delivery and increasing the minimum qualifications for experience, education and training for administrators and direct care staff.

The report that follows presents the proposed cost model for residential services developed by CHPS.

### **FOUNDATIONAL CONCEPTS – GOALS, PRINCIPLES AND ASSUMPTIONS**

Goals, principles and assumptions for the residential cost model were developed as a part of the ongoing system reform efforts conducted by DDS and in SB 1038.

#### *Guiding Principles*

1. Choice – to facilitate to the extent possible a person’s informed choice in matters that affect quality of life.
2. Lifestyle – to provide sufficient support to ensure health, safety, respect, and the opportunity to make and sustain friendships.
3. Community Inclusion – to support full and equal participation in consumer’s natural communities, including activities with people who do not have disabilities.
4. Family Unity – to provide supports and services valued by children and their families and which enrich their lives.
5. Personal Outcomes – to allow a chosen or desired activity, life goal, or every day activity to be the anticipated result of the funded supports and services.
6. Quality Supports and Services – to support every person’s ability to pursue futures of their own design through flexible, creative, individually tailored services and supports in the least restrictive setting through a coordinated statewide service system.
7. Consumer Satisfaction – to allow maximum “customer-friendliness” and provide sufficient flexibility that the provider community is able to respond appropriately to the changing life goals, desires, and chosen outcomes.

#### *Requirements in SB 1038 that Impact the Cost Model*

- 1) Focus on individual consumer services more than facility classification.
- 2) Allow additional flexibility in the delivery and reimbursement of consumer services.

- 3) Promote greater integration, independence, productivity, and satisfaction among consumers.
- 4) Make changes without major disruptions for affected facilities or consumers.
- 5) Ensure the aggregate facility payments support the provision of services to each person in accordance with his or her individual program plan and applicable program requirements.
- 6) Reflect cost elements that include, but are not limited to:
  - a) Basic living needs
  - b) Direct care (tying service levels, relative need, and individual plan)
  - c) Special services (training, treatment, and supervision) required to be provided by the residential facility
  - d) Indirect costs calculated as projected costs for cost-effective operations
  - e) Property costs as represented by the fair market rental value of a model facility.
- 7) Take into account factors such as:
  - a) Facility size as represented by licensure and vendorization
  - b) Geographic variations in cost of living indices
  - c) Common levels of direct care for similar groupings of individuals
  - d) The presence of dually diagnosed individuals in a facility
  - e) Positive outcome attainment on the facility and individual level
  - f) Elimination of the variation in payment depending on whether the facility is owner operated or staff operated
- 8) Provide a process for updating the cost model data elements related to variables such as:
  - a) Economic trends in the state
  - b) Changes in the state or federal minimum wage
  - c) Increases (decreases) in fees, taxes, or other business costs
  - d) Increases (decreases) in federal supplemental security income or the state supplement program
- 9) Hold all individual facilities harmless from negative impact for one year.

*Other Policy Considerations*

In conjunction with meeting stated policy objectives of DDS, the cost model also strives to maximize cost-effectiveness, facilitate implementation and minimize disruption within the provider community and Regional Centers.

*Other Factors*

In addition to the Guiding Principles and Conceptual Requirements documented above, the new residential services cost model also allows for:

1. Support of the Department's policy to improve quality through training and wages rather than funding additional staff.
2. Compliance with federal Medicaid requirements.

3. Resolution of the issues articulated in the California State Auditor report of October 1999, focusing on inadequate funding, low wage scales for direct care, reducing case management caseloads, and improving the regional center budget process.
4. Support of each form of service being delivered.
5. Uniformity of cost elements, allowable expense ranges, and reasonable fund balances.
6. Use of “best practices” identified through an analysis of other states financial models and processes.
7. Administrative ease in updating and maintaining the various cost elements in the rate.

*Operational Requirements*

There are no clearly stated operational requirements in the statute for the redesign of the cost model. However, the cost model has been designed for optimal impact by adhering to basic operating principles of the industry, supported by research into emerging industry standards in the field of residential supports and services for people with developmental disabilities. The new cost model therefore:

1. Supports personal choices to:
  - a. Live in the least restrictive setting.
  - b. Move to a new home in a community of choice.
  - c. Change the patterns of supports or services available in his or her home.
  - d. Enjoy the highest possible quality of life.
2. Enables individuals to pursue personal outcomes that are private and individual.
3. Encourages “everyday” relationships and the ability to share in activities in the community with disabled and non-disabled citizens.
4. Maintains an adequate supply of quality and responsive supports and services in every community by:
  - a. Paying market prices for staff.
  - b. Paying market prices for homes, supplies and equipment and their maintenance.
  - c. Investing in the continued upgrades of staff skills and expertise, and technology.
  - d. Incorporating overhead for necessary administrative capacities for quality assurance, continuous quality improvement, and financial accountability.

- e. Providing management flexibility to shift resources (within parameters) to maximize productivity, respond to changing customer demand or need, or respond to emerging technology in the field.
- f. Maximizing the predictability of income or revenue, given customer choice, needs and characteristics.
- g. Stimulating competition.

The new residential services cost model design was developed with these principles, assumptions, requirements and objectives in mind.

It is important to note that the first iteration of the cost model is intended to cover homes that serve no more than 15 children or adults with developmental disabilities. Once the model has been finalized and agreed upon for homes of this size, it will be amended to create a payment system for larger homes.

## **PROCESS**

The first step in the development of the residential cost model was to complete a study regarding residential rate models in California and other states. Based on this research, CHPS recommended a methodology for construction of the model and sought to identify appropriate data to include in its formulas. In order for data to be considered adequate for the model, it had to be developed by a recognized source, updated regularly, contain sufficient detail to allow a geographic differential, fit into a relational database and be easily obtained.

CHPS identified items to include in the model and possible data sources. The information was routinely shared with DDS as a part of CHPS ongoing reporting responsibilities. Since DDS was very committed to its system reform efforts and wanted to keep its various committees informed of the progress of the development of the model, and since there was interest in obtaining information from the groups that would be impacted by the model, DDS asked CHPS to make a series of presentations to the Service Delivery Reform committees. Where appropriate, CHPS was asked to use the feedback provided by the committees to inform future recommendations.

The ensuing feedback process presented unanticipated issues. As stakeholders participated in the process, the model began to be perceived as a foundation upon which to build and enhance baseline assumptions, rather than as a framework within which to consider options. Ultimately, this led to stakeholders benchmarking each aspect of the cost model at favorable levels for the provider participants. Because the presentations took place while the various components of the model were being developed, there was not an opportunity to discuss how the incremental decisions recommended by the stakeholders impacted the overall model. Although efforts were made to occasionally amend stakeholder input, the committee members were more focused on the discrete components

than on providing expert guidance regarding a fluid model that would ultimately take competing priorities into consideration.

Rather than ask the stakeholders who participated in the process to amend the model, CHPS, in consultation with DDS, presents the model as developed by the stakeholders in the next section. The final section of this report describes the CHPS model. The CHPS model takes the stakeholder input into consideration but looks at the impact of the interrelationships within the model, and maintains a commitment to relying on industry standards, best practices and cost-efficient operational benchmarks.

It is important to recognize that there are still unresolved issues in both the stakeholder and the CHPS models. The models are presented here for consideration as part of the process, but they are not yet complete.

## **COST MODEL FOR RESIDENTIAL SERVICES**

### **Methodology**

#### *Design*

The residential services cost model is organized around two payment platforms. The Home and Its Operation is the “fixed” payment platform for residential services. The Individualized Supports & Services portion is designed to be developed into a “portable” payment platform that can be used to determine how much funding follows an individual should he or she choose to move to a different residence.

Each payment platform uses data elements required by legislation, DDS policy, and good management practice. Data elements that are included are responsive to industry standards, cost of living adjustments, individual choice and need, and regional variations. Additionally, each payment platform is designed to maximize the use of data elements that can be updated annually based on broad, industry-related standards that are available from sources outside of DDS. DDS (or its delegate) will therefore be able to use data collected, maintained and analyzed by others to update its cost model and payment levels. Where such data are not available, the cost model includes elements that can be entered into the cost model program as agreed upon amounts that can be trended using a cost of living adjustment or by completing simple research into current costs.

The two payment platforms, when combined, cover all the major elements required by legislation (basic living needs, direct care, specialized services, and indirect expense) related to recurring needs to sustain an individual in the home of his or her choice.

*The Home & Its Operation*

Definition

“The Home & Its Operation” incorporates two categories listed in SB 1038: “basic living needs” and “property costs”. This provides the “residential platform” for the cost model. These costs are considered the “fixed costs” of operating a home as a “facility” or as a “residence”.

Expenses included in this payment platform can be categorized in three groups:

- 1) The cost of owning (or renting or leasing) and operating a home given its size and geographic location;
- 2) The cost of delivering the baseline level of direct care staffing needed to safely meet the ADL and community integration needs of the people who live there; and,
- 3) Indirect expenses.

The value of this conceptual approach is that it provides a simple payment platform for home-based fixed costs. It provides a predictable yet responsive payment platform and methodology that will adjust easily to the national trend towards consumer choice.

It must be noted that the “baseline” staffing expense included as part of the “fixed” payment platform is ONLY responsible for the basic community integration and ADL supports required to maintain any group of consumers who live in the home. All additional ADL or specialized needs (medical, behavioral, etc.) dictated based on the requirements of specific individuals as documented in the Individual Program Plan (IPP) are addressed in the second payment platform – “Individualized Supports & Services”.

Components

The components of The Home and Its Operation are detailed below:

<b>COST ELEMENTS</b>	<b>AMOUNT</b>	<b>DESCRIPTION/DATA SOURCE</b>
<i>Property Costs</i>		
Housing	Variable based on size and location of home	Cost to own or rent a home. Based on HUD Fair Market Rental (FMR) values in each Metropolitan Statistical Area (MSA). HUD data includes insurance, utilities (except telephone) and taxes.
Capital Maintenance	A set percent of housing cost above FMRV	Cost to maintain the home and its furnishings. Based on similar amounts in other states.

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<b>COST ELEMENTS</b>	<b>AMOUNT</b>	<b>DESCRIPTION/DATA SOURCE</b>
Telephone	\$25/home/month	Cost of basic phone service for personal use of consumers. Based on data from Pacific Bell.
Food	\$/person/month	Cost of food for consumers. Based on USDA monthly costs.
Transportation	Covers only local, home-related, not to programs or services	Based on IRS rates for miles and costs, multiplied by number of people in the home.
Services	Cost per home per month	Cost of routine home and property services, e.g., lawn care, trash removal. Based on local experience.
<i>Baseline Staffing</i>		
Wages	Variable based on location of home	Cost to staff home according to existing regulations in Title 17 and Title 22. Wages based on Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) survey.
Replacement Factor	Percent of wages (including supervisor wages)	Cost of "replacement" staff to cover vacation, holidays, illness and training.
Supervision	Variable based on location of home	Cost of supervisory staff for direct care staff, assuming 1 Professional Level I supervisory staff for every 10 direct care staff. Wages based on Bureau of Labor Statistics Occupational Employment Statistics (OES) survey.
Fringe Benefits	% of wages	Cost of mandatory and non-mandatory fringe benefits for direct care staff. Based on research regarding current costs.

COST ELEMENTS	AMOUNT	DESCRIPTION/DATA SOURCE
Indirect Expenses	Cost of covering organizational infrastructure.	Indirect costs associated with baseline staffing, including administrative expenses. Based on average allowed percentage in other states
Geographic Adjustment		<p>Costs related to housing are adjusted based on variation between regions observed in the HUD FMR data.</p> <p>Costs related to staffing are adjusted based on variation between regions observed in the BLS OES data.</p>

*Individualized Supports and Services*

Definition

“Individualized Supports and Services” is that portion of a person’s residential care that is above the baseline care provided in the Home and Its Operation platform. Whether a consumer requires additional support funded through the ISS will be determined as part of their Individual Program Plan (IPP). The best way to conceptualize the different platforms is to consider that the Home and Its Operation platform is tied to the facility. The ISS is tied to the person, and is, therefore, portable.

Expenses included in this payment platform can be categorized in two groups:

- 1) Expenses directly related to individual choice, capacities and needs; and
- 2) Indirect expenses.

A “portable” funding platform must be tailored to the individual. This payment platform provides funding for additional supports or choices (over the baseline) that the individual will need to sustain them in the home and community, regardless of where they live.

This portable package is the individualized complement to the basic package for anyone living in the home. A zero-based approach has been taken; that is, nothing is added through this payment platform unless it is specifically identified in an IPP and requires resources in excess of the baseline provided through The Home and Its Operation.

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The cost model accomplishes this by designing Individualized Supports and Services to capture those expenses tied directly to a person’s individual capacities, choices and/or needs as described in an IPP or in personal outcomes. The proposed cost model characterizes these expenses as including:

- Added direct care staffing for extra (or extraordinary) ADL support needs. This staffing is defined as services needed to provide adequate supports for the person’s life at home and for any basic movement within his or her community.
- Added direct care staffing to maximize attainment of personal outcomes. This staffing is defined as additional direct care staff to enable the person to pursue activities outside the home that are specifically related to articulated personal outcomes.
- Added staffing to deal with medical or behavioral issues.

### Components

The components of Individualized Supports and Services are listed below:

<b>COST ELEMENTS</b>	<b>AMOUNT</b>	<b>DESCRIPTION/DATA SOURCE</b>
Wages	Variable based on location of home	Cost to provide staff to support individuals’ needs within the home. Four levels of direct care staff are defined: Para-Professional I, Para-Professional II, Professional I and Professional II. In addition, several types of staff required for specialized services (behavioral and medical) are itemized. Wages based on Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) survey.
Fringe Benefits	% of wages	Cost of mandatory and non-mandatory fringe benefits for direct care staff. Based on research on costs within California
Replacement Factor	% of wages (including supervisor wages)	Cost of “replacement” staff to cover vacation, illness, paid holidays and training.
Supervision	Variable based on location of home	Cost of supervisory staff for direct care staff, assuming 1 Professional Level I supervisory staff for every 10 direct care staff. Based on Bureau of Labor

COST ELEMENTS	AMOUNT	DESCRIPTION/DATA SOURCE
		Statistics Occupational Employment Statistics (OES) survey.
Indirect Expenses	A percent of total staffing costs.	Indirect costs associated with the Individualized Supports and Services Platform, including administrative expenses. Based on average allowed percentage in other states.
Geographic Adjustment		Costs related to staffing are adjusted based on variation between regions observed in the BLS OES data.

### Analysis and Supporting Data for Stakeholder Model

#### *Housing*

##### Rates

The rate components for housing costs are established based on data from the Department of Housing and Urban Development (HUD). Each year, HUD publishes updated Fair Market Rental (FMR) values for each state and Metropolitan Statistical Area (MSA). The stakeholder version of the residential services cost model relies on the median (50<sup>th</sup> percentile) FMR values published by HUD in 2000. Baseline housing rates are based on the median FMR value of a four-bedroom home.

Telephone costs are outside the FMR value set by HUD. Regional costs for phone service in California are approximately \$25 per month.

The capital maintenance costs in the Stakeholder model are set at 48% of the total housing costs, based on an average of \$100 per bedroom per month.

Food costs, as mentioned, are identified through data from the USDA. The USDA identifies various levels of costs, based on consumer and what are termed “moderate and liberal” plans. The stakeholder model reimburses homes for \$244 per person per month, based on the Liberal Plan for adult males in 4 person homes.

The transportation model supported by the stakeholders includes leasing costs of \$480 per vehicle per month, based on an average lease cost of \$5,800 per year. This model assumes reimbursement for one vehicle for each 6 consumers in a

home. In addition, operating costs are reimbursed at the IRS rate of 34.5 cents per mile, for 1,000 miles per month.

The model reimburses for services in the home, such as lawn care and refuse removal. The stakeholders' model sets this fee at \$200 per month.

Regional Adjustment

Since housing costs vary widely, particularly in a state as diverse as California, it is important for the residential services cost model to account for these geographic differences. The percentage of variation from the “baseline” described above is used to adjust the allowed housing cost by region.

AREA NAME	Median FMR (4 Bedroom)	Variance from Median
IMPERIAL	\$830	0%
INYO	\$838	1%
COLUSA	\$839	1%
GLENN	\$839	1%
MODOC	\$839	1%
PLUMAS	\$839	1%
SISKIYOU	\$839	1%
TEHAMA	\$839	1%
TRINITY	\$839	1%
LASSEN	\$840	1%
Bakersfield, CA MSA	\$854	3%
Yuba City, CA MSA	\$862	4%
Fresno, CA MSA	\$867	4%
Visalia-Tulare-Porterville	\$883	6%
SIERRA	\$883	6%
KINGS	\$892	7%
MARIPOSA	\$915	10%
Redding, CA MSA	\$919	11%
MENDOCINO	\$952	15%
Merced, CA MSA	\$954	15%
Chico-Paradise, CA MSA	\$998	20%
DEL NORTE	\$1,001	21%
Modesto, CA MSA	\$1,021	23%
HUMBOLDT	\$1,030	24%
CALAVERAS	\$1,031	24%
AMADOR	\$1,041	25%
LAKE	\$1,050	27%
Stockton-Lodi, CA MSA	\$1,056	27%
Riverside-San Bernardino	\$1,080	30%

AREA NAME	Median FMR (4 Bedroom)	Variance from Median
TUOLUMNE	\$1,096	32%
Sacramento, CA PMSA	\$1,120	35%
Yolo, CA PMSA	\$1,188	43%
Salinas, CA MSA	\$1,194	44%
NEVADA	\$1,241	50%
San Luis Obispo-Atascadero	\$1,312	58%
MONO	\$1,312	58%
Los Angeles-Long Beach	\$1,351	63%
SAN BENITO	\$1,354	63%
Vallejo-Fairfield-Napa	\$1,467	77%
San Diego, CA MSA	\$1,470	77%
Ventura, CA PMSA	\$1,516	83%
Santa Barbara	\$1,556	87%
Orange County, CA PMSA	\$1,619	95%
Santa Rosa, CA PMSA	\$1,622	95%
Santa Cruz-Watsonville	\$1,889	128%
Oakland, CA PMSA	\$1,891	128%
San Francisco, CA PMSA	\$2,241	170%
San Jose, CA PMSA	\$2,280	175%

Supporting Information

In order to generate FMR values, HUD bases their calculations on information gathered through the Census, the Annual Housing Surveys completed to update the Census, and data gathered through annual Random Digit Dialing (RDD) telephone surveys. Ultimately these sources generate the range of rents that “recent movers” pay for housing. “Recent Movers” are those Americans who have rented new housing in the past fifteen months. These data are updated annually based on the Consumer Price Index (CPI) and the RDD survey.

HUD generates data that reflects national FMRs, but also publishes data by state and regional areas. The residential rate setting formula used by DDS will be based upon data generated for metropolitan statistical areas (MSAs).

*Staffing*

Rates

The rates for staffing costs are established based on data from the Bureau of Labor Statistics (BLS) in cooperation with state Employment Security Agencies. Each year, the BLS publishes updated wage data for each state and MSA based on the Occupational Employment Statistics (OES) survey. The residential services cost model relies on median (50<sup>th</sup> percentile) OES wage data for the

state of California. The median was selected for this calculation because the data regarding wages are not normally distributed throughout the state, and some very high cost areas skew the mean.

Wage levels were created by selecting occupational titles from the OES list that had education and experience requirements that were similar to those identified by the SDR Personnel Committee, and could reasonably be expected to be within the same labor pool as employees currently found within DDS residential programs. These wage levels were combined to create several categories of professional and paraprofessional staff. The occupations used to define direct care and specialized services staff categories are listed below.

<b>Occupational Title</b>
<b><i>Para- Professionals</i></b>
Residential Counselors
Human Services Workers
Recreation Workers
Teacher Aides, Paraprofessional
Teacher Aides and Educational Assistants, Clerical
Nursing Aides, Orderlies, and Attendants
Home Health Aides
Psychiatric Aides
Physical and Corrective Therapy Assistants and Aides
Occupational Therapy Assistants and Aides
<b><i>Professionals</i></b>
Social Workers, Except Medical and Psychiatric
Teachers and Instructors, Vocational Education/Training
Recreational Therapists
Licensed Practical Nurses
<b><i>Specialized Services</i></b>
Social Workers, Medical and Psychiatric
Instructional Coordinators
<b><i>Assessment/Case Management Staff</i></b>
Respiratory Therapists
Occupational Therapists
Physical Therapists
Speech-Language Pathologists and Audiologists

<b>Occupational Title</b>
<b><i>Para- Professionals</i></b>
<b><i>"Medical" Therapists</i></b>
Corrective and Manual Arts Therapists
Therapists, All Other
<b><i>"Other" Therapists</i></b>
<b><i>Registered Nurses</i></b>
<b><i>Dietitians and Nutritionists</i></b>
<b><i>Psychologists</i></b>

For purposes of this model, Paraprofessional I and II wage rates are based on the same occupational titles. Differences in wage rates are set based on years of experience.

The SDR Personnel Committee has recommended that the basic level of staffing for all DDS programs should be at the Professional 1 level. According to the most recently published OES data, this rate is \$13.50 per hour. The Stakeholders' group has noted that there is a lag between when OES data is collected, and when it is published, and has recommended that this rate be trended forward to adjust for this lag. This suggestion has been seriously considered, however, for purposes of the calculations presented below, the trend factor has not yet been added.

The stakeholders' model fully funds staff to be available at residential programs for 24 hours 7 days a week. Ultimately, therefore, the Professional I wage rate is applied for a total of 168 hours per week.

In addition to baseline pay, the need to support a consistent benefit package to employees has been a serious issue for reforming the system. The benefit package supported by the stakeholder group includes a replacement factor set at 13.5%. This factor includes 10 vacation days, 10 sick/personal days, 10 holidays and 5 days for training. There is also a 28.74% benefit factor added to support workers' compensation, payroll taxes, a health care benefit, and other mandatory fees. This factor is somewhat larger than that which has been budgeted by DDS for the regional centers in the past, and reflects the increases in cost related to workers' compensation. This percentage was developed by CHPS and includes employer contributions to health care at approximately 50% of the cost. Stakeholders had requested that health benefits be included in the model, but they were not consulted about the rate at which employers would contribute to the cost.

Regional Adjustment

Although staffing costs do not vary as widely as housing costs, it is still important for the residential services cost model to account for geographic differences.

**TAB H**

The rates used are based on the minimum and maximum adjusted wages across California as a whole. Because wage data for all occupations are not reported consistently across all MSAs, the subset of occupations that had data reported for every MSA in California was identified. A median hourly wage statistic for these occupations is used to measure variance across MSAs. The percentage of variation from the lowest cost region (Merced) is used to adjust the allowed wage costs by region per the table below:

<b>MSA</b>	<b>Median of Median <sup>1</sup></b>	<b>Variance from Median</b>
Merced	\$10.43	0%
Redding	\$10.63	2%
Fresno	\$10.72	3%
Visalia	\$10.72	3%
Chico-Paradise	\$11.18	7%
Yuba	\$11.28	8%
Modesto	\$11.37	9%
Riverside	\$11.43	10%
San Luis	\$11.49	10%
Stockton	\$11.51	10%
Bakersfield	\$11.64	12%
San Diego	\$11.71	12%
Santa Rosa	\$12.12	16%
Orange County	\$12.19	17%
Ventura	\$12.33	18%
Yolo	\$12.37	19%
Santa Barbara	\$12.42	19%
Sacramento	\$12.43	19%
LA-Long Beach	\$12.65	21%
Salinas	\$12.81	23%
Santa Cruz	\$12.88	23%
North Coast	\$13.01	25%
Vallejo	\$13.41	29%
Northern Counties	\$13.58	30%
Southwest Central	\$13.86	33%
Imperial	\$14.09	35%
Oakland	\$14.24	37%
San Francisco	\$14.46	39%
Mother Lode	\$14.63	40%
San Jose	\$14.78	42%
<sup>1</sup> Selected occupations reported in all CA MSAs		

Supporting Information

The Bureau of Labor Statistics generates wage data using the Occupational Employment Statistics (OES) survey and a Standard Occupational Classification (SOC) created by the federal Office of Management and Budget (OMB).

The OES survey is an annual mail survey measuring occupational employment and wage rates for workers in nonfarm establishments, by industry. The OES program samples and contacts approximately 400,000 establishments each year and, over 3 years, contacts approximately 1.2 million establishments. While estimates can be made from a single year of data, the OES survey has been designed to produce estimates using the full 3 years of sample. The full sample allows the production of estimates that are tied to geography, industry, and occupation.

The new SOC system, which will be used by all Federal statistical agencies for reporting occupational data, consists of 821 detailed occupations, grouped into 449 broad occupations, 96 minor groups, and 23 major groups. The OES program provides occupational employment and wage data at the major group and detailed occupation level. The OES survey provides average (mean) and median wages for each occupation. For the purposes of the cost model, median hourly wages for selected occupations were used to create the base rates.

*ISS*

While the ISS portion of the model is consumer driven and, therefore, difficult to predict, certain assumptions were made about the levels of individual supports likely to be offered throughout the system. The assumptions regarding support levels were driven by two factors. The first was the Title 17 regulations regarding the level of consultant hours and additional supports that must be available in each existing "level" home from 2 to 4I. The second was the level of staff that might be required to perform such functions.

To create an estimated fiscal impact statement the Stakeholders' model is based on the assumption that the full staffing for 168 hours at a professional level in the baseline home reduces the need to add enhanced staffing above the Title 17 requirements for homes by level. The fiscal assumptions also consider that since the level of staffing in the baseline home is professional, the largest percentage of additional staff (not including consultant hours) will be set at paraprofessional levels.

*Indirect Costs*

The model supports administrative infrastructure by applying an indirect cost component, which is calculated as a percent of total wage costs. Indirect costs typically include items such as agency administrative compensation for executive, financial, quality assurance and other management activities, and administrative facility costs. The stakeholders’ model sets this rate at 18.5%, which includes a basic rate of 17.5% that is often paid in other states, plus a 1% add-on for costs related to the Service Delivery Reform efforts, which may include, for example, enhanced training time required by existing staff.

**Fiscal Impact Projections for the Stakeholders Model**

Given the assumptions and specific values imbedded in the Stakeholder’s model, the fiscal impact estimate indicates that full funding of the model would require approximately \$1.2 billion dollars. This is the cost to the state once SSI payments from the federal government have been netted out. This compares to an estimated payment under the ARM model, given similar assumptions about funding programs at full occupancy, of \$442.5 million dollars. In addition to the total estimate, data are presented for a subset of MSAs in the table below.

**TABLE 1:**

**ESTIMATED FISCAL IMPACT OF STAKEHOLDER CONSTRUCTED COST MODEL**

MSA	Capacity	RM Payments/100	Stakeholder’s Cost Model/Total
All MSA Totals	21,581	442,553,304	1,210,153,960
Los Angeles - Long Beach	5,250	108,155,748	293,019,059
Riverside - San Bernardino	2,162	40,576,596	113,513,209
Oakland, CA PMSA	1,645	33,751,356	109,249,924
San Diego, CA MSA	1,758	33,080,448	93,671,453
Orange County, CA PM	1,544	33,768,720	84,299,420
Sacramento, CA PMSA	1,514	27,339,624	79,336,158
San Jose, CA PMSA	1,025	27,493,212	71,454,012
San Francisco, CA PM	716	15,312,648	48,550,505
Fresno, CA MSA	824	17,279,676	38,486,397

## Analysis and Supporting Data for CHPS model

As previously explained, the CHPS model has been developed in conjunction with information provided by stakeholders, and is based on industry standards, best practices, cost-effective management principals and professional experience. As various iterations of the model have been constructed, CHPS has attempted to balance the model so that no size or level home has been particularly advantaged or disadvantaged. This work is ongoing.

This model also establishes priorities among the specific goals of the model. The CHPS model enhances funding for wages and benefits, given the assumption that the greatest quality enhancement will be realized with qualified and stable staffing in the residential programs.

### *Housing*

#### Rates

Within the Home and Its Operation platform, the CHPS model reimburses providers at the HUD 40<sup>th</sup> percentile. This level, which is always published by HUD, is the level HUD relies on to reimburse states and others for government supported housing units. In fact, the 40<sup>th</sup> percentile was the only data published until recently, and may be the only data that is published in the future.

The CHPS model also benchmarked the data using the HUD 3 bedroom rate, based on the assumption that there will be 2 consumers in each bedroom. The model increases the baseline costs for each person over 6 within a home, and decreases the baseline for each consumer under 4 in the home. Capital maintenance costs based on a 3 bedroom home are 44%.

It should be noted that many facilities that are one person homes are, in fact, facilities that have only one DDS consumer in the home, but which are also funded through other systems. In the current model, these homes are being reimbursed for fixed costs as if there are no other consumers or funding sources, thereby overlooking the economies of scale that are realized in larger homes. Additional research on how to identify which homes may be larger facilities, and how to adequately reimburse in those cases, is still underway.

Telephone costs in the CHPS model are set at the previously noted \$25 per month. Food costs reflect the USDA's moderate plan, which is set at \$164.70 per person per month for adult males in 4 person homes. The industry standard suggests that the FDA moderate plan is consistent with average food needs. Should individuals have additional or special food needs, they can be supplemented within the ISS.

As noted, the transportation model supported by the stakeholders includes leasing costs and maintenance costs related to one vehicle for each 6 consumers. However, the IRS rate that the maintenance costs are benchmarked at is designed to reimburse for all costs related to transportation. Therefore, the CHPS model eliminates the cost of a lease, but maintains reimbursement at IRS rates for 1,000 miles per month.

The model reimburses providers \$100 per month for services in the home, such as lawn care and refuse removal.

#### Regional Adjustment

All regional adjustments in the CHPS model are completed in exactly the same way as in the Stakeholders' model. It is important to note, however, that when reviewing the fiscal impact of the CHPS model, more than three-quarters of the increase in funding is dedicated to covering the regional adjustments within the model.

#### *Staffing*

#### Rates

The CHPS model incorporates Paraprofessional IIs for baseline staffing. As mentioned, the stakeholders' have pointed out that OES wages in these titles may be too low to attract and retain the level of qualified staff that the programs are seeking. Given that there is a lag in the time between when OES collects their data and when they are published, the CHPS model trends the wage rates forward based on the Consumer Price Index (CPI). Given these factors, the median baseline wage is set at \$10.70, ranging from \$8.84 in the lowest cost region to \$12.53 in the highest.

Funding staff to be available within a residential program for 24 hours 7 days a week does not take into consideration that consumers are generally working or in day programs throughout the day. Therefore, the CHPS model establishes a baseline staffing standard of 138 hours per week. This assumes that consumers are out of the home in jobs or programs at least 6 hours a day, 5 days a week. In addition, live-in staff are rarely paid for sleep time. Therefore, 56 hours a week have been reduced in the baseline staffing for live-in programs. However, because time-and-a-half pay is also required for some of the live-in hours, the total time paid in live-in models is 95 hours.

The replacement factor recommended by CHPS is set at 12%. This factor includes 10 vacation days, 8 sick/personal days, 10 holidays and 3 days for off-site training. There is also a 28.74% benefit factor added to support workers' compensation, payroll taxes, a health care benefit, and other mandatory fees.

As in other accounting models, the CHPS model includes a 5% vacancy adjustment factor in the overall fiscal model to account for staff vacancies. The industry standard for such adjustments runs from 5-8%.

### Regional Adjustment

The regional adjustment used for wages is based on the same methodology as the Stakeholder model.

### *ISS*

The assumptions supporting the ISS for the fiscal impact analysis begin with baseline ISS hours as defined in Title 17. Given that homes will no longer be identified by level, and that there may be movement within the system, we have marginally enhanced the hours for basic support, and for consulting as well. Further, because CHPS incorporates Paraprofessional IIs in baseline staffing, the fiscal analysis reflects adding professional staff hours through the ISS.

It is important to note that these assumptions are useful only for the purposes of creating a fiscal impact projection. Ultimately, the payment provided to a program to care for consumers will be based on the Regional Center's determination regarding the appropriate amount of support hours that should be available to each consumer.

### *Indirect Costs*

The model supports administrative infrastructure by applying an indirect cost component, which is calculated as a percent of the total wage costs. CHPS model includes an indirect cost rate of 17.5% that is similar to amounts paid in other states.

### *Fiscal Adjustments*

As mentioned, the CHPS model has adjusted the formulas to ensure that homes of various sizes and levels in different regions are not advantaged or disadvantaged by their position within the system.

### **Fiscal Impact Projections for the CHPS model**

Given the assumptions and specific values imbedded in the CHPS Model, the fiscal impact estimate indicates that full funding of the model would require approximately \$599 million dollars. This is the cost to the state once SSI payments from the federal government have been netted out. This compares to an estimated payment under the ARM model, given similar assumptions about

## TAB H

funding programs at full occupancy, of \$442.5 million dollars. In addition to the total estimate, data are presented for a subset of MSAs in the table below.

MSA	Capacity	RM Payments/100	CHPS Cost Model/Total
All MSA Totals	21,581	442,553,304	598,999,672
Los Angeles - Long Beach	5,250	108,155,748	143,087,691
Riverside - San Bernardino	2,162	40,576,596	52,527,443
Oakland, CA PMSA	1,645	33,751,356	54,689,464
San Diego, CA MSA	1,758	33,080,448	44,460,469
Orange County, CA PM	1,544	33,768,720	45,489,590
Sacramento, CA PMSA	1,514	27,339,624	37,956,185
San Jose, CA PMSA	1,025	27,493,212	42,302,965
San Francisco, CA PM	716	15,312,648	23,980,977
Fresno, CA MSA	824	17,279,676	18,871,081

### UNRESOLVED ISSUES

The Cost Model is in draft form at this time, with many issues still unresolved. While there is general agreement about the basic structure, many policy decisions are yet to be made about individual cost elements, the value assigned to cost elements, and the more detailed structure of the model. Specific issues to be resolved include:

- 1) ensuring that the requirements of Title 17 and Title 22 are fully covered in the model, including consultant hours and similar issues.
- 2) Balancing the increased allocations across program models to ensure that appropriate increases are received across program levels and different sized homes in different regions.
- 3) Amending the model to appropriately reimburse for one person "homes" that may be part of other facilities.
- 4) Amending the model to serve homes larger than 15 consumers.

### IMPLICATIONS FOR IMPLEMENTATION

While many issues must be considered as implementation of the model is reviewed, several are apparent at this time:

- Wages paid, if commensurate with minimum standards for direct support personnel, could substantially increase the budget for services and supports.
- Determinations of the Individualized Supports and Services component of the residential rate could prove to be administratively complex, thereby causing a significant increase in regional center workload.
- There should be an appeal mechanism created within DDS so that providers can participate in a definitive process if they disagree with the payment established for their program by either platform.
- DDS and other system participants must create accountability mechanisms for all system participants.
- Since the cost model is still in development, there may be significant implications for implementation that are not evident now.

These and other issues will be fully explored as the process continues.