DDS Quality Incentive Program and the 90/10 Issue

MARCH 22, 2023

Agenda

I. Background

II. Challenges

III. Potential Solutions

End goals/Vision of the QIP

1. **Every individual receives person-centered high-quality services.** This means that, at a minimum, the service they receive is in line with the values, practices and requirements set out in the federal HCBS settings rule.
2. **Individuals and their families have the possibility and support to make an informed choice about the service(s) they receive.**
3. **Service providers are recognized and incentivized for providing high quality services.**

In order to meet the end goals/vision there must be:

- **More high-quality, "5 star" providers** in all areas of the state, including in non-disability specific settings, that are geographically and culturally appropriate.
- **Greater capacity at existing "5 star" providers** to engage more people.

Guiding Principles

1. **Long-Term Quality.** Robust, multi-year QIP.
2. **Person-Centered.** PC planning (ind.), PC support (DSP), PC thinking (system).
3. **Access and Equity.** All individuals engaged and supported.
4. **Collaboration**. Stakeholder engagement.
5. **Alignment**. Streamlining and aligning current efforts (PAVE, HCBS, DSP U, CERMS, etc.)
6. **Effective Practice.** Building on what works in other states and sectors.
7. **Data.** Capacity to meaningful data collection essential.
8. **Consistency.** Across RCs, providers, geographic regions, etc.
9. **Continuous Improvement.** Focus on support, improvement rather than compliance.

The Law – three phased implementation

1. Commencing April 1, 2022, the department shall implement a rate increase for service providers that equals **one-quarter of the difference** between current rates and the fully funded rate model for each provider.
2. Commencing January 1, 2023, and continuing through the 2023–24 fiscal year, the department shall adjust rates to equal **one-half of the difference** between rates in effect March 31, 2022, and the fully funded rate model for each provider.
3. Commencing July 1, 2024, the department shall implement the fully funded rate models. The fully funded rate models shall be implemented using two payment components, a base rate equaling **90 percent of the rate model**, and a quality incentive payment, **equaling up to 10 percent of the rate model**, to be implemented through the quality incentive program described in subdivision (e).

Roadmap: Challenges & Solutions

Challenge #1 – New Foundation, Structure

- *Solution – Learn from Others*
- *Solution – Build to Outcomes*
- *Solution – Quality Providers*

Challenge #2 – Retaining System Funding

- *Solution – Reinvest Unearned Incentives*

Challenge #3 – ID of Measures

- *Solution – Core and Service-Specific*

Challenge #4 – Timing & Predictability

- *Solution – Base Rate on Previous Year*

Challenge #5 – Potential Rate Decreases

- *Solution – Set a Baseline Rate*

Challenge #1 – New Foundation/Structure

This is hard work, and we are building a brand-new payment structure. Other states are trying this work too and California can learn from others as well as share its experiences. Similar human service systems are also engaged in this work, presenting opportunities for learning and sharing. The development process should make use of technical expertise, learn from other systems and states, and proceed carefully to ensure that the QIP in practice reflects its stated goals.

Solution #1a – Learn from Others

Engage experts in value-based funding in other sectors and explore wider practice and knowledge on conceptualizing and measuring quality. Examine how values-based funding has been implemented in other sectors such as health and education. Draw on effective practices identified from quality frameworks in use across the world (e.g., NCI, HCPLAN, etc.) as well as literature, research, and factors that are unique to California. During the roll out, make use of pilots, testing and evaluation to ensure a full and proper development of measures and documentation.

Solution #1b – Build to Outcomes

Start with HCBS compliance & pay for reporting, build to outcomes. HCBS compliance must be met to participate in the QIP. There are multiple challenges to building a system (DDS, RCs, Providers) that has capacity to measure and report on outcomes. The first few years of the QIP should focus on building a culture of accountability/reporting and developing the necessary data and data collection systems to measure outcomes. Then, the QIP should transition to measuring outcomes. This will set up the system for success and for individuals to receive high quality services.

Solution #1c – Quality Providers

Focus on quality providers through technical assistance and corrective action. An important aspect to incorporate is a corrective action process given that the QIP's goal is focused on quality versus just compliance. There should be multiple opportunities for a provider to submit corrective action and then receive a rate adjustment should the corrective action be acceptable. Aligned with the corrective action should be a technical assistance effort (perhaps through a third-party contract like the Disability Thrive Initiative) to support all providers in understanding the QIP and in meeting quality benchmarks.

Challenge #2 – Retaining System Funding

The payments are structured as “up to 10%” meaning that any incentives not earned could revert to the general fund costing the system hundreds of millions of dollars at a time of extreme workforce crisis and lack of services.

The Administration and Legislature agreed to spend the full 100% of funding on the system and we don’t want to lose that funding that is needed now.

Solution #2 – Reinvest Unearned Incentives

Reinvest any unearned incentives. Ensure than any unearned incentive funds (which could be hundreds of millions of dollars) are retained in the DDS system. Options for using these funds could include: support for families, individuals, regional centers and providers on HCBS compliance; additional incentive payments for high performing providers in excess of the 10% such as enhanced placement fees or staff certifications; additional support for DSP training and/or DSP retention payments; or infrastructure upgrades (e.g. public website, coordinated with CERMS, on QIP reporting).

Challenge #3 – Identification of Measures

Existing service-specific quality measures only cover a few services.
The rate models currently cover 78 services, but there are currently individual incentive measures for only 4 services; all other services have no means to earn their "10% incentive payment" unless incentives are paid at the vendor level. Furthermore, the incentives developed for 4 services are fixed amounts of money that are not tied to 10% of a provider's rate so don't align with the July 1, 2024 implementation.

The following 4 services have incentives: 113 (2), 952 (2)
The following 74 services have no incentives: 025 (2), 055 (6), 062, 063 (6), 073, 091, 093, 108, 109, 110, 111, 115, 116, 117, 420 465 475, 505 (3), 510 (3), 515, 520, 525 (3), 605, 612, 613, 615, 616, 620, 635, 645, 650, 680 (2), 805, 860, 862 (2), 864, 875, 880, 882, 883, 894 (2), 896 (2), 900, 901, 902, 903, 904, 905, 910, 915, 920, 950, 954

Solution #3 – Core and Service-Specific

Use a core and service-specific model. There should be a core set of indicators that go across all service types/vendorization codes (e.g., workforce capacity, service access, individual & family satisfaction) and then a series of service-specific indicators clustered by service type (e.g., employment, access to preventative services, early intervention) as required.

Start with core measures; phase in service-specific measures. Starting at the "vendor" level with core measures will ensure that every provider has the opportunity to earn their full 10%. Phase in service-specific measures by vendorization as those measures are developed.

Challenge #4 – Timing and Predictability

Systematically identifying, measuring and verifying outcomes is time-consuming. If payments are based on current performance, this can lead to issues of delays, backpay (retro payments), and uncertainty about rates and re-payment.

Solution #4 – Base Rate on Previous Year

Determine the 10% rate based on performance over the *previous* calendar year so there are no back payments, and all providers know their rate in advance.

For example, for 2024-2025:

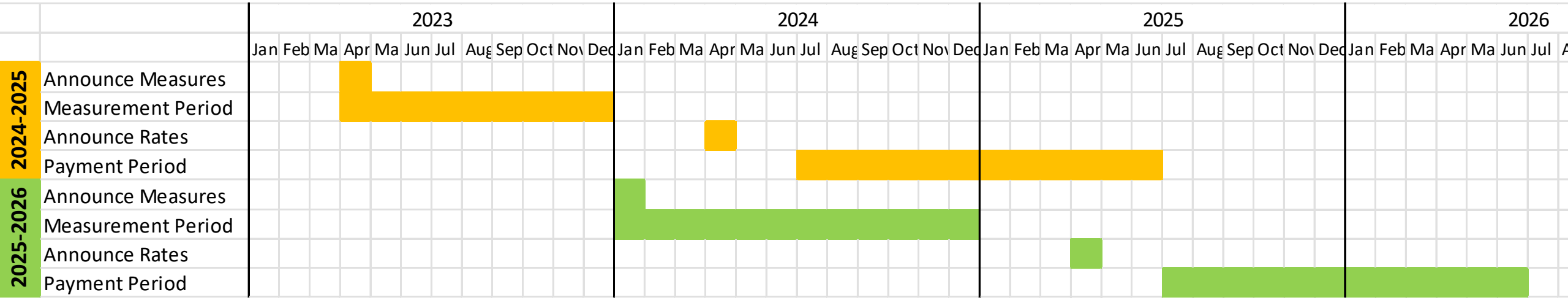
April 1, 2023: Announce measures (January 1 in subsequent years)

April – December, 2023: Performance period

April 1, 2024: DDS announces rates effective on July 1, 2024

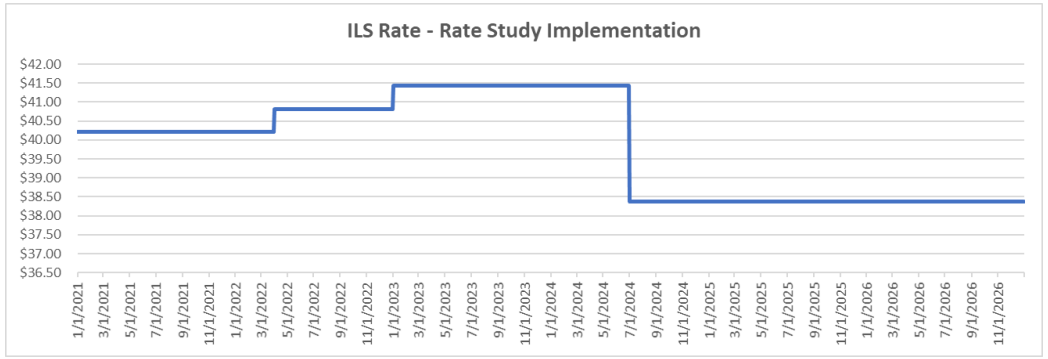
July 2024 – June 2025: Effective period of the rate

Solution #4 – Base Rate on Previous Year (cont.)



Challenge #5 – Potential for Rate Decreases

The phased implementation uses two different methods to calculate percentages. This means that some services could sustain rate decreases as early as July 1, 2024, that will bring their rates below their 2021 rates if they do not earn the incentive payments.



Challenge #5 – Potential for Rate Decreases (cont.)

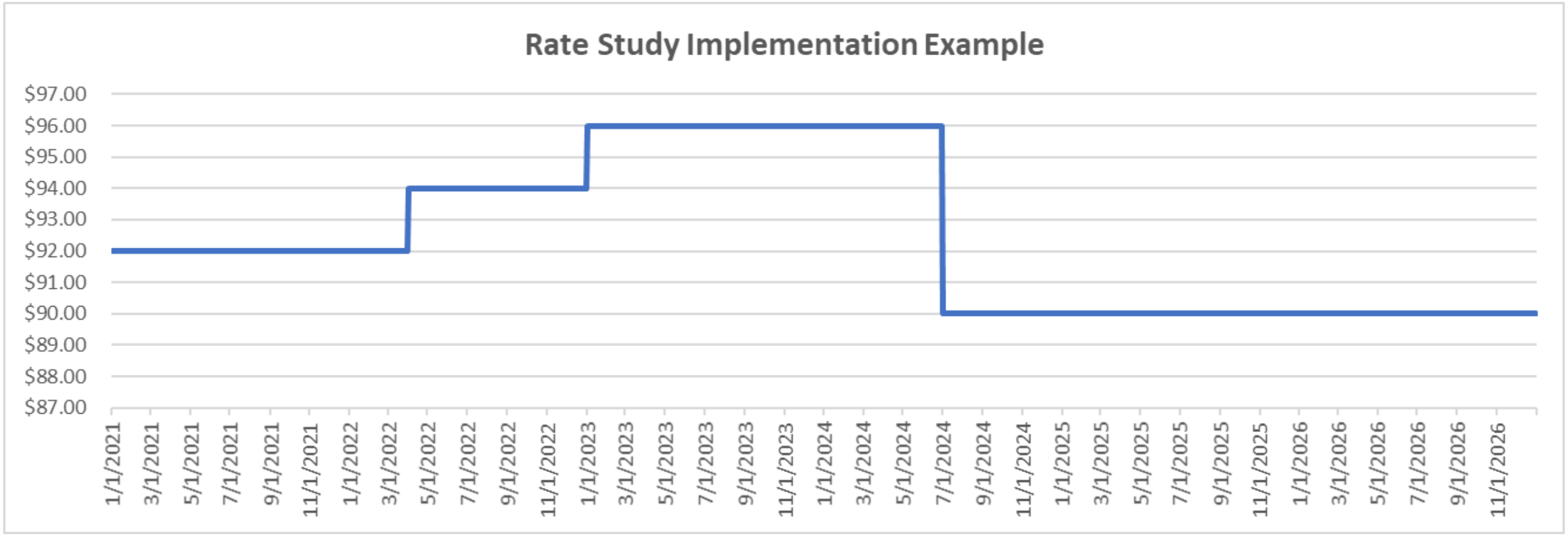
Example

Rate on January 1, 2021 = $92

Rate Model Rate = $100

1. April 1, 2022 = $94 ($92 + 25% of $8)
2. Jan 1, 2023 = $96 ($92 + 50% of $8)
3. July 1, 2024 = $90 (90% of $100) plus up to $10 (10% of $100) through incentive program.

Challenge #5 – Potential for Rate Decreases (cont.)

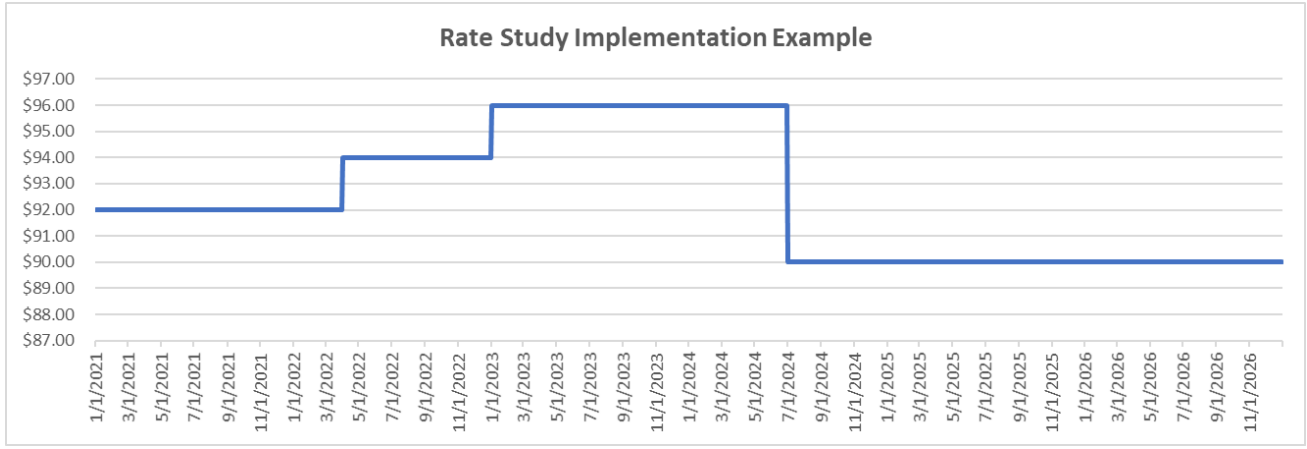


Solution #5 – Set a Baseline Rate

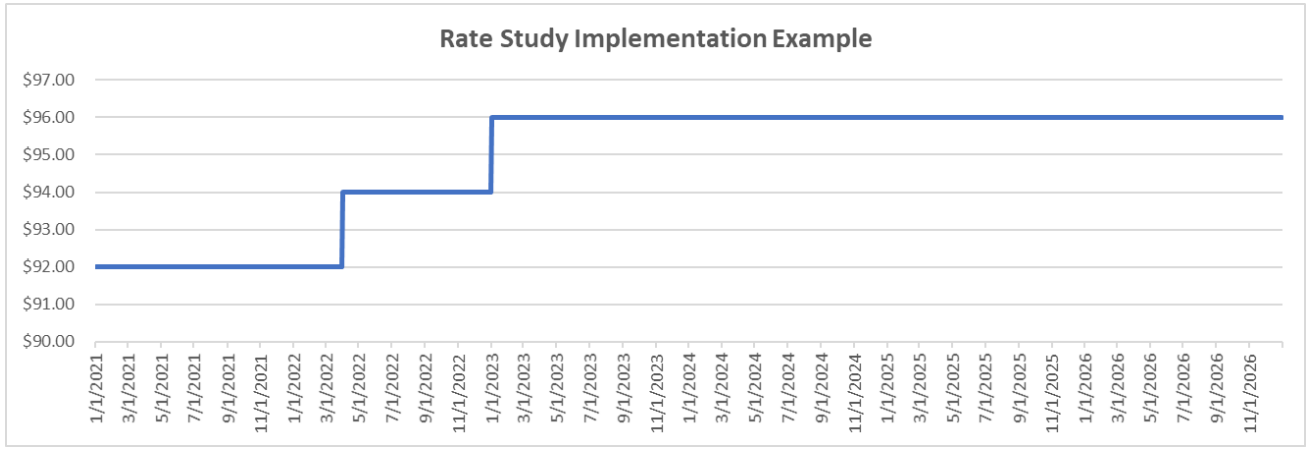
Set the Jan 1, 2023 rate as the baseline rate. For those providers eligible for rate increases, ensure that their rates never go below their rate on January 1, 2023. This will ensure that providers don't receive a rate decrease, which was never intended as part of rate model implementation. See example next slide.

Solution #5 – Set a Baseline Rate (cont.)

Without baseline fix.



With baseline fix.



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