AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER SHIRLEY N. WEBER, PH.D., CHAIR

WEDNESDAY, MARCH 5, 2014
1:30 P.M. - STATE CAPITOL ROOM 4202

ITEMS TO BE HEARD

ITEM	DESCRIPTION	
5180	**DEPARTMENT OF SOCIAL SERVICES**	1
ISSUE 1	IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM – BUDGET AND PROGRAM REVIEW, INCLUDING: • 7 PERCENT 2014-15 ACROSS THE BOARD REDUCTION • FAIR LABOR STANDARDS ACT IMPLEMENTATION, GOVERNOR'S OVERTIME RESTRICTION PROPOSAL	1
ISSUE 2	SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP) – BUDGET AND PROGRAM REVIEW	16

ITEMS TO BE HEARD

5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM – BUDGET AND PROGRAM REVIEW

Please see the "Panel" listing at the end of this section for guidance on how this issue will be presented and discussed in the course of the hearing.

PROGRAM DESCRIPTION

The Budget includes nearly $2 billion General Fund ($7.2 billion total funds) for the In-Home Supportive Services (IHSS) program in 2014-15. IHSS provides an alternative to out-of-home care for low-income aged, blind and disabled persons. IHSS consists of four programs: the Medi-Cal Personal Care Services Program (PCSP), the IHSS Plus Option (IPO) – a Medi-Cal State plan option that replaced the IHSS Plus Waiver Program (IPW), the Community First Choice Option (CFCO), and the IHSS Residual (IHSS-R) program. To qualify for PCSP, IPO, and CFCO services, recipients must first meet eligibility requirements for the Medi-Cal program. This requirement generally means that the individual is income eligible for Medi-Cal, has a chronic disabling condition, and has an assessed need for services to remain safely at home. The IHSS-R program serves individuals who are ineligible for Medi-Cal, but meet the SSI/SSP income standards.

To qualify for IHSS program services, recipients, as mentioned above, must have demonstrated a need for care and have been personally assessed by a caseworker in order for them to remain safely in their home and avoid out-of-home care. IHSS services include domestic and related services (e.g. housework, meal preparation, laundry, shopping), personal care services, accompaniment to medical appointments, protective supervision for mentally impaired recipients who place themselves at risk for injury, hazard, or accident, and paramedical services when directed by a physician.

The IHSS program is administered through the counties. County social workers determine IHSS eligibility and perform case management after conducting a standardized in-home assessment of an individual's ability to perform activities of daily living. Based on authorized hours and services, IHSS recipients are responsible for hiring, firing, and directing their IHSS provider(s). About 70 percent of IHSS recipients receive their care from a family member or relative provider. Individuals seeking to become a provider in the IHSS program must undergo a criminal background check, attend a provider orientation, and meet other requirements.

For 2014-15, the estimated average annual cost per recipient for IHSS is about $14,000 (total funds). This number assumes the full-year impact of the 7 percent reduction as well as the estimated cost to implement the Governor's FLSA proposal (six months of impact because of its mid-year implementation). For comparison purposes, for 2014-15, the estimated average annual cost per beneficiary for skilled nursing facility (SNF) care is about $70,000 (total funds). This number is based on estimated fee-for-service utilization and expenditures.

CASELOAD

Average monthly caseload in this program is estimated to be 453,417 recipients in 2014-15, a 1.2-percent increase from the 2013-14 projected level.

The IHSS caseload experienced increased growth until policy decisions impacted eligibility and provider access into the program in FY 2009-10. Since 2010, the caseload has experienced a modest year-over-year increase, as reflected in the current projections.

In 2012, there were approximately 380,000 IHSS providers with hourly wages varying by county and ranging from $8.00 to $12.20 per hour. Prior to July 1, 2012, county public authorities or nonprofit consortia were designated as "employers of record" for collective bargaining purposes on a statewide basis, while the state administered payroll and benefits. Pursuant to 2012-13 trailer bill language, however, collective bargaining responsibilities in the eight counties participating in the Coordinated Care Initiative (CCI) will shift to an IHSS Public Authority administered by the state.

DSS estimates that 385,425 individuals will work as IHSS providers in 2014-15.

7 PERCENT 2014-15 ACROSS THE BOARD REDUCTION

Background. Several previously enacted IHSS program reductions—intended to realize ongoing General Fund savings and initiated during a period of budget deficits—were not implemented because the reductions were challenged in class-action lawsuits and subsequently enjoined on a preliminary basis by court orders while the lawsuits proceeded. The three enacted-but-enjoined reductions included:

1. Establishing a stricter threshold of need to receive IHSS (challenged in Oster v. Lightbourne, et al., commonly referred to as Oster I)
2. Reducing IHSS hours by 20 percent (challenged in Oster v. Lightbourne, et al., commonly referred to as Oster II), and
3. Reducing state participation in IHSS provider wages and benefits (challenged in Dominguez v. Brown, et al.)

In March 2013, the Department of Social Services (DSS) and Department of Health Care Services (DHCS) reached a settlement agreement with plaintiffs that would resolve the lawsuits by repealing the three enjoined reductions and implementing a new reduction plan intended to realize some General Fund savings while lessening the magnitude of service cuts. The settlement agreement was enacted in Senate Bills 67 and 68 (Chapters 4 and 5, Statutes of 2013). The bills authorized an eight-percent across-the-board reduction to recipient hours, which was an increase of 4.4 percent on top of the 3.6 percent reduction that has been in effect since 2010-11, to begin July 1, 2013 and to last for one year.

7 Percent Reduction in 2014-15. In 2014-15, and on an on-going basis, there would be a reduction of seven percent, unless it is partially or fully "triggered off" by the state obtaining federal approval for an assessment on home care services that draws down federal funds. The bill also repealed the prior reductions to services, hours, and provider wages that were the subject of the legal settlement.

The Governor's Budget proposes no change to the 7-percent reduction in authorized hours that will take effect July 1, 2014, replacing the current 8-percent reduction. The administration has not as yet come forth with a proposal on a home health assessment that could draw down additional federal funds to replace the 7-percent reduction. The Department of Health Care Services (DHCS) states that it is currently working with the Centers for Medicare and Medicaid Services (CMS) to explore options for provider assessment in accordance with the settlement agreement, but has not offered more specific information than this.

FLSA, GOVERNOR'S OVERTIME RESTRICTION PROPOSAL

New FLSA Rule. The federal Department of Labor released new Fair Labor Standards Act (FLSA) regulations in September 2013 that affect home care workers. A home care worker can be any individual who provides home care services, including certified nursing assistants, home health aides, or personal care aides such as providers in the IHSS program. Personal care refers to assistance with activities of daily living, such as bathing, grooming, and bowel and bladder care, provided to a consumer by a home care worker. The new federal labor regulations, effective January 1, 2015, make two significant changes, discussed below, that affect the home care industry. These new federal labor regulations have budgetary implications for both the state's IHSS program and the Department of Developmental Services (DDS). The Subcommittee will discuss the implications for DDS in more depth at its scheduled March 19, 2014 hearing.

The FLSA regulations require home care workers to be paid for certain work activities, effective January 1, 2015. Generally, employers have been exempt from the requirement to pay home care workers for the following work activities that will now require payment.

- ✓ **Wait Time During Medical Appointments.** Time spent waiting for consumers during medical appointments must be paid.

- ✓ **Travel Time During the Work Day**. Time spent traveling during the employee's regular work hours, such as travel time to shop for food or perform other errands on behalf of the consumer, must be paid. For home care workers employed by a "third–party employer," travel time between consumers during the workday must also be paid. (A third–party employer is an employer other than the consumer receiving services. In the case of the IHSS program, the state can be understood to be the third-party employer.)

- ✓ **Mandatory Worker Training.** Time spent attending training required by the employer must be paid.

- ✓ **Federal Labor Regulations Require Home Care Workers to Receive Overtime Pay for Working More Than 40 Hours Per Week.** Employers of home care workers have been exempt from the requirement to pay overtime at the rate of one-and-a-half times the regular pay rate for all hours worked that exceed 40 in a week. However, effective January 1, 2015, federal labor regulations require home care workers to be paid overtime. Under federal law, the requirement to pay overtime may not be waived by agreement between the employer and employee. Further, an announcement or notice by the employer that no overtime work will be permitted will not infringe on the employee's right to receive overtime pay for hours that exceed 40 in a workweek. In other words, the employer is required to pay overtime when it is claimed by an employee on his/her timesheet, regardless of whether the overtime is authorized or not.

- ✓ **Narrow Exemptions to Overtime Pay Requirement When Consumer, His/Her Family, or Household Is the Employer.** When a worker is employed by a consumer receiving services or the consumer's family or household, the federal labor regulations provide for narrow exemptions to the requirement to pay overtime. One of these exemptions, known as the "live–in domestic service worker exemption," is available when a worker is employed by and resides with the consumer receiving services or the consumer's family or household. In these cases, the consumer, his/her family, or household may claim the live-in domestic service worker exemption to avoid paying the worker overtime for hours that exceed 40 in a workweek (and would instead pay at least the state-mandated hourly minimum wage for all hours worked). However, this exemption is not available to a third-party employer, such as the state in the existing program model of IHSS.

Governor's Proposal. The Governor proposes to prohibit IHSS providers from working overtime and to create a Provider Backup System to assist recipients in an unexpected circumstance to obtain a provider for continued care when their regular provider would exceed the limitations on hours worked by continuing to provide services. The administration estimates the annual ongoing cost of funding the three main components

of its IHSS proposal—(1) paying for newly compensable work activities, (2) funding administrative activities to prevent overtime, and (3) maintaining a "Provider Backup System"—is $239 million ($113 million General Fund) annually.

Who Is Impacted? About 37,000 recipients or 8.2 percent of the estimated caseload in 2014-15 are expected to receive more than 160 service hours per month from a single IHSS provider. The IHSS recipients who receive more than 160 service hours per month are generally individuals who are reliant on the IHSS program for significant assistance with activities of daily living. About half of IHSS recipients (an estimated 222,000 recipients) receive their care from a live-in provider, and 84 percent of these live-in providers are family members of the recipient. These family members could be, for example, a parent providing services to a minor child, a spouse providing services to a wife or husband, or an adult child providing services to a parent.

This chart outlines the components of the administration's proposal, further detailed in the narrative below, alongside the estimated cost of complying with federal labor regulations absent major program changes in IHSS.

Costs of Governor's Proposal	**2014-15**		**2015-16**		**Costs of Complying with FLSA Absent Program Changes**	**Annualized**	
Dollars are in millions	GF	TF	GF	TF		GF	TF
Newly compensable work activities (wait and travel time)	$40	$87	$88	$188	Newly compensable work activities (wait and travel time)	89	192
Administrative activities to restrict overtime	27	53	10	19	Administrative activities to implement new payments	13	26
Provider Backup System (including higher wage for backup providers and related costs)	10	21	15	32	Overtime Costs	186	402
Totals	**$77**	**$161**	**$113**	**$239**		**$288**	**$620**

Pay for Newly Compensable Work Activities. The Governor's budget proposes $87 million ($40 million General Fund) in 2014-15 to comply with the federal labor regulations that require the state to compensate IHSS providers for certain previously exempted work activities beginning January 1, 2015, or, for six months of 2014-15. The department estimates that the full-year cost is $188 million ($88 million General Fund) in 2015-16. The Governor's budget funds compensation for wait time during medical appointments and travel time during the workday, but not the mandatory provider orientation, as explained below.

Providers' Wait Time During IHSS Recipients' Medical Appointments. The current in–home IHSS assessment conducted by a county social worker assesses a consumer for the amount of time needed to travel to medical appointments, but makes no assessment for the amount of wait time that may be involved. The Governor's budget assumes that the 85 percent of IHSS recipients who receive medical accompaniment will have their provider wait three hours per month, on average, during appointments. Based on these assumptions, the six–month cost of this work activity is estimated to be $81 million ($37 million General Fund) in 2014-15. However, because the exact amount of time that providers wait at medical appointments is unknown, the actual cost of paying IHSS providers for wait time during recipients' medical appointments is uncertain.

Providers' Travel Time Between IHSS Recipients. The Governor's budget estimates that 19 percent of IHSS providers serve multiple recipients. It is assumed that these providers who work for multiple recipients will spend one hour per month, on average, traveling between recipients. Based on these assumptions, the six–month cost of this work activity is estimated to be $6 million ($3 million General Fund). Like wait time during medical appointments, there is currently no data collected by the IHSS program on the exact amount of time IHSS providers spend traveling between IHSS recipients during the workday.

Mandatory Provider Orientation. While the federal labor regulations require IHSS providers to be paid for any mandatory training, the Governor's budget does not request funding for the cost of paying individuals to attend the mandatory orientation prior to enrollment as an IHSS provider. The DSS has indicated that it assumes that the state may not need to pay individuals for participating in the mandatory orientation since it occurs before the individual enrolls as an IHSS provider.

Administrative Costs to Prohibit IHSS Providers From Working Overtime. The Governor's budget proposes to respond to the federal labor regulations requiring overtime pay for home care workers by establishing an administrative structure that would prohibit IHSS providers from working overtime, at an estimated cost of $53 million ($27 million General Fund) in 2014–15. This restriction would generally require an IHSS recipient who receives more than 40 hours of care per week from a single provider to secure a second provider. To help IHSS providers set their schedules to avoid working overtime, the proposal requires all recipients and providers to complete "workweek agreements" to ensure no provider is scheduled to work more than 40 hours per week. These workweek agreements must be submitted to the county, reviewed by a county social worker, and entered by clerks into CMIPS II. The full-year cost of the administrative activities to restrict overtime is estimated to be $19 million ($10 million General Fund) in 2015-16. These administrative costs are estimated to decrease in 2015-16 primarily because the processing of workweek agreements by county social workers and clerks mostly occurs in the first year of implementation.

In addition to the workweek agreements, as a method to deter providers from working overtime, the proposal provides for suspending IHSS providers who claim more than 40 hours per week on their timesheet on at least two occasions. After the first instance of overtime claimed on a timesheet, the IHSS provider would receive a warning notice that he/she cannot claim more than 40 hours per week on his/her timesheet. After the second instance, the IHSS provider would be suspended from the program for a period of one year.

County social workers and clerks would conduct all administrative activities associated with the overtime restriction, including: (1) mass mailings about the overtime restriction and workweek agreement, (2) answering questions from IHSS providers and recipients about the overtime restriction, (3) reviewing the workweek agreements and entering the agreements into CMIPS II, (4) suspending and reenrolling certain IHSS providers, (5) adding IHSS providers to the Public Authority registry, and (6) coordinating services for the Provider Backup System, described below.

Provider Backup System for Unforeseen Circumstances. The Governor's budget proposes $69 million ($32 million General Fund) in 2014–15 for the costs associated with establishing a Provider Backup System at the county level. This system would supply a backup provider for an unforeseen circumstance in which an IHSS recipient is in need of immediate assistance but his/her regular provider has already worked 40 hours within the week, and other options, such as a second provider or the informal support of a family member or neighbor, are unavailable. In such circumstances, the consumer could call the system to request a backup provider who would be available in a short amount of time to provide assistance. Service hours delivered by a backup provider would be counted toward, and not in addition to, a recipient's total allotment of monthly IHSS hours. The backup provider would receive a higher wage than the standard rate in the county to compensate him/her for the need to provide services on short notice.

The majority of the costs for the Provider Backup System funds a wage premium for backup providers above the county's negotiated wage in order to compensate them for providing services on short notice. The estimate assumes that the cost of compensating the backup provider would be, on average, 25 percent higher per hour than the estimated statewide average cost per hour of $12.33 in 2014–15. This translates into a wage premium of $3.08, and an average wage of $15.41 per hour for backup providers in 2014–15. The exact amount of the wage premium for backup providers will be specified in forthcoming budget–related legislation. The administration assumes that IHSS recipients with at least 60 monthly service hours will use the Provider Backup System.

Reaction from Consumers, Advocates, and Other Stakeholders.

Consumer and provider groups, advocates, and counties have submitted lengthy written comments on this proposal. The Subcommittee is in receipt of a letter signed by 49 organizations comprising the IHSS Coalition that expresses much of the feedback and concerns included below. The following is a representation of the many issues raised with the Governor's proposal:

- **Continuity of Care:** The overtime prohibition would force those who have an IHSS provider working more than 40 hours a week to find someone else to work the hours above 40. Seniors and people with disabilities who require care beyond 40 hour a week would be forced to rely on temporary or alternative caregivers with less experience and familiarity with their unique needs. Especially concerning are the impacts on children and adults with disabilities for whom consistency is an essential part of care, including people with dementia who can suffer adverse consequences in the hands of unfamiliar caregivers.

- **Sensitive Provider Preferences and Relationships.** Almost two-thirds of IHSS recipients receive care from a provider who is related to them. Moreover, about 46 percent of IHSS recipients receive care from either their own parent, spouse, or adult child (defined as a "close relative"). In about half of cases, IHSS providers live in the same home as the IHSS recipient. When IHSS services are provided by a person having the legal duty to provide for the care of his or her child, the parent provider will receive payment for IHSS only when that person leaves full-time employment or is prevented from obtaining full time employment because no other suitable provider is available, and, if care is not given by that person, the child may be subject to inadequate care or inappropriate placement.

- **IHSS Providers Are Not Interchangeable**: Personal care is very private. Consumers, including seniors, have strong preferences and needs when it comes to the people who do this work. Some consumers are monolingual in a language other than English; some prefer a worker of one gender, or from a similar cultural background. Some will not accept care from anyone other than a spouse or family member or other trusted provider. Consider the parents who have been the sole caretakers for their children, with significant disabilities, for years or decades. Those parents will lose the income, which has provided a roof and stable life, will have to go find other work while leaving the child in the hands of a stranger.

- **Erosion of Consumer Choice.** Consumer choice is a cornerstone of the IHSS program, which will be deeply eroded by this proposal. IHSS consumers have the right to hire, fire and supervise their provider and they take into consideration their unique language needs along with the intimate nature of personal care service. Consumers often train their IHSS provider to handle their personal care services. Imposing a 40-hour cap per provider to avoid paying overtime would force consumers to hire new providers and, by doing so, could put themselves at risk for

substandard care because the new provider would not be familiar with their unique needs.

- **Availability of Workforce.** The Governor's proposal assumes that an additional 30,000-40,000 providers would need to be recruited for the Back-Up system. Recruiting that many additional providers, between July and January, will be a huge challenge in most counties. To make the Back-Up System work, a large pool of IHSS providers would need to be ready at a moment's notice to fill in for another provider. Rural counties in particular have raised this concern, but this problem also exists in larger counties with rural, outlying areas. Even in metropolitan areas such as the Bay Area and Los Angeles, travelling just a few miles through highly congested areas can be a deterrent to caregiving for short periods of time.

- **Reductions to Provider Income/Consumer Household Income.** By prohibiting work after 40 hours, the proposal sharply limits the ability of caregivers to provide for their families. The sole source of income for 63% of providers is from the IHSS program. Because of the loss of hours, IHSS providers would lose income. IHSS providers who are living near or below the poverty level will be severely impacted by these cuts. Many providers are eligible for food stamps, and few have access now to health insurance. Many IHSS providers would lose their health benefits because the cut in hours could put them below the eligibility levels to qualify for health benefits through their Public Authority. In about half of cases, IHSS providers live in the same home as the IHSS recipient. The loss of income to the provider would impact the overall household income, leaving the consumer with insufficient funds to pay rent. The unintended consequence could force many IHSS consumers to move out of their homes and into institutional care.

- **Olmstead Considerations.** In its 1999 Olmstead decision, the US Supreme Court confirmed that, unnecessary institutionalization of people with disabilities violates their civil rights. Insofar as consumers' homes and care are disrupted by the overtime ban, and consumers face otherwise unnecessary institutionalization, the state will be defying the Olmstead mandate.

- **Workweek Arrangements.** Funding for county IHSS administrative costs for social workers to respond to questions from consumers and providers about the new overtime policy and workweek arrangement may be understated. Counties and Public Authorities experienced a high volume of calls and walk-ins by consumers and providers with problems and questions about the new timesheet for CMIPS II. Lessons learned by the pilot counties and Public Authorities were helpful through the conversion process to help as new counties and PAs cut over to CMIPS II. The budget proposal assumes implementation for all 58 counties on January 1, 2015 – and there won't be any pilot process to develop best practices. Hence, the workload may be much higher than anticipated by the administration to explain the new overtime policy and establish workweek arrangements between consumers and providers.

- **Providing Paramedical Care Will Require Training and/or Support.** Paramedical care can be administered at the direction of a licensed medical practitioner. Back-up providers will need to be trained to step-in on a moment's notice to provide assistance on a variety of paramedical needs (i.e. colostomy irrigation, inserting catheters, tube feeding, etc.). Lack of training or support places the consumer at risk for not having their need met. This may require additional county staff work to ensure back-up providers are able to perform this service, or alternative arrangements can be made to ensure consumer safety consistent with the consumer's emergency back-up plan.

- **Provider Penalty for Claimed Overtime.** The administration is proposing to terminate IHSS providers with 4 hours of unauthorized overtime on a second offense for one year. This proposal is very harsh and generates a number of questions. IHSS providers receive their new timesheet with the paycheck from the prior pay period. If there is a problem with processing a timesheet, the provider doesn't get a paycheck in a timely manner and also doesn't receive a timesheet for the next pay period. The concern is that providers could be terminated without receiving sufficient notice.

- **Provider Appeals.** CDSS indicates they intend to establish an appeals process for providers to pay out the reason/justification for unauthorized overtime so that a terminated provider could be reinstated. There are no details and the administration indicated input would be obtained through a stakeholder process.

- **Wait Time During Medical Accompaniment and Travel Time**. The FLSA regulations require payment of wages for actual time spent by a provider who is assigned to more than one client per day and for wait time while accompanying a consumer to a medical appointment. The Governor's budget appropriately designates funds to comply with these provisions of the FLSA.

- **Matching Providers and Consumers.** Appropriate matches between providers and consumers will be challenging and raises liability concerns for counties: Many IHSS consumers have complex needs that will require matching the clients to a provider who can meet their needs (e.g. language, skills for paramedical care, etc.). Moreover, the county is tasked with finding a provider who can work on the days and at the times needed by the client, and who is willing to travel to wherever the client resides. This is no easy feat, and indeed, counties have a greater concern about the liability that we are assuming for meeting this need for a backup provider. What if the county cannot accommodate the request? Does the county authorize the overtime and if so, is the provider penalized? If counties identify a provider, what if something happens in the home and the client is injured? Will the county be held liable? The statute that currently provides indemnification to counties also says counties are not the employer for hiring, firing, and directing work. Counties are concerned that this proposal would have them acting in an employer capacity that current law does to not establish for them, and as such, the indemnity that current law provides for counties may also not apply. In addition, DSS estimates the

workload associated with matching providers and consumers will take approximately 30 minutes to do so. The actual time will vary based on the individual needs of consumers.

- **Increase in Hospitalizations and Institutional Care.** It is likely that some consumers will be at risk of hospitalization and institutional care under this proposal. The best case scenario is that relatively few will be at risk if an adequate supply of back-up providers can be recruited and properly matched with consumers who need such care. However, even under this scenario, these consumers will be receiving care from new providers/back-up system providers who are not as familiar with the consumer's care-giving needs. However, if the system is not set up to function well (due to lack of providers, etc.), then a greater number of IHSS consumers will be placed at risk. This would also potentially result in non-compliance with Olmstead requirements.

IHSS IN THE COORDINATED CARE INITIATIVE

The Governor's Budget proposes no further changes for the IHSS program as a component of the Coordinated Care Initiative (CCI) in 2014-15 with a phased-in approach depending on the county. No earlier than April 2014, certain Medi-Cal beneficiaries residing in a county authorized to participate in the CCI demonstration will begin transitioning from the traditional fee-for-service model to a managed care model for receiving health care services, including IHSS services. The Governor states that under the CCI, the fundamental structure of the IHSS program will remain the same, with eligibility determination, assessment of hours, and program administration conducted by county social workers and administrative staff.

Statewide Public Authority. Pursuant to current law, a Statewide Public Authority is to be established after the completion of enrollment of all eligible Medi Cal beneficiaries in CCI plans. The current schedule of enrollment in managed care plans will be completed by San Mateo by February 2015, and the remaining counties by June 30, 2015. Under CCI, IHSS is included as a benefit of the managed care plans under Medi-Cal and Medicare; and its cost (IHSS provider wages and benefits, IHSS service hours) becomes part of the capitation rates paid to the CCI managed care plans. As counties fully transition under CCI they will move their collective bargaining function to the new Statewide Authority.

Positions Update. Both DSS and the California Department of Human Resources (CalHR) were granted approval in the 2013-14 Budget to hire staff to carry out implementation functions associated with the creation of a Statewide Public Authority. Due to the passage of Senate Bill 1036 (Chapter 45, Statutes of 2012), CalHR received funding for four new positions to assess the level of resources necessary for CalHR to prepare for and implement collective bargaining on behalf of the Statewide Authority and to meet the obligations of the IHSS Employer-Employee Relations Act (IHSSEERA) for the eight demonstration counties. The four classifications and hire dates are: a Staff

Benefits Personnel Program Analyst (October 1, 2013); two Labor Relations Managers (November 6 and November 12, 2013); and a Labor Relations Counsel (December 2, 2013).

In the three months since the positions were filled, the CalHR IHSS team began building working relationships and partnering with the eight demonstration counties and various stakeholders, including DSS, by initiating face-to-face meetings to begin the initial assessment of the nature, scope, and workload requirements of the IHSS program. This includes, but is not limited to, attending, participating, and presenting at the Public Employment Relations Board (PERB) meetings and hearings regarding IHSSEERA; conducting preliminary research to build profiles of the health programs benefitting IHSS providers; researching and analyzing current and prior IHSS Memoranda of Understanding; drafting legislation to address open-meeting act exemptions; analyzing comparisons with respect to using outside resources for negotiations; compiling and organizing health, dental, and vision benefits data; and researching and analyzing fact-finding and arbitration decisions and their program impact.

The team continues to provide ongoing support on a variety of issues including, but not limited to, analyzing the application of the current and recently adopted FLSA regulations; performing legislative analysis on IHSS-related bills; analyzing and preparing recommendations for PERB's notice of rulemaking package for IHSSEERA regulations; providing consultation, analysis, and opinion letters regarding the IHSS program; and providing general support in the interpretation of the IHSSEERA.

As of this writing, for DSS Adult Programs, all seven approved CCI positions have been filled, but DSS is still recruiting for three of the four Statewide Authority positions.

Role of IHSS in CCI. IHSS is one of the home and community based long-term services and support that are integrated as benefits of the managed care plans in CCI counties. Under CCI, managed care plans are to provide care management and coordination in such a way that will result in improved health and independence and reduction in utilization of emergency department, hospital and nursing facility. For CCI plan enrollees who have multiple chronic conditions and depend on others for activities of daily living, IHSS is and will continue to be the major home-based service for CCI plan enrollees.

IHSS will continue to be administered by counties; including the IHSS assessments authorized by county social workers. IHSS recipients will continue to hire, fire and supervise IHSS providers under the self-directed model. All of the current regulations governing the operation of IHSS from notices to assessment to fair hearing, the responsibilities of DSS and the counties, and the role of the county Public Authorities to maintain a registry and other administrative duties remain the same under CCI. IHSS becomes a benefit of the CCI managed care plans and therefore, (a) the capitation rates paid by DHCS to the managed care plans will include the cost of IHSS for CCI plan enrollees, and (b) managed care plans are responsible for the actual cost of IHSS

incurred by their enrollees (if the cost is higher than what is in the rate, the plans are liable or vice versa).

Managed care plans are required to include county IHSS social workers in their interdisciplinary team care planning process to create individualized care plans. Upon their own determination, CCI plan enrollees can include their IHSS providers in this interdisciplinary team care planning process. This effort would improve the communication, quality of care plans, and care coordination among county IHSS eligibility workers, IHSS providers, enrollees' physicians, and other medical and service providers involved in the care of the CCI plan enrollees, making achieving health maintenance and reduction of utilization of hospitals and nursing facilities possible. Under CCI, IHSS will continue to be the major home and community based services for seniors and persons with disabilities.

Uniform Assessment Tool. Pursuant to SB 1036, DHCS, CDSS, and CDA are to develop a Universal Assessment Tool (frequently referred to as Uniform Assessment Tool) to assess Medi-Cal beneficiary's need for Home and Community Based Services. The goal is to enhance personalized care planning under CCI and create a mechanism that home and community based providers, who are currently using different programmatic based tools, can standardize, communicate and coordinate with each other on beneficiary's assessments and care needs. Under CCI, the long-term services and support which includes home and community-based services (CBAS, IHSS, MSSP) are benefits of the managed care plans. The latter are also required to conduct assessments, care planning, authorizing services and coordinating service delivery with their provider networks, physicians, hospitals, CBAS, County IHSS, NF, MSSP, and other medical services. The Universal Assessment is to create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services.

DHCS is working closely with CDSS and CDA, creating a stakeholder workgroup (advocates, consumers, county IHSS, CBAS, MSSP, legislative staff, and health plans) and a process that facilitates the development of this tool. The workgroup has been meeting with the goal to establish a draft tool by 2014-15, to be piloted in no more than four CCI counties in 2015-16 and for adoption in 2016 by providers and health plans. SCAN Foundation is funding the effort of the stakeholder workgroup which also involves also UCLA, USC and UCSF researchers.

PUBLIC AUTHORITY ADMINISTRATION RATE

The Subcommittee adopted uncodified language as part of the 2011-12 budget that required the California Association of Public Authorities (CAPA) to develop recommendations to revise the Public Authority rate methodology. The language was recodified last year, with the only change of deleting the deadline for recommendations. CAPA reports that its progress has been affected by the necessity of reconciling its work with the county MOE mechanism before it can form recommendations to revise

the PA rate methodology. CAPA also needs to take into consideration what changes to the PA rate might be necessary when collective bargaining shifts to the Statewide Authority. This methodology remains in development and the Subcommittee may request further information or an update at another hearing either in the current budget cycle or in a future one.

DHCS TRAILER BILL PROPOSAL ON BACKGROUND CHECKS

DHCS has released TBL regarding Medi-Cal provider background checks. Questions have been raised about the intent of DHCS to include IHSS providers in the expanded requirement to obtain an FBI clearance. The DOJ has offered information that this requirement would add $17 to the cost of provider background checks for IHSS workers. The applicability of this trailer bill proposal to IHSS is still unclear and the Subcommittee is awaiting clarification from the administration.

PANELS

Panelists have been asked by the Subcommittee to make presentations on the issues discussed in this agenda.

Opening Panel

- Will Lightbourne, Director, and Eileen Carroll, Deputy Director, Adult Programs Division, California Department of Social Services, joined by representatives of the Department of Health Care Services
  - IHSS Overview and Current Program Update
- Rashi Kesarwani, Legislative Analyst's Office
  - Review of Governor's Proposal

7% ATB Reduction

- Brandi Wolf, Deputy Policy Director for SEIU ULTCW, making brief introductory remarks
- Tammy Stiles, Provider in Mendocino County
- Michelle Rousey, Consumer in Alameda County, representing the IHSS Coalition
- Jane Kardas, Consumer in Mendocino County, representing the IHSS Coalition
- Gary Passmore, Vice President, Congress of California Seniors

Governor's Overtime Restriction Proposal

- Frank Mecca, Executive Director, County Welfare Directors Association of California
- Karen Keeslar, California Association of Public Authorities
- Deborah Doctor, Disability Rights California
- Rebecca Malberg, SEIU-UHW
- Kristina Bas Hamilton, Director of Budget and Policy, UDW/AFSCME Local 3930, making brief introductory remarks
- Cindy Chapman, Provider and member of UDW/AFSCME Local 3930, Placer County
- Mark Beckwith, Consumer in Alameda County, representing the IHSS Coalition

Public Comment

Staff Recommendation:

Staff recommends holding all IHSS issues open.

ISSUE 2: SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT

The Supplemental Security Income/State Supplementary Payment (SSI/SSP) program provides a monthly cash benefit to enable needy aged, blind, and disabled people to meet their basic living expenses for food, clothing, and shelter. The 2014-15 Governor's Budget includes $10.1 billion ($7.3 billion federal funds, $2.8 billion General Fund) for the SSI/SSP program.

CASELOAD AND ELIGIBILITY

Caseload is estimated to be 1.3 million recipients in 2014-15, a 0.8 percent increase over the 2013-14 caseload. The SSI/SSP caseload consists of 27 percent aged, 2 percent blind, and 71 percent disabled persons.

To be eligible for SSI/SSP, a person must be at least 65 years old, blind, or disabled (including blind or disabled children). A qualified recipient must file an application with the Social Security Administration (SSA). Federal criteria are used to determine eligibility. A qualified SSI recipient is automatically qualified for SSP. To be eligible for SSI and maintain eligibility, a person must meet certain income and resource requirements.

GRANTS

SSI is a federally funded benefit; SSP is state-funded and added on to the SSI benefit. The maximum amount of aid is dependent on the following factors:

- Whether one is aged, blind, or disabled;
- The living arrangement;
- Marital status; and,
- Minor status.

Effective January 2013, maximum SSI/SSP grant levels were $866.40 ($710.00 SSI and $156.40 SSP) per month for individuals ($10,397 per year) and $1,462.20 per month for couples ($17,546 per year).

The SSA applies an annual cost-of-living adjustment (COLA) to the SSI portion of the grant equivalent to the year-over-year increase in the Consumer Price Index (CPI). The current projected CPI growth factors are 1.5 percent for 2014 and 1.0 percent for 2015. Maximum SSI/SSP monthly grant levels increased effective January 1, 2014 to $877.40 for individuals and to $1,478.20 for couples. Effective January 1, 2015 they will be further adjusted to $884.40 for individuals and to $1,488.20 for couples.

As part of the 2009-10 Budget agreement, state COLAs for SSI/SSP beneficiaries were indefinitely suspended, and depend upon future statutory authorization. This occurred after many years of COLA suspension, whereby SSI/SSP grants were reduced to

minimal levels. As part of the 2011-12 Budget, the state chose to reduce the SSP standard of the SSI/SSP program to the federally required MOE level of the 1983 payment standards for individuals only. Prior actions had reduced the grant levels for couples to the MOE floor, leaving some margin on the grants for individuals given their level of poverty. The MOE refers to a federal provision that limits the reduction a state can make to their SSP benefit levels without penalty. If a state were to reduce its SSP benefit levels below MOE levels, it would lose federal funding for Medi-Cal.

California is now at the MOE floor, or the lowest benefit level possible, for the entire SSI/SSP caseload. Advocates have raised serious questions about the sufficiency of the SSI/SSP grant levels given the cost of living in California and conversation on this topic is expected as part of the Assembly's budget review.

CASH ASSISTANCE PROGRAM FOR IMMIGRANTS

The Cash Assistance Program for Immigrants (CAPI) provides benefits to aged, blind, and disabled legal immigrants. The CAPI benefits are equivalent to SSI/SSP program benefits, less $10 per individual and $20 per couple. The CAPI recipients in the base program include immigrants who entered the United States (U.S.) prior to August 22, 1996, and are not eligible for SSI/SSP benefits solely due to their immigration status; and those who entered the U.S. on or after August 22, 1996, but meet special sponsor restrictions (have a sponsor who is disabled, deceased, or abusive). The extended CAPI caseload includes immigrants who entered the U.S. on or after August 22, 1996, who do not have a sponsor or have a sponsor who does not meet the sponsor restrictions of the base program.

FEDERAL COLA PASS-THROUGH

Passes through the annual federal cost−of−living adjustment (COLA) to the SSI portion of the grant equivalent to the year−over−year increase in the Consumer Price Index (CPI). The current CPI growth factors are 1.5 percent for 2014 and a projected 0.6 percent for 2015. Maximum SSI/SSP monthly grant levels will increase by $11 and $16 for individuals and couples, respectively, effective January 2014. Maximum SSI/SSP grant levels before this COLA increase are $866 per month for individuals and $1,462 per month for couples. Cash Assistance Program for Immigrants (CAPI) benefits are equivalent to SSI/SSP benefits, less $10 per month for individuals and $20 per month for couples.

The average monthly caseload in this program is estimated to be 1.3 million recipients in 2014−15, a slight increase over the 2013−14 projected level. The SSI/SSP caseload consists of 27 percent aged, 2 percent blind, and 71 percent disabled persons. Includes $2.8 billion General Fund for the SSI/SSP program. This represents a 1.2-percent increase ($34 million) from the revised 2013−14 budget.

ADVOCATES' REQUESTS

Many advocates have written with requests for the Subcommittee to consider an augmentation to the SSI/SSP grants. Some of these advocates write that since 1989-90 the purchasing power of the individual SSI/SSP grant has declined by 32 percent, and that the grant is worth just 90.2 percent of the federal poverty level. If the grant cuts had not occurred and the COLAs applied each year, the SSI/SSP grant for individuals would be worth 106.7 percent of the federal poverty level. The effect of the grant cuts and the repealing of the COLAs was to push 1 million blind, aged and disabled Californians below the federal poverty level.

These advocates from multiple organizations, including the California Association of Food Banks, Western Center on Law and Poverty, Senior Services Coalition, and Coalition of California Welfare Rights Organizations, urge the reinstitution of the SSI/SSP COLA and urge greater attention to the grant levels in social service benefits programs to combat California's extremely high poverty rate.

PANEL

- Will Lightbourne, Director, and Eileen Carroll, Deputy Director, Adult Programs Division, California Department of Social Services
- Legislative Analyst's Office
- Department of Finance
- Public Comment

Staff Recommendation:

Staff recommends holding these issues open.