AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

WEDNESDAY, MARCH 8, 2017
2:30 P.M. - STATE CAPITOL, ROOM 444

(PLEASE MONITOR THE DAILY FILE FOR A POSSIBLE ROOM CHANGE.)

LIST OF PANELISTS IN ORDER OF PRESENTATION

5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM – BUDGET REVIEW AND EFFECTS OF THE COORDINATED CARE INITIATIVE CHANGES

- Will Lightbourne, Director, and Debbi Thomson, Deputy Director, Adult Programs Division, Department of Social Services
- Iliana Ramos, Department of Finance
- Jackie Barocio, Legislative Analyst's Office
- Frank Mecca, Executive Director, County Welfare Directors Association
- Representative, California State Association of Counties
- Karen Keeslar, California Association of Public Authorities
- Tia Orr, Government Relations Director, Service Employees International Union (SEIU) California
- Kristina Bas Hamilton, Legislative Director, United Domestic Workers (UDW)/AFSCME Local 3930
- Representative, SEIU Local 2015
- Curt Child, Legislative Director, Disability Rights California
- Public Comment

ISSUE 2: IMPLEMENTATION OF THE FAIR LABOR STANDARDS ACT FOR IHSS

- Will Lightbourne, Director, and Debbi Thomson, Deputy Director, Adult Programs Division, Department of Social Services
- Iliana Ramos, Department of Finance
- Jackie Barocio, Legislative Analyst's Office
- Curt Child, Legislative Director, Disability Rights California
- Charlie Bean, IHSS Consumer, Humboldt County
- Karen Keeslar, California Association of Public Authorities
- Kristina Bas Hamilton, Legislative Director, UDW/AFSCME Local 3930
- Tiffany Whiten, Long Term Care Director, SEIU California
- Public Comment

ISSUE 3: TIMESHEET AND PAYROLLING CHANGES FOR IHSS

- Will Lightbourne, Director, and Debbi Thomson, Deputy Director, Adult Programs Division, Department of Social Services
- Iliana Ramos, Department of Finance
- Jackie Barocio, Legislative Analyst's Office
- Public Comment

VOTE-ONLY ITEM

5160 DEPARTMENT OF REHABILITATION

ISSUE 1: GOVERNOR'S REDUCTION TO INDEPENDENT LIVING CENTERS AND ADVOCACY REQUEST

BACKGROUND

The Subcommittee heard this issue at its March 1, 2017 hearing and put over an action to be taken at the outset of this hearing. Please see that agenda for additional details and information on this item.

By way of brief background, the Governor proposed to remove a $705,000 augmentation that was provided in the 2016 Budget for three of the Independent Living Centers (ILCs), including the Disability Resources Agency for Independent Living (DRAIL), serving Amador, Calaveras, Tuolumne, Mariposa, Stanislaus, and San Joaquin Counties; the Independent Living Center of Kern County (ILCKC), serving Kern County; and Placer Independent Resources Services, Inc., serving Placer, El Dorado, and Alpine Counties.

ADVOCACY RESPONSE

The California Foundation for Independent Living Centers has weighed in in strong opposition to this cut. In addition, the Subcommittee is in receipt of a letter from Assemblymember Rudy Salas, signed by multiple other Members in both the Assembly and Senate, requesting that the funding that was appropriated last year be restored.

Staff Recommendation:

Staff recommends rejection of this cut to the ILCs as proposed in the Governor's Budget.

ITEMS TO BE HEARD

5180 DEPARTMENT OF SOCIAL SERVICES

ISSUE 1: IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM – BUDGET REVIEW AND EFFECTS OF THE COORDINATED CARE INITIATIVE CHANGES

PANEL

- Will Lightbourne, Director, and Debbi Thomson, Deputy Director, Adult Programs Division, Department of Social Services
  - Please provide a brief overview of the IHSS program, covering major caseload and cost changes and the basic funding structure for the program.
  - Please describe the effects on IHSS as a result of the termination of the Coordinated Care Initiative (CCI).
- Iliana Ramos, Department of Finance
- Jackie Barocio, Legislative Analyst's Office
- Frank Mecca, Executive Director, County Welfare Directors Association
- Matt Cate, Executive Director, California State Association of Counties
- Karen Keeslar, California Association of Public Authorities
- Tia Orr, Government Relations Director, Service Employees International Union (SEIU) California
- Kristina Bas Hamilton, Legislative Director, United Domestic Workers (UDW)/AFSCME Local 3930
- Representative, SEIU Local 2015
- Curt Child, Legislative Director, Disability Rights California
- Public Comment

BACKGROUND

Program Description. The In-Home Supportive Services (IHSS) program provides personal care and domestic services to low-income individuals to help them remain safely in their own homes and communities. In order to qualify for IHSS, a recipient must be aged, blind, or disabled and in most cases have income below the level necessary to qualify for Supplemental Security Income/State Supplementary Payment (SSI/SSP) cash assistance. The recipients are eligible to receive up to 283 hours per month of assistance with tasks such as bathing, dressing, housework, and meal preparation. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider, oftentimes a family member or relative. Social workers employed by county welfare departments conduct an in-home IHSS assessment of an individual's needs in order to determine the amount and type of service hours to be provided. The average number of service hours that will be provided to IHSS recipients is projected to be 105 hours per month in 2017-18.

Funding for IHSS. The IHSS program is predominately delivered as a Medi-Cal benefit for low-income populations. The IHSS program is subject to federal Medicaid rules, including the federal medical assistance percentage (FMAP) reimbursement rate for California of 50 percent of costs for most Medi-Cal recipients. Additionally, about 40 percent of IHSS recipients, based on their assessed level of need, qualify for an enhanced federal reimbursement rate of 56 percent, referred to as Community First Choice Option. As a result, the effective federal reimbursement rate for IHSS is about 54 percent. The remaining costs of the IHSS program are paid for by the state and counties.

IHSS Program Federal, State, and County Funding[a]
Governor's Budget

(Dollars in Millions)

	2016-17	2017-18
Total IHSS Program Cost	**$9,960**	**$10,623**
Federal	5,314	5,690
General Fund	3,529	3,154
County	1,117	1,779
Share of IHSS Program Cost		
Federal	53%	54%
General Fund	35	30
County	11	17

[a] 2016-17 and 2017-18 cost estimates reflect estimates from the 2017-18 Department of Social Services' Local Assistance Estimates Binder

Note: 2017-18 estimates reflect the termination of the IHSS county maintenance of effort and restoration of prior state-county cost-sharing ratios

Creation of the IHSS MOE. Historically, the state paid for 65 percent of nonfederal program costs and counties paid for the remaining 35 percent. Beginning in 2012-13, the Coordinated Care Initiative (CCI) replaced the prior county contribution rate with a county IHSS maintenance-of-effort (MOE). The county MOE generally sets counties' contributions to IHSS at their 2011-12 expenditure levels and increases the contributions annually by 3.5 percent plus any additional costs associated with locally negotiated IHSS wage increases. Since the implementation of the MOE, the state General Fund has assumed all nonfederal IHSS costs above counties' MOE expenditure levels. All 58 counties contribute to the IHSS MOE; the application of the MOE was not restricted to the seven counties in the CCI.

As part of the 2017-18 budget, the Governor has eliminated the IHSS county MOE pursuant to a "poison pill" provision in CCI-related legislation, returning counties to their historic cost-sharing ratio. This action and effects on IHSS are discussed later in this section.

BUDGET OVERVIEW

The Governor's budget proposes a total of $10.6 billion (all funds) for IHSS in 2017-18, which is about $660 million (7 percent) above estimated expenditures in 2016-17. The budget includes about $3.1 billion from the General Fund for support of the IHSS program in 2017-18. This is a net decrease of $375 million (11 percent) below estimated General Fund costs in 2016-17. It is important to note that the year-over-year net reduction in IHSS General Fund expenditures masks a number of cost increases, savings, and cost shifts.

Increase in IHSS Basic Services Costs. Caseload growth, a rise in hours per case, and wage increases for IHSS providers are key cost drivers of increasing IHSS service costs. The chart below provided by the Legislative Analyst's Office (LAO) provides a historical overview of changes in these factors.

Recent Growth in Key In-Home Supportive Services (IHSS) Cost Drivers

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17[a]	2017-18[a]
IHSS Caseload							
Monthly average	432,650	443,264	425,526[b]	443,734[b]	467,099[b]	491,141[b]	516,935[b]
Percent change	—	2%	-4%	4%	5%	5%	5%
Hours Per Case							
Monthly average	85	86	92	95	105	105	105
Percent change	—	1%	6%	4%	10%	—	—
IHSS Hourly Wage							
Hourly average	$9.75	$10.01	$10.16	$10.30	$11.03	$11.19	$11.45
Percent change	—	3%	1%	1%	7%	1%	2%

[a]2016-17 and 2017-18 reflect estimates from the 2017-18 Governor's Budget proposal.
[b]These caseload numbers do not include modest increases to IHSS caseload attributed to the Affordable Care Act and the Coordinated Care Initiative.

Increasing Caseload. Within the past three years, the IHSS caseload has grown at an average rate of about 5 percent annually. The Governor's proposal assumes similar growth in 2017-18, with average monthly caseload for IHSS estimated to be a little over 515,000.

Average Hours Per Case. The Governor's budget assumes that IHSS average hours per case in 2016-17 and 2017-18 will be roughly the same as average monthly IHSS paid hours in 2015-16. In 2015-16, average hours per case increased by 10 percent (a higher growth rate than prior years), which was partially attributable to the 7 percent restoration of IHSS service hours. As shown in the LAO chart, average hours per case have been steadily increasing in recent years. To the extent that 2016-17 and 2017-18 experience growth in the average hours per case similar to prior years (average growth of 2 percent annually), General Fund costs for IHSS in 2017-18 would be about $100 million higher than estimated in the Governor's budget.

State and Local Wage Increases. In addition to increasing caseload and hours per case, provider wage increases at the county and state level have contributed to increasing IHSS service costs. The Governor's budget includes $41 million General Fund ($135 million total funds) for the combined impact of recent state minimum wage increase from $10.00 to $10.50 per hour on January 1, 2017 and the scheduled increase from $10.50 to $11.00 per hour on January 1, 2018. The budget also reflects wage increases negotiated at the county level for IHSS providers. IHSS wages are scheduled to continue to increase incrementally every year as a result of scheduled increases in the state minimum wage through January 1, 2022 (reaching $15 per hour). As the state minimum wage increases, it will affect more counties and therefore have a greater effect on IHSS service costs.

Continued Restoration of Service Hours From 7 Percent Reduction. The Governor's budget includes $190 million General Fund ($623 million in total funds) to continue to restore IHSS service hours that were eliminated as a result of a previously enacted 7 percent reduction in service hours, with statute providing that the restoration is conditional on the recently passed managed care organization (MCO) tax being in place. The MCO tax is expected to be effective through 2018-19.

Federal Labor Regulations That Affect Home Care Workers. In February 2016, the state implemented the new federal labor regulations for IHSS providers following a one-year delay due to federal court action. The federal regulations require the state to (1) pay overtime compensation, at one-and-a-half times the regular rate of pay, to IHSS providers for all hours worked that exceed 40 in a week, and (2) compensate IHSS providers for time spent waiting during medical appointments and traveling between the homes of IHSS recipients.

In preparation for the new IHSS overtime rule, the Legislature adopted statutory workweek caps generally limiting the number of hours an IHSS provider can work to 66 hours per week. When multiplied by roughly four weeks per month, this weekly limit is about equal to the maximum number of service hours that may be allotted to IHSS

recipients per month (283 hours per month). Additionally, in 2016, the Department of Social Services (DSS) administratively established two types of exemptions in response to federal guidance asking states implementing workweek caps for IHSS to consider provider exemptions in situations where the caps could lead to increased risk of institutionalization for the consumer. These issues are discussed further in Issue 2 of for IHSS in this agenda.

County MOE and General Fund Interaction. Since the IHSS county MOE was instituted, the General Fund has borne a disproportionate amount of growing IHSS program costs, growing at an average rate of 20 percent annually, from $1.7 billion in 2012-13 to an estimated $3.5 billion in 2016-17. County IHSS program costs, by contrast, have increased at an average rate of around 4 percent annually over the same period.

State law contains a poison pill provision that automatically discontinues the pilot program if the Director of Finance determines that the CCI does not generate annual net General Fund savings and is therefore not cost-effective. The Governor's budget reflects a determination that the CCI is not cost-effective, which the administration primarily attributes to growing General Fund costs under the IHSS county MOE. As a result, the Governor proposes that the IHSS county MOE will end on July 1, 2017 and be replaced with the prior IHSS program cost-sharing ratio of counties paying 35 percent of nonfederal program costs and the state paying the remaining 65 percent.

Increasing Use of General Fund for IHSS Program Under County IHSS MOE

(Dollars in Millions)

		IHSS County MOE					
	2011-12[a]	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18[a]
Total IHSS Nonfederal Costs	**$2,652**	**$2,650**	**$2,879**	**$3,220**	**$3,815**	**$4,646**	**$4,933**
General Fund	1,726	1,706	1,926	2,215	2,737	3,529	3,154
County	926	945	953	1,005	1,078	1,117	1,779
Share of Nonfederal Cost							
General Fund	65%	64%	67%	69%	72%	76%	64%
County	35	36	33	31	28	24	36[b]

[a]Reflects established state-local cost-sharing relationships for IHSS when the Coordinated Care Initiative, and thus the IHSS MOE, was not operative.

[b]County ratio includes higher county costs related to wages and benefits above $12.10 per hour and other IHSS programmatic costs, resulting in a slightly higher county share of nonfederal costs than the statutory rate of 35 percent.

Note: 2016-17 and 2017-18 reflect estimates from the 2017-18 Governor's budget proposal.

IHSS = In-Home Supportive Services and MOE = maintenance-of-effort.

GOVERNOR'S CCI PROPOSAL AND EFFECTS ON IHSS MOE

The Governor's 2017-18 budget terminates the CCI but proposes a two-year continuation of major CCI components. Despite the termination of the CCI, the administration has communicated that it encourages counties and managed care plans to continue to work together to coordinate the IHSS benefit. In addition, the administration has recognized the fiscal challenges that ending the IHSS MOE presents to counties and has signaled an intent to work with counties to mitigate these fiscal challenges. In conjunction with the release of the Governor's 2017-18 budget, the DOF has estimated that the CCI will generate net General Fund costs of $278 million in 2016-17 and $42 million in 2017-18.

Recognizing the merits of the policy goals behind the CCI, the Governor's budget proposes the continuation of major components of the CCI. The Governor is proposing the continuation of (1) Cal MediConnect on a continuing pilot basis, (2) mandatory enrollment in managed care for dual eligibles, and (3) integrated LTSS other than IHSS under managed care. Continuation of any components of the CCI will require statutory authorization from the Legislature. The Governor's budget proposes a two-year continuation of Cal MediConnect. Without this extension, Cal MediConnect would end in January 2018. This will be discussed further in the Sub. 1 hearing on March 13, 2017.

Removal of IHSS From the CCI. By eliminating the CCI but proposing to continue certain CCI components, the Governor would effectively remove the IHSS components from the demonstration. This would result in the following changes:

- **Restoration of the Historical State-County IHSS Cost-Sharing Arrangement.** As they did prior to the IHSS MOE, counties will pay 35 percent of non-federal IHSS program costs and the state will pay the remaining 65 percent beginning July 1, 2017. The DOF estimates that this will transfer approximately $600 million in IHSS costs from the General Fund to the counties in 2017-18.

- **Termination of State-Level Bargaining for IHSS Provider Wages and Benefits.** Bargaining for IHSS wages and benefits in CCI counties reverts from the state to the counties. Since no agreements for increased wages were negotiated or approved by the Statewide Authority, all IHSS bargaining responsibilities have already shifted back to the seven CCI counties. The seven counties with CCI pilots – Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara – had transferred their IHSS collective bargaining responsibilities to the Statewide Authority.

- **End of Development of Universal Assessment Tool.** Efforts to develop a universal assessment tool have ended. To date, a full universal assessment tool has not been constructed or piloted, although the workgroup established by the CCI has carried out significant work in the early development of the tool.

- **Elimination of Funding for Care Coordination.** The Governor's budget proposal eliminates funding that was provided under the CCI for IHSS social workers to participate in interdisciplinary team meetings that included managed care plans and IHSS providers. Although funding is eliminated, the administration has stated that it intends to "encourage" continued coordination between managed care plans and the IHSS program.

Below is the Administration's accounting of the General Fund savings associated with the MOE termination and cost shift.

Multi-year GF Impact of CCI Elimination
($ millions)

GF Impact	2017-18	2018-19	2019-20	2020-21
IHSS Savings (3.8% annual growth applied)	($626)	($650)	($674)	($700)
Increased CalWORKs Costs	$0	$28	$42	$63
Total	($626)	($622)	($632)	($637)

LAO FEEDBACK

The LAO summarizes the major implications of ending the IHSS MOE and returning to the historical state-county cost-sharing arrangement:

- ***Ending the IHSS MOE Provides Significant Relief for the General Fund While Significantly Increasing Costs for Counties.*** Specifically, by returning to the 1991 realignment cost-sharing ratios, counties' 2017-18 costs for IHSS will increase by the same amount of General Fund savings (over $600 million).

- ***1991 Realignment Revenues Will Not Be Sufficient to Pay for Counties' Increased IHSS Share of Cost.*** The revenues that fund counties' IHSS program costs under 1991 realignment will not be sufficient to cover the increases in IHSS county costs, creating immediate and ongoing challenges for counties in the hundreds of millions of dollars.

In their publication "2017-18: The Coordinated Care Initiative: A Critical Juncture," the LAO notes that while the Department of Finance's methodology for determining whether the CCI generates net General Fund savings is in line with statute, the Governor's proposal does not address the impact of ending the IHSS MOE on counties and programs that draw on 1991 Realignment revenues. The LAO recommends exploring several options, including:

- Continuing to try to integrate IHSS into whatever new managed care system replaces the CCI.

- Providing counties a one-time General Fund grant or loan to cover the IHSS costs incurred in 2017-18.

- Reexamining the cost-sharing ratio for IHSS, including potentially removing the requirement for counties to cover wages above $12.10.

COUNTY AND ADVOCATES' RESPONSE

The Subcommittee has received a multitude of letters from senior and disability rights advocates, county health and human services associations, individual counties, and labor unions opposing the cost shift imposed by the Governor as part of the CCI unwinding. This group includes the California State Association of Counties (CSAC), the County Welfare Directors Association of California (CWDA), the California Association of Public Authorities (CAPA), the County Health Executives Association of California (CHEAC), the County Behavioral Health Directors Association (CBHDA), the Urban Counties of California (UCC), and the Rural County Representatives of California (RCRC). They collectively oppose the cessation of the Coordinated Care Initiative, the dismantling of the county In Home Supportive Services (IHSS) Maintenance of Effort (MOE) cost sharing arrangement, the dissolution of the Statewide IHSS Authority, and shifting collective bargaining for IHSS workers from the Statewide IHSS Authority to the seven CCI counties.

Opposition to Cost Shift. These groups state that the cascade of events proposed by the Governor will cause a devastating cost shift to counties and will imperil funding for critical county health, mental health, and public safety programs. Under the Governor's proposal, the counties state that they will assume 35 percent cost responsibility for increasing costs that were imposed as part of state decisions affecting the IHSS program, including minimum wage increases, overtime payment, paid sick leave, and restoration of the 7 percent hours reduction. Stakeholders state that the new costs for counties under the Governor's approach are untenable not only for IHSS, but are of such fiscal magnitude without a predictable and commensurate revenue source that they would inevitably cause adverse effects across county programs.

Opposition to Dissolution of IHSS Statewide Authority. The CCI deal also included a provision to transfer IHSS collective bargaining from counties participating in the CCI to the state and intent language to eventually expand the CCI to all 58 counties while

also transferring their collective bargaining responsibilities to the IHSS Statewide Authority. The seven CCI counties where bargaining did transfer to the IHSS Statewide Authority were notified last week of the official transfer of collective bargaining back to the county level and the resumption of their responsibility to bargain with IHSS workers for wages and benefits. The notification letters state that the counties are only responsible for the terms of the county-bargained contracts at the time they had been transferred to the Statewide Authority, rather than any new contract changes approved by the Statewide Authority in the intervening time; however, both counties and IHSS workers are unclear about the timeline for resuming bargaining.

Provider representative groups are asking for the IHSS Statewide Authority to be maintained, allowing the State to control future decisions relative to IHSS wages and benefits, and thus control program costs. In the current system, the State must fund wage and benefit increases that are negotiated by counties without state input. Additionally, it requires funding separate administrative structures at each county and leads to a decentralized, confusing, and overly costly system. Statewide bargaining would allow the state to better manage the IHSS workforce and improve service delivery. It would additionally eliminate duplication and inefficiency.

Long-Term Care Stakeholders' Input. Advocates additionally request reconsideration of the termination of the Universal Assessment Tool, citing its value and the work completed thus far. They also request consideration of a Long Term Supports and Services infrastructure plan for the State.

STAFF COMMENTS AND QUESTIONS

Staff recommends that the Subcommittee consider raising the following question to the Administration:

1. What were the impacts and outcomes for IHSS consumers in the CCI before it was discontinued?

2. What are the possible fiscal effects and program impacts for counties if the cost shift were to go into effect unmitigated?

3. What changes are already happening at the county level now given the lack of determination regarding cash flow support and the estimated new local costs associated with the dissolution of the MOE?

4. What cash flow assistance has the Administration crafted to correspond with the Governor's CCI decisions and to mitigate the consequences to the counties?

5. What were the recent activities of the IHSS Statewide Authority before the CCI decision?

6. What was the status of the Universal Assessment Tool before it was halted?

Staff Recommendation:

Staff recommends that the Subcommittee take the following action to mitigate the fiscal challenges posed by the impact on IHSS of the Governor's action related to the CCI and the IHSS MOE:

1. **Reestablish the IHSS County Maintenance of Effort (MOE) and increase the amount** by $626 million, reinstituting the previously applicable 3.5% annual growth factor. This achieves and locks in the General Fund savings included in the Governor's proposed budget for 2017-18 and future years.

2. **Recognize that 1991 Realignment Sales Tax Growth Funds will grow** over time to ultimately cover and then exceed the increased County MOE costs. It is important to note that it will take several years for revenue growth in the funds to fully cover the new costs of the increased MOE.

3. **Protect county budgets by supplementing 1991 Realignment funds with other state funds until growth funds fully cover the new costs of the increased MOE.** This supplement would come from a newly created state special fund called the **County Budget Protection Fund**, which would be funded with transfers from available balances of other state funds. This Fund would provide a temporary supplement to Realignment revenues to allow IHSS to be fully funded without impacting county budgets in any adverse way. Once the Realignment revenues exceed the new level of increased MOE costs, excess Realignment revenues would replenish the County Budget Protection Fund and then transfer back to the special fund reserves. Preliminary estimates are that the County Budget Protection Fund would need to provide roughly $500 million to cover the first year of the shortfall, with this amount decreasing every year until the supplement is no longer needed after approximately seven years.

4. **Consistent with this action, retain the California IHSS Authority, or Statewide Authority,** where ultimately wages and benefits for providers would be collectively bargained. The approach on how counties would enter the Statewide Authority in the absence of connection to the CCI will be addressed in the coming weeks as the spring budgeting process unfolds.

This action accomplishes the following:

- Secures the General Fund savings included in the Governor's proposed budget.

- Protects county budgets from having to cover any of the increased IHSS costs. All increased costs shifted to counties will be covered by growth in 1991 Realignment Funds and by the state-funded supplement issued through the County Budget Protection Fund. Therefore, any cost pressures caused by the ending of the CCI on any other area of county budgets, county programs, and county employees are eliminated.

- Protects county budgets from future spikes in IHSS program costs, since the MOE will cap the county costs while the state will take on the risk of increased program costs.

- Retains the Statewide Authority to negotiate wages and benefits, ultimately for all 58 counties, which corresponds to the State maintaining control over the policy levers that result in fiscal changes to the IHSS program given the retention of the fixed costs of the increased county MOE.

ISSUE 2: IMPLEMENTATION OF THE FAIR LABOR STANDARDS ACT FOR IHSS

PANEL

- Will Lightbourne, Director, and Debbi Thomson, Deputy Director, Adult Programs Division, Department of Social Services
  - Please provide an update on Fair Labor Standards Act (FLSA) implementation.
  - Please discuss the exemptions process and your observations on their use over the past year.
  - Please describe what actions the Administration has taken on implementing the violations policy and why.
- Iliana Ramos, Department of Finance
- Jackie Barocio, Legislative Analyst's Office
- Curt Child, Legislative Director, Disability Rights California
- Charlie Bean, IHSS Consumer, Humboldt County
- Karen Keeslar, California Association of Public Authorities
- Kristina Bas Hamilton, Legislative Director, UDW/AFSCME Local 3930
- Tiffany Whiten, Long Term Care Director, SEIU California
- Public Comment

BACKGROUND

On February 1, 2016, the state implemented the new federal labor regulations for IHSS providers following a one-year delay due to federal court action. The federal regulations require the state to (1) pay overtime compensation, at one-and-a-half times the regular rate of pay, to IHSS providers for all hours worked that exceed 40 in a week, and (2) compensate IHSS providers for time spent waiting during medical appointments and traveling between the homes of IHSS recipients.

The 2016 implementation schedule is included below.

Completion Date	Milestone	State/County Activities
February 1, 2016	**Implementation of overtime**	**Implementation of Federal Labor Standards Act (FLSA) requirements – SB 855 and SB 873 workweek and overtime provisions.** • CDSS released ACL 16-01 to provide counties with instructions, including the policies and procedures for implementation of the overtime, workweek requirements, (pursuant to SB 855 and SB 873). These included the revised forms and notices (including the workweek agreements for providers and recipients).
		Timesheets and Travel Claim Form - Timesheet (SOC 2261) and CMIPS modifications were made to accommodate the payment of overtime implemented on February 1, 2016 as well as claiming of travel time.
Feb 9, - Feb 26, 2016	**Training Sessions**	**Training-for-Trainer (T4T) sessions commenced February 9, 2016, and concluded February 26, 2016.** • CDSS conducted the training sessions statewide to approximately 320 trainers at the counties, Public Authorities (PAs), and labor organizations.
February 21, 2016	**Overtime Exemption 1**	**Overtime Exemption 1: Live-In Family Care Provider Overtime Exemption.** • CDSS released ACL 16-07 to provide counties with information for implementing Overtime Exemption 1. IHSS providers who want to qualify for Overtime Exemption 1 must submit the completed SOC 2279 to CDSS by April 1.
April 15, 2016	**Forms and Workweek Agreements**	**Deadline for <u>completed forms</u> SOC 846, SOC 2256 and SOC 2255 to be returned (completed) to counties for processing**
May 1, 2016	**Violations**	**Violations (Non-Compliance with Workweek and Overtime Requirements).** • Grace period ends. Violations for non-compliance with workweek and overtime requirements were to be formally enforced beginning May 1, 2016. DSS took administrative actions to delay effects of violations and to forgive them on a time-limited basis program-wide. Subsequent, similar actions were taken as late as December 2016.
May 2016	**Overtime Exemption 2**	**Overtime Exemption 2: Extraordinary Circumstances.** • CDSS developed a second exemption to allow IHSS providers to work beyond a recipient's maximum weekly hours or beyond the 66-hour workweek limitation. No notice was provided to consumers or providers.

BUDGET OVERVIEW

The 2017-18 budget includes $463 million in nonfederal (state and county) funds for compliance and administration of the federal labor regulations, an increase of $28 million (6 percent) over estimates for 2016-17. The table below illustrates these costs for both the current (2016-17) and budget year (2017-18).

Updated IHSS Nonfederal Costs to Comply With Federal Labor Regulations[a]
(In Millions)

	2016-17		2017-18
	Appropriation	Revised	Governor's Budget
Overtime premium pay	$230	$255	$271
Travel time and medical accompaniment	180	172	183
Provider exemptions	22	5	6
Administration	2	3	3
Totals	**$434**	**$435**	**$463**

[a]For 2016-17, the nonfederal costs are 100 percent General Fund. For 2017-18, the nonfederal funds are assumed to be 35 percent county and 65 percent General Fund.

ISSUES IN IMPLEMENTATION

Continued Limitations on Overtime. The estimates of IHSS provider overtime costs reflect statutory caps, generally limiting the number of hours an IHSS provider can work to 66 hours per week. The majority of IHSS providers work less than 40 hours a week, with about 20 percent of IHSS providers working more than 40 hours per week and receiving overtime pay. As discussed more fully below, IHSS recipients and providers may work additional overtime hours and exceed the 66-hour workweek cap by obtaining an exemption. In addition, IHSS recipients may request additional overtime hours when they require more support in a given workweek, for example, if they fall ill. Upon county approval, IHSS recipients are expected to adjust their provider's remaining workweek hours so that total monthly hours worked does not exceed the provider's authorized monthly hour cap. The Governor's budget estimates that 23 percent of providers will typically work more than 40 hours per week in 2017-18. Of those providers, it is estimated that they will, on average, work 61 overtime hours per month, or a total of about 55 hours per week, in both 2016-17 and 2017-18, an increase of 5 hours from 2016-17 budget estimates.

Continued Compensation for Travel Time and Medical Accompaniment. The Governor's budget also includes the continuation of compensable hours for medical accompaniment, estimated to average three hours per month, and travel time, under certain conditions. Specifically, compensable travel time applies only to IHSS providers who work for multiple recipients and includes hours spent traveling between the homes of recipients. Based on actual data, the budget estimates that half of providers with multiple recipients will spend and claim an average of 17 travel hours per month, an increase of about 7 hours from the administration's initial estimate in 2016-17.

Lower-Than-Expected Issued Exemptions to Overtime Limits for Certain Providers. In 2016, DSS issued guidance to counties establishing two exemptions to the 66-hour workweek cap for certain providers with multiple recipients. For both exemptions, the weekly maximum allowable hours are extended from 66 hours per workweek to 90 hours per workweek (not to exceed 360 hours per month).

The first exemption applies to IHSS providers who are related to, live with, and work for two or more IHSS recipients on or before January 31, 2016. Eligible recipients were notified of the exemption and mailed application forms by DSS. The second exemption applies to IHSS providers who work for two or more IHSS recipients whose extraordinary circumstances place them in imminent risk of out-of-home institutionalized care. Qualifying extraordinary circumstances include (1) complex medical or behavioral needs that requires a live-in provider, (2) residence in a rural and remote area where available providers are limited and as a result the recipient is unable to hire another provider, or (3) an inability to hire a provider who speaks his/her same language in order to direct his/her own care. For the most part, recipients or providers contact their IHSS county social worker to determine whether they meet the eligibility criteria for an extraordinary circumstances exemption. Before an IHSS county social worker submits a formal request for an extraordinary circumstances exemption to the state, it must be determined that the recipient, with county assistance, has explored and exhausted all other options to meet their additional service needs, such as hiring another provider.

At the time the 2016-17 budget was enacted, it was estimated that approximately 1,200 IHSS providers would receive a family exemption and 5,000 providers would receive an extraordinary circumstances exemption (out of an estimated 462,000 IHSS providers). As of January 2017, about 1,400 providers were issued family exemptions and about 50 providers were issued extraordinary circumstances exemptions. As a result, the Governor's January proposal includes significantly lower estimates for issued extraordinary circumstances exemptions (135 in 2016-17 and 385 in 2017-18).

The following has been provided by DSS:

IHSS Timesheets, Overtime & Exemptions

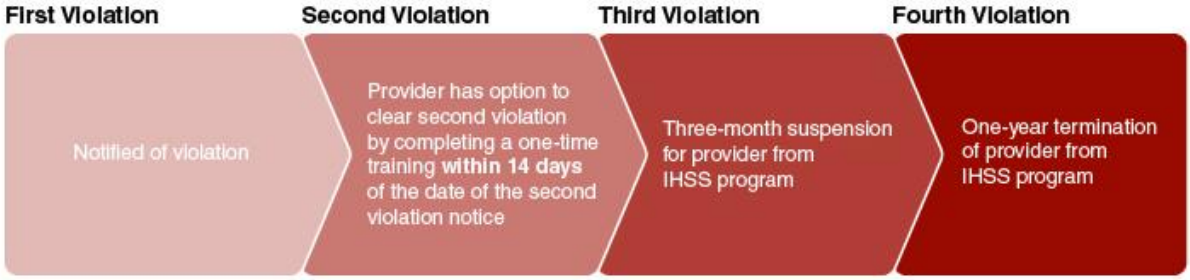
Timesheets and Overtime (OT)		
November 2016	**December 2016**	**January 2017**
• 99,670 Providers Paid OT* • 5,675,819 Total OT Hours Paid • 57 Avg. OT Hours per Provider Paid OT • $ 37,820,704 Total OT Paid	• 103,210 Providers Paid OT* • 6,311,621 Total OT Hours Paid • 61 Avg. OT Hours per Provider Paid OT • $ 42,057,360 Total OT Paid	• 104,326 Providers Paid OT* • 6,878,596.9 Total OT Hours Paid • 66 Avg. OT Hours per Provider Paid OT • $ 45,835,393 Total OT Paid
*Timesheets submitted in November, regardless of when services were performed. As of 11/30/16.	*Timesheets submitted in December, regardless of when services were performed. As of 12/31/16.	*Timesheets submitted in January, regardless of when services were performed. As of 01/31/17.
An average of 21-23% of total timesheets processed monthly are paid with overtime.		

Exemptions 1 & 2	
Exemption 1 (as of 02/03/2017)	**Requests Received: 1,424 Approved, 571 Ineligible, 8 In Review**
Exemption 2 (as of 01/17/2017)	**Requests Received: 56 Approved, 70 Ineligible, 7 In Review**

Increasing Number of Timesheet Violations. Starting July 1, 2016, DSS began issuing timesheet violations to providers for exceeding their authorized monthly work caps or permitted travel time (up to 28 hours per month). As shown in Figure 3, violations are administered based on a four-level violation system, with consequences becoming more severe as a provider continues to work above their monthly work cap or allotted travel time. The total number of providers with timesheet violations has increased from 2,912 in July 2016 (the first month in which providers could receive a timesheet violation) to 4,699 in December 2016. Despite these increases, providers with second and third violations remain a significantly small portion of the overall IHSS provider population. IHSS providers have the option to clear second violations through a one-time training about workweek and travel time limits.

Figure 3

IHSS Timesheet Violation System



IHSS = In-Home Supportive Services Program.

The following has been provided by DSS:

IHSS Provider Violations

Effective July 1, 2016, violations were enforced. A violation can only occur once per month per provider, regardless of the number of errors.

Violation Type	Violations Incurred Nov-16*	Violations Incurred Dec-16*	Violations Incurred Jan-17*
Exceeds Weekly Max of 66 Hours (Multiple Recipients)	1,599	1,834	1,510
Exceeds Overtime Max (Single Recipient)	1,935	2,737	2,386
Exceeds Travel Time	117	128	115
Statewide Total	**3,651**	**4,699**	**4,011**
	*Violations incurred in November, regardless of when services were performed. As of 11/30/16.	*Violations incurred in December, regardless of when services were performed. As of 12/31/16.	*Violations incurred in January, regardless of when services were performed. As of 01/31/17.

Note: Violations are tracked in the month they are triggered by a submitted timesheet regardless of service period. For example, timesheets for services between Nov. 16-Nov. 31 were not submitted until after Dec. 1. All violations on these timesheets were counted in December.

CONTINUED MONITORING AND REPORTING

The department will provide data in quarterly reports starting six months after implementing the FLSA that will include data on the number of timesheets with overtime, the number of exemptions, payroll stats, etc. This is in addition to the requirement for a study that was included in SB 855. The first report to the Legislature is due in April 2017, and is currently undergoing administrative review. The report will include updated facts and figures used to build the May Revision.

LAO REACTION

The LAO states that the Legislature may consider statutorily establishing exemptions. The state legislation implementing the federal labor regulations does not provide specific authority for DSS to exempt certain providers from the workweek caps this legislation established, and the administration is not proposing trailer bill language to codify these exemptions in statute. To increase its oversight of the exemption policy, the Legislature may wish to consider adopting trailer bill language to ensure that there is statutory authority for provider exemptions to the workweek caps that is in line with legislative intent.

ADVOCATES' FEEDBACK

The IHSS Coalition is composed of fifty organizations representing IHSS consumers, providers and advocates. The IHSS Coalition is proposing to address Exemption 2 concerns by: (1) modestly expanding the exemption criteria, (2) require notification to consumers and providers about the criteria and process to request an exemption, and (3) establish a fair and reasonable appeals process.

Regarding the exemption criteria, the Coalition states that protections are needed to allow for situations when a provider can work above the CDSS cap of 66 hours/week in certain, limited situations, including:

- Providers who are the parent, step-parent, grandparent or legal guardian of two or more children (including providers approved after Jan 31, 2016);

- Spouses, domestic partners, adult children caring for parents, adult siblings, and adult grandchildren, when no other suitable provider is available; and

- Individual consumer situations when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient[1]s health (including physical, psychiatric or emotional) or safety would be at risk.

- In addition, statute should allow some providers to work over 90 hours/week in limited situations based on individual consumer needs when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient¹s health (including physical, psychiatric or emotional) or safety would be at risk.

The Coalition states that it anticipates that these changes will reduce harm to a relatively small group of IHSS consumers and providers as they try to comply with the new overtime rules. The state's estimated 5,000 providers could meet the specific criteria for this exemption and could be allowed to work up to 12 hours per day, or 90 hours per week, not to exceed 360 hours per month. Funding based on this estimate was included in the final 2016-17 state budget. However, as of December 29, 2016, there were 52 providers approved, 68 denied, and 11 pending for Exemption 2. The Coalition states that this data validates the observation that the criteria for Exemption 2 is too narrow.

STAFF COMMENT

Staff recommends that the Subcommittee pose the following questions to the Administration:

1. Why have exemptions been so undersubscribed from what was anticipated in the 2016 Budget?

2. What kinds of challenges with accessing the exemptions are you aware of? How have you addressed these?

3. What issues and value do you see in the noticing suggestion from advocates?

4. What issues and value do you see in the appeals suggestion from advocates?

Staff Recommendation:

Staff recommends that the Subcommittee take the following action:

Approve an enhanced and clarified exemption process for vulnerable IHSS recipients, adopting the proposal from the IHSS Coalition, with placeholder trailer bill language from Disability Rights California, to expand qualified exemptions, create an appeals process, and provide for a program notice. The original appropriation for the exemptions should be utilized to cover the cost of this exemption policy modification intended to create rightful access to vulnerable IHSS consumers in the program. DSS is asked to provide an estimate to the Subcommittee prior to the May Revision.

ISSUE 3: TIMESHEET AND PAYROLLING CHANGES FOR IHSS

PANEL

- Will Lightbourne, Director, and Debbi Thomson, Deputy Director, Adult Programs Division, Department of Social Services
  - Please describe the recent activities and projected timelines for Electronic Visit Verification for IHSS.
  - Please describe the progress of discussions around how to better automate timesheets and how this affect both providers and consumers in the program.
- Iliana Ramos, Department of Finance
- Jackie Barocio, Legislative Analyst's Office
- Public Comment

BACKGROUND

Electronic Visit Verification. H.R. 2646 was signed in December of 2016, and contains provisions related to Electronic Visit Verification, or "EVV". These provisions would require states to implement EVV systems for Medicaid-funded personal care and home health care services, such as IHSS. The bill stipulates that the electronic system must verify (1) the service performed, (2) the date and time of service, and (3) the location of the service, and (4) the identities of the provider and consumer. Currently, IHSS has no such system. California has until January 2019 to comply for personal care services, and until January 2023 for home care services. As federal rulemaking and guidance is not yet available, and the department does not yet have a timeline for when they would have a proposal for an EVV system. DSS will work with stakeholders to gather input.

Electronic Timesheets. In the last several years, there have been various instances with the processing of paper timesheets that have resulted in delays in payment to providers. The State Auditor is scheduled to release an audit on the broader issues facing the IHSS payroll system in March of 2017. These payroll issues were also discussed in more detail in a Senate Human Services Committee hearing on November 1, 2016.

In an effort to streamline timesheet processing, and in response to requests from IHSS stakeholders, DSS has announced plans to implement online IHSS timesheets in three pilot counties in May 2017. According to DSS, the online timesheet system will use technology that is intuitive and easy to use on PCs, smartphones and tablets. It will provide real-time data validation, which means timesheet errors can be corrected before the timesheet is submitted. Providers and recipients will be able to submit electronic signatures, eliminating the need to place timesheets in the mail. If providers and recipients adopt this optional technology, it is expected to reduce timesheet errors and significantly reduce the time it takes to pay providers by eliminating mail time. The

department is also working on plans to increase the use of direct deposit as well as other electronic funds transfer options.

DSS has issued a request for proposals (RFP) for the contract to operate the payroll system (CMIPS II). The RFP requires the vendor to "assess the current payrolling approach and recommend available business, technology and process improvements."

STAFF COMMENT

Staff recommends that the Subcommittee posit the following requests and questions to the Administration:

1. Please provide an update on the status of EVV.

2. Please provide more details on the electronic timesheet pilot. When will you have feedback to share from the pilot, and when do you expect the pilot to finish and electronic timesheets to roll out to all counties? How are you working with stakeholders to ensure that consumers and providers are aware of changes in the timesheet process?

3. Please provide more information on both the department's efforts to improve the direct deposit process and other electronic funds transfer options.

Staff Recommendation:

Staff recommends that the DSS be asked to provide an update and scheduled next steps, with any associated cost estimates if known, in writing to the Subcommittee prior to the May Revision on these two subjects.