SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Mimi Walters
Senator Bill Monning

March 13, 2014
9:30 a.m. or Upon Adjournment of Session
Room 4203

Consultant: Samantha Lui

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4170 Department of Aging

1. Overview

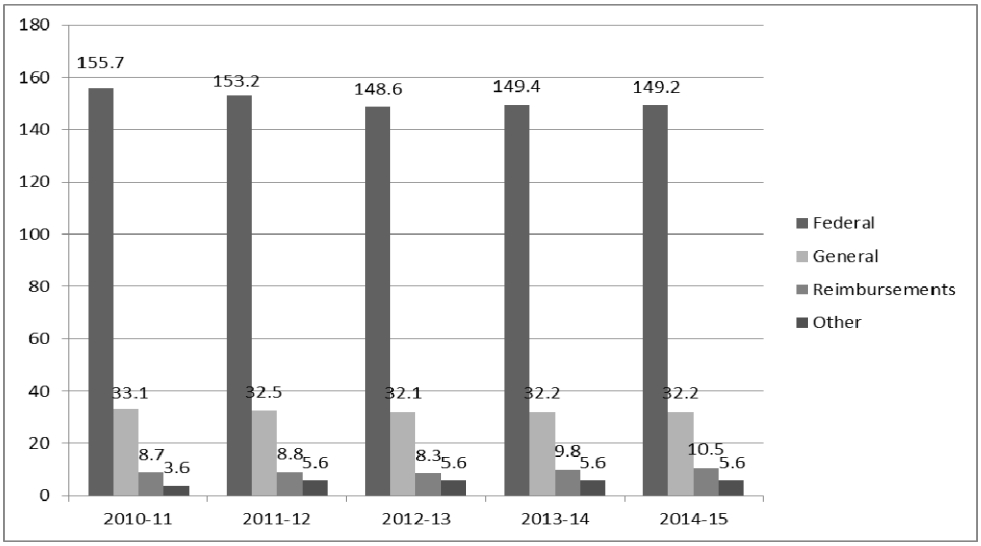
With a proposed 2014-15 budget of $197.47 million ($32.2 million General Fund) and 117.8 authorized positions, the California Department of Aging (CDA) administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. The department is the federally designated State Unit on Aging, and administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program.

Area Agencies on Aging. CDA contracts with a statewide network of 33 Area Agencies on Aging (AAAs), which directly manage federal and state-funded services to help older adults find employment, support older adults and individuals with disabilities to live as independently as possible in the community, promote healthy aging and community involvement, and assist family members in their caregiving. Each AAA provides services in one of the 33 designated Planning and Service Areas (PSAs), which are service regions consisting of one or more counties and the City of Los Angeles. Examples of AAA services include: supportive and care management services; in-home services; congregate and home delivered meals; legal services; Long Term Care Ombudsman services; and elder abuse prevention.

CDA also contracts directly with agencies that operate the Multipurpose Senior Services Program (MSSP) through the Medi-Cal home and community-based waiver for the elderly, and certifies Community Based Adult Services (CBAS) centers for the Medi-Cal program.

Funding. Below is a figure of CDA's funding history for the last five years, starting in fiscal year (FY) 2010-11 to the proposed 2014-15 budget year.

Budget Act Totals by Fund
FY 2010/11 to 2014/15*
(in Millions)



*Amounts above do not include federal sequestration reductions.

Between July 2007 and June 2012, the CDA budget was reduced by approximately $30.1 million in GF. This includes the elimination of state funding for Community-Based Services, Supportive Services, Ombudsman and Elder Abuse Prevention, Senior Community Employment, and a reduction in MSSP funding.

Current Competitive Federal Demonstration Grants. CDA has been awarded several competitive federal demonstration grants, which include the following:

- **U.S. Department of Transportation New Freedom Initiative Grant**
  CDA was awarded a $400,000 Department of Transportation New Freedom Grant from June 1, 2011 to December 31, 2013. The grant seeks to increase accessibility and availability of transportation services for older adults and adults with disabilities, and provides mobility management training to California's 33 AAAs.

- **Administration on Aging, Chronic Disease Self-Management Education Grant**
  CDA was awarded a $1.72 million, three-year (September 1, 2012 to August 31, 2015) federal Administration on Aging grant to fund the Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education (CDSME) grant project. CDA has partnered with the California Department of Public Health (CDPH) to expand the availability of the Chronic Disease Self-Management Program and Diabetes Self-Management Program to individuals who are low-income, limited or non-English speaking, Medi-Cal eligible, and/or veterans. CDA, in partnership with CDPH, will contract with Partners in Care, which will subcontract with the AAAs, or the public health departments, in Los Angeles, Orange, Napa, San Diego, San Francisco, Solano, and Sonoma counties.

Federal Funding for Consumer Counseling. The 2013 budget provided additional expenditure authority to the Department of Aging of $660,000 to reflect a one-time federal grant to provide training for Health Insurance Counseling Program (HICAP) staff and one-on-one dual eligibility health insurance counseling related to Cal MediConnect. HICAP provides free and objective information and counseling about Medicare. Volunteer counselors assist individuals understanding their rights and health care options.

Staff Comment & Recommendation. This is an informational item, and no action is required.

Questions

1. Please briefly summarize the department's most critical roles and programs.

2. Please provide an update on the distribution of the federal funds for HICAP for Coordinated Care Initiative.

2. Multi-Purpose Senior Services Program (MSSP) - Update

Background. MSSP provides social and health case management services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be aged 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services, and then, work with the clients, their physicians, families, and others to develop an individualized care plan. Services provided with MSSP funds include: care management; adult social day care; housing assistance; in-home chore and personal care services; respite services; transportation services; protective services; meal services; and, special communication assistance.

CDA currently oversees operation of the MSSP program statewide and contracts with local entities that directly provide MSSP services to around 12,000 individuals. The program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services waiver.

MSSP as Part of the Coordinated Care Initiative. The Coordinated Care Initiative (CCI)[1] is intended to integrate medical, behavioral, long-term supports and services (LTSS), and home and community-based services through a single Medi-Cal health plan for persons eligible for both Medicare and Medi-Cal, or "dual eligible," in eight demonstration counties. Under CCI, Medi-Cal beneficiaries will be required to join a participating Medi-Cal managed care health plan to receive their Medi-Cal health benefits, including MSSP. Additionally, CCI will integrate LTSS into Medi-Cal managed care for individuals eligible for Medi-Cal, but not Medicare. For recipients in non-demonstration counties, the MSSP program's current eligibility process and programmatic requirements will continue without changes. The MSSP sites in the CCI counties will continue to provide waiver services to clients for 19 months after the transition to managed care.

The MSSP operates in 48 counties. Fifteen of the 39 MSSP sites are in Coordinated Care Initiative (CCI) demonstration counties. The current MSSP 1915 (c) Home- and Community-Based Services Waiver will expire on June 30, 2014. DHCS and CDA are working together to submit a waiver renewal application which will continue MSSP through June 30, 2019. The waiver renewal addresses transitioning MSSP from a Medi-Cal fee-for-service (FFS) benefit to a managed health care benefit, no earlier than April 1, 2014, in one CCI county (San Mateo), and in the remaining seven CCI counties no sooner than July 1, 2014.

160 MSSP waiver participants will transition into Medi-Cal managed care in San Mateo County, no sooner than April 1, 2014. 5,233 participants will transition into Medi-Cal managed care in Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara Counties, no sooner than July 1, 2014. The remaining 4,047 MSSP waiver participants will continue in the MSSP Waiver under FFS Medi-Cal.

Staff Comment & Recommendation. This is an informational item, and no action is required.

[1] For more information, please see the Senate Budget and Fiscal Review Committee and Senate Health Committee's joint oversight hearing of the CCI on February 6, 2014. Background materials may be accessed here: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/02062014SBFR_HealthJointHearingAgendaCCI.pdf

Questions

1. Please briefly describe how the Administration is engaging MSSP sites and staff during CCI implementation.

2. Looking ahead a few years, does the Administration intend for MSSP to continue to be budgeted as a separate LTSS program? Would CDA maintain its programmatic oversight role? How would federal funding potentially change?

3. Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant

Budget Issue. CDA requests $820,000 in budget authority ($153,000 in FY 2013-14; $276,000 for FY 2014-15; $311,000 for FY 2015-16; and $80,000 for FY 2016-17) for a three-year (October 1, 2013, to September 30, 2016) grant from the federal Administration on Community Living.[2] The grant funding will focus on building a dementia-capable integrated system of care for patients with Alzheimer's disease, or related disorders, enrolled in California's Cal Medi-Connect. Specifically, the grant will educate care managers to provide person-centered services; and, provide care coordination to individuals and family caregivers, including referrals to services and community support. CDA would work with the California Department of Health Care Services, California Alzheimer's Association Chapters, and interested managed care plans to target patients, family caregivers, and care managers associated with health plans in the Coordinated Care Initiative (CCI) pilot counties. Local Alzheimer's Association Chapters will fully cover the match requirement.

The department indicates that the following seven health plans are scheduled to be involved:

- Health Plan of San Mateo (Year 1)
- Care 1st Health Plan (Year 1)
- Health Net (in the City of Los Angeles) (Years 1 and 2)
- LA Care (Year 2)
- Anthem/CareMore (Year 2)
- Santa Clara Family Health Plan (Year 2)
- Alameda Alliance for Health (Year 2)

In Year 3, CDA seeks to expand the care manager training to interested health plans in Riverside and/or San Bernardino counties.

Background. As the federally designated State Unit on Aging, CDA administers a range of programs, supported by state and federal funds, to provide non-institutional services for older Californians and functionally impaired adults, including the Multipurpose Senior Services Programs (MSSP), Community Based Adult Services (CBAS), and the Alzheimer's Day Care Resource Centers. In April 2013, the Administration on Aging released a competitive funding opportunity for State Units, and CDA was awarded $820,000 for its proposal to work with local Alzheimer's Association Chapters to target patients, family caregivers, and care managers associated with health plans in the pilot counties involved.

Staff Comment & Recommendation. Approve. It is recommended to approve this proposal, as no concerns have been raised.

Questions.

1. Please briefly summarize the proposal, including expected goals and outcomes.

[2] The Administration on Community Living bring together the efforts of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for increasing access to community supports

4. Aging and Disability Resource Connection Transfer

Budget Issue. The budget proposes to transfer the Aging and Disability Resource Connection (ADRC) program's administration and oversight from the California Health and Human Services Agency (CHHS) to CDA, and to transfer 2.6 one-year limited-term positions from CHHS to CDA. The budget requests $275,000 in reimbursement authority to fund ADRC program oversight activities. CDA reimbursement authority will be required to collect federal funds from the Department of Health Care Services and State Independent Living Council via interagency agreements.

Background. In 1999, the U.S. Supreme Court's *Olmstead* decision affirmed that the Americans with Disabilities Act applied to individuals with all disabilities, and underscored a person's right to receive community-based long-term services and supports (LTSS) in the most integrated setting as possible. As a result, in 2003, the Administration on Aging (now, called the Administration for Community Living) joined with the Centers for Medicare and Medicaid Services (CMS) to promote and fund ADRC centers and programs.

The ADRC model builds on existing networks and funding to Area Agencies on Aging (AAAs) and Independent Living Centers, and are intended to be a trusted resource for individuals (public and/or private pay) looking for information on the full range of LTSS options. According to the Administration of Community Living's Semi-Annual Report (April 1 to September 30, 2013), ADRCs collectively served more than 33,000 Californians. In California, seven ADRC partnership serve 11 counties (Butte, Colusa, Del Norte, Glenn, Nevada, Orange, Plumas, Riverside, San Diego, San Francisco, and Tehama), and one new ADRC (Alameda County) is in the final planning stages.

In 2007, a CMS demonstration grant, California Community Choices Project, established additional regional ADRCs and state level program support at CHHS, managed by a unit of 2.6 positions. Over the past five years, this effort has been funded by federal grants and limited foundation support.[3] ADRC funding is currently supported with reimbursements from an interagency agreement with the Department of Health Care Services using its remaining 2010 Money Follows the Person (MFP) federal grant funds. That funding, and the authority for the current positions, was approved for one year as part of the 2013-14 budget, and ends June 30, 2014. Federal funding for local ADRCs has, historically, been through opportunities where only a state entity is eligible to apply.

Staff Comment & Recommendation. Approve. Maintaining the State's ADRC program infrastructure allows California's ADRCs to receive future federal funds, as federal funding opportunities require the State to be the applicant. No concerns have been raised with the proposal.

Questions

1. Please briefly explain the Aging and Disability Resource Connection program, including its current service-delivery model, funding sources, and staffing. Why should CDA oversee the ADRC programs?

[3] CHHS ADRC program staff partnered with The SCAN Foundation to select two ADRC partnerships, San Diego and Nevada counties, to work with a team of technical consultants from Mercer. SCAN contracted directly with Mercer to develop innovative models for the delivery and financing of community-based LTSS. Final products were released in February 2014, and posted online at http://communitychoices.info.

5. Model Approaches to Statewide Legal Assistance Systems - Phase II Grant

Budget Issue. CDA requests $536,000 in federal local assistance expenditure authority ($179,000 for FY 2013-14 through Section 28 process; $179,000 for FY 2014-15; and, $179,000 for FY 2015-16) over three state fiscal years (August 1, 2013, to July 31, 2016). The Phase II grant project builds upon the prior Phase 1 grant by delivering Older Americans Act (OAA) funded legal services to older adults in greatest need. CDA would continue their partnership with Legal Services of Northern California (LSNC) and the Legal Aid Association of California to implement the grant. The California Model Approaches Advisory Group will monitor project activities and progress. There is no state General Fund impact. CDA's local partners will meet 100 percent of the match requirements.

The project would provide resources for older adults to attend legal education presentations, receive or view online self-help legal education materials, and receive referrals to legal assistance via the statewide aging and disability networks.

Background. As the federally designated State Unit of Aging, CDA receives OAA funding, which it allocates to the 33 local Area Agencies on Aging (AAAs) to provide senior legal services through a network of contracted local providers. In 2009, CDA, in partnership with the Legal Services of Northern California and Legal Aid Association of California, applied for and were awarded a four-year federal Model Approaches to Statewide Leal Assistance Systems Phase I grant.

With the Phase I grant, CDA and its partners developed a model of delivering coordinated, cost-effective legal services, responsive to the needs of seniors, particularly those who are low-income or have limited English proficiency. Also, under the Phase I grant, CDA, LSNC, and the Legal Aid Association of California established the California Model Approaches Advisory Group, comprised of representatives from AAAs, local senior legal services providers, members of the Judicial Council, State Bar Access to Justice Commission, and academia. This Advisory Group prioritized recommendations for future coordination of work, including: increased sharing of tools and resources; increased partnership among legal services and AAAs; and, increased education about legal services.

In May 2013, the Administration of Community Living released a competitive three-year funding opportunity for State Units on Aging to implement a Phase II grant to continue efforts begun under the Phase 1 grant. CDA was awarded the Phase II grant, and will continue to partner with LSNC and the Legal Aid Association of California.

Staff Comment & Recommendation. Approve. It is recommended to approve this proposal, as no concerns have been raised.

Questions

1. Please briefly summarize the Model Approaches Phase II grant. Will findings from the Model Approaches Advisory Group be shared with the Legislature?

2. How will these services be sustained after the Phase II grant expires in FY 2015-16?

5180 Department of Social Services, Community Care Licensing (CCL)

1. Overview

Budget Issue. With a total proposed budget of about $118 million (approximately $36 million GF), the Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of approximately 66,000 licensed community care facilities, and has responsibility for protecting the health and safety of individuals served by those facilities.

Background. CCL licenses facilities, including childcare centers, family childcare homes, foster family and group homes, adult residential facilities, and residential care facilities for the elderly. CCL does not license skilled nursing facilities, which instead, are licensed by the Department of Health Care Services; or, facilities that provide alcohol and other drug treatment. The figure below shows some of the facilities licensed by CCL.

Facility Type	Description
Child Care Licensing	
Family Child Care Home	24 hr. non-medical care in licensee's home.
Children's Residential Facilities	
Crisis Nursery	Short-term, 24-hr., non-medical care for eligible children under 6 years of age.
Group Homes	24-hr., non-medical care to children in structured environment; facilities are of any capacity.
Small Family Homes & Foster Family Home	24-hr. care in the licensee's home for 6 or fewer children, who have disabilities.
Transitional Housing Placement	Provides care for 16+ yrs. old in independent living.
Adult & Elderly Facilities	
Adult Day Programs	Community based facility/program for person 18+ years old.
Adult Residential Facilities (ARF)	24-hr. non-medical care for adults, 18-59 years old.
Adult Residential Facility for Persons with Special Healthcare Needs	24-hr. services in homelike setting, for up to 5 adults, who have developmental disabilities, being transitioned from a developmental center.
Residential Care Facilities for the Chronically Ill	Facilities with maximum capacity of 25.
Residential Care Facilities for the Elderly (RCFE)	Care, supervision, and assistance with activities of daily living to eligible persons, usually 60+ yrs. old. Facilities range from 6 beds or less, to over 100 beds.
Continuing Care Retirement Communities (CCRC)	Long-term continuing care contract; provides housing, residential services, and nursing care.
Social Rehabilitation Facilities	24-hr. non-medical care in group setting to adults recovering from mental illness.
Special Agencies	
Certified Family Homes (CFH)	CFHs are certified by foster family agencies.

Background Check. Applicants, licensees, adult residents, and employees of community care facilities who have client contact must receive a criminal background check. An individual submits fingerprint imaging to the California Department of Justice (DOJ). The Caregiver Background Check Bureau, within CCL, processes and monitors background checks. If an individual has no criminal history, DOJ will forward a clearance notice to the applicant or licensee and to the Caregiver Background Check Bureau within the Community Care Licensing Division. If an individual has criminal history, DOJ sends the record to the Bureau, where staff reviews the transcript and determines if the convictions for crimes may be exempt.

For individuals associated with a facility that cares for children, an additional background check is required through the Child Abuse Central Index.

According to DSS, approximately 200,000 background checks are completed annually, with approximately 1,200 (0.6 percent) individuals denied criminal record clearance or exemptions.

Facility licensing practices and requirements. All facilities must meet minimum licensing standards, as specified in California's Health and Safety Code and Title 22 Regulations. According to DSS, around 1.4 million Californians rely on CCL enforcement activities to ensure that the care they receive is consistent with standards set in law.

DSS must conduct pre- and post-licensing inspections for new facilities, including when a previously licensed facility changes hands. In addition, the department must conduct unannounced visits to licensed facilities under a statutorily required timeframe. Prior to 2003, these routine inspection visits were required annually for all facilities except family child care homes, which received at least triennial inspections. In 2003, a human services budget trailer bill AB 1752 (Budget Committee), Chapter 225, Statutes of 2003, reduced the budget for CCL by $5.6 million, and reduced the frequency of these inspections. As a result, CCL must visit a small number of specified facilities and conduct random, comprehensive visits to at least 10 percent of the remaining facilities annually.

Ultimately, the department must visit all facilities at least once every five years, which is less frequent than required in most states. In addition, there is a "trigger" by which annually required inspections increase if citations increase by 10 percent from one year to the next. For FY 2012-13, the annual required inspection requirement was met 80 percent of the time, while the annual random inspection requirement was met 94percent of the time.

Below is a chart that summarizes the type of inspection conducted in licensed facilities, how many inspections utilized the Key Indicator Tool (KIT), and how many comprehensive inspections were triggered after the KIT.

CCL Inspections in All Facilities
By Type of Inspection and Protocol
Fiscal Year 2012-13

Type of Inspection	Total of Inspections	How many inspections utilized the Key Indicator Tool (KIT)?	How many inspections that utilized the KIT triggered a comprehensive inspection?
Annual Required Inspection	6,054	5,515 (91.1%)	419 (7.6%)
Random Inspection	17,233	16,682 (96.8%)	1,217 (7.3%)
Required Five-Yr. Visit	3,984	3,673 (92.2%)	375 (10.2%)

*As of SFY 2012-13 Quarter 3, CDSS is able to document percentage of inspection visits utilizing comprehensive versus KIT. Additionally, CDSS is now able to document the percentage of KIT visits that triggered a comprehensive visit.

Key Indicator Tool. After the 2003 changes and because of other personnel reductions,[4] CCL fell behind in meeting the visitation frequency requirements. In response, DSS designed and implemented the key indicator tool (KIT), which is a shortened version of CCL's comprehensive licensing inspection instruction, for all of its licensed programs. The KIT complements, but does not replace, existing licensing requirements. A KIT measures compliance with a small number of rules, such as inspection review categories and facility administration and records review, which is then used to predict the likelihood of compliance with other rules. Some facilities, such as facilities on probation, those pending administration action, or those under a noncompliance plan, are ineligible for a key indicator inspection and will receive an unannounced comprehensive health and safety compliance inspection.

CCL has contracted, until December 31, 2014, with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development and refinement of the KIT. CSUS, ISR is currently reviewing and analyzing four years of licensing data, both pre and post KIT implementation. However, due to the unforeseen data clean-up and the narrative basis of the data, the project's approach is currently being re-examined.

Complaints. Complaints are handled at regional offices. Licensing analysts, who would otherwise be conducting inspections, stay in the regional office, two times a month, to receive complaint calls and address general inquiries and requests to verify licensing status from the public. CCL must respond to complaints within 10 days, and may conduct related onsite investigations. During FY 2012-13, DSS received 13,127 complaints and initiated 12,996 (99 percent) of these investigations within ten days of receipt. The department indicates that as of February 10, 2014, there are 5,291 complaints pending, of which 3,151 (59.5 percent) have been ongoing more than 90 days.[5]

Licensing fees and penalties. Licensed facilities must pay an application fee and an annual fee, which is set in statute. The revenue from these fees is used to partially offset the cost of CCL enforcement and oversight activities. In addition to these annual fees, facilities are assessed civil penalties if they are found to have committed a licensing violation. Also, civil penalties assessed on licensed facilities are deposited

[4] CCL estimates that over 15 percent of its staff was lost due to retirements, transfers, and resignations, as well as a prolonged period of severe fiscal constraints.
[5] DSS notes that due to the complexity of complaints and other entity involvement, such as law enforcement, complaints may require more than 90 days of investigation.

into the Technical Assistance Fund, and are required to be used by the department for technical assistance, training, and education of licensees.

In FY 2013-14 to date, CCL collected 94 percent of its annual fees. During state FY 2012-13, CCL invoiced $1,370,400 in civil penalties; the amount of civil payments received for FY 2012-13 was $572,000.[6]

Training. Licensing managers, who review complaint investigations and administrative actions by licensing analysts, currently receive 80 hours of state mandated, general supervisory training. However, this training does not provide curriculum specific to CCL licensing managers. Currently, licensing program analysts must complete 18 hours of webinar training and 80 hours of in-person training.

Recent Events. Several high-profile cases in child and adult residential facilities recently surfaced, pertaining to the following:

- **2011 Bureau of State Audits Report**.[7] In October 2011, the California State Auditor issued a report, which found that more than 1,000 addresses for licensed facilities and out-of-home child placements matched with addresses for registered sex offenders in the DOJ's Sex and Arson Registry. DSS immediately began legal actions against eight licensees and issued 36 exclusion orders, barring individuals from licensed facilities; counties also removed children and ordered sex offenders out of homes. While county child welfare service agencies performed the required background checks, the audit report found that they did not consistently notify DSS of deficiencies or forward required information to DOJ.

- **Castro Valley Assisted Living Facility.** In October 2013, DSS closed Valley Springs Manor, a Residential Care Facility for the Elderly (RCFE) located in Castro Valley, but news articles reported that more than a dozen elderly residents were left in the facility more than two days after the state ordered the facility to be closed.

Staff Comment & Recommendation. This is an informational item, and no action is required.

Questions

1. Please provide a brief overview of CCL's program and budget.

2. Please provide a brief update on the department's contract for the KIT analysis. When can the Legislature expect to see a report on whether the KIT has been successful and accurate in identifying compliance?

[6] The department notes that civil payments may not coincide with the invoiced amount because payments in FY 2012-13 may have been for civil penalties assessed in the previous fiscal years. Also, penalty assessments may be appealed, reduced, or dismissed.

[7] Full text of the 2011 report can be found at http://www.bsa.ca.gov/pdfs/reports/2011-101.1.pdf.

2. Quality Enhancement and Program Improvement

Budget Issue. The Governor's budget includes $7.5 million ($5.8 million GF) and 71.5 positions for quality enhancement and program improvement measures. The additional positions and resources seek to improve the timeliness of investigations; help to ensure the CCL Division inspects all licensed residential facilities at least once every five years, as statutorily required; increase staff training; and, establish clear fiscal, program, and corporate accountability. Specifically, the budget includes the following components:

- **Additional positions.** The additional 71.5 positions include:
  - Six special investigator assistants;
  - 21 associate governmental program analysts;
  - One office services supervisor and one office technician;
  - One nurse practitioner;
  - Five licensing program managers, of different management levels;
  - Five staff services managers, of different levels;
  - 30.5 licensing program analysts; and,
  - One attorney.

  70.5 positions are requested to be made permanent.

- **Staff training and development.** The budget provides for increased training for new field staff and training for supervisors and managers by expanding the Licensing Program Analyst academy, implementing ongoing training, and strengthening the Administrator Certification Section. Recognizing the changing needs of clients in RCFEs, the Governor's budget proposes that DSS will assist with policy and practice development for medical and mental health conditions in community facilities, as follows:

  - **Establish medical expertise resources.** Although CCL has no staff with medical expertise, DSS licenses facilities that do allow for incidental medical care. Also, DSS has historically maintained a contract with a nurse consultant to provide medical expertise on specific complaint investigations. The Governor's budget proposes to utilize its one Nurse Practitioner position to develop a process and regulations regarding medical conditions and treatments that can be maintained and provided in community care settings, such as chemotherapy.

  - **Create a Mental Health Populations Unit.** With the upcoming Affordable Care Act, and SB 82 (Budget and Fiscal Review Committee), Chapter 34, Statutes of 2013[8], implementation, the Governor proposes to create a Mental Health Populations Unit, which would provide technical assistance to enforcement staff and licensees, as well as to individuals who reside in facilities who have increasing mental health care needs. Specifically, the unit would review and develop bill analyses for proposed legislation on Social Rehabilitation Facilities, coordinate interdepartmental communications, and develop regulations with stakeholders to meet additional program needs.

[8] SB 82 triples the number of social rehabilitation facility (SRF) beds, or crisis stabilization beds, for individuals with higher mental health acuity needs.

- **Establish a Corporate Accountability Unit.** With increased applications for Residential Care Facilities for the Elderly and corporate mergers and acquisitions for facilities, the additional attorney and associate governmental program analyst would perform the following duties: identify and address systemic noncompliance and ensure corrective actions; create management reports that identify patterns and trends; make corrective action recommendations; and, follow-up on corrective action plans to ensure that licensees with poor compliance patterns do not support operational expansions.

- **Increased civil penalties.** According to DSS, because the current civil penalty structure is related to a "per violation" event, the current maximum civil penalty, even in response to serious injury or death of a resident, is $150. The Governor's budget proposes to increase civil penalties for three different types of serious noncompliance, for all facility categories, except foster family homes, specifically:

  - **Zero Tolerance Violations.** Currently, the assessed immediate civil penalty is $150 per day, per violation until corrected. As proposed, an immediate civil penalty assessment[9] would be imposed equal to five times (500 percent) of the facility's annual fee per day, per violation, until and including the day the deficiency is corrected. The budget also adds "any violation that results in the injury, illness, or death of a client" to the list of zero tolerance violations.

  - **Repeat Violations.** The budget proposes to authorize DSS to impose an initial immediate civil penalty assessment on repeat violation equal to three times (300 percent) the facility's annual fee, per violation, in addition to a civil penalty assessment equal to 1.5 times (or 150 percent) the annual license fee per day, per violation, until and including the day the deficiency is corrected.

  - **Failure to Correct.** Currently, the assessed civil penalty is $50 per day, per cited violation, up to a maximum of $150 per day. The budget proposes that if the facility fails to correct a deficiency by the identified due date, a civil penalty equal to 25 percent of the annual fee per day, per violation, until and including the day the deficiency is corrected would be imposed.

  If two or more civil penalties are applicable, the budget proposes to assess the facility, or individual, at the higher penalty rate. In addition, the budget proposes to expand how revenues that are received from civil penalties can be used.

  Below is a chart, which compares current law and the Governor's proposal regarding select CCL civil penalties for serious violation

[9] Examples of violations that would qualify for an immediate civil penalty assessment include: absence of supervision; fire clearance violations; accessible firearms; presence of an excluded person; and, accessible bodies of water.

Selected CCL Civil Penalty Levels for Serious Violations: Current Law and Governor's Proposal

	Current Law			Governor's Proposal		
	Initial	Repeat Within 12 Months		Initial	Repeat Within 12 Months	
Examples of Facilities	(Per Day)	(First Day)	(Each Additional Day)	(Per Day)	(First Day)	(Each Additional Day)
Residential Care Facility for the Elderly (4-6 People)	$150	$150	$50	$2,270	$1,362	$681
Adult Day Program (16-30 Adults)	150	150	50	760	456	228
Family Child Care Center (1-8 Children)	150	150	50	365	219	110
Child Care Centers (31-60 Children)	150	150	50	2,420	1,452	726

Source: Legislative Analyst's Office. *The 2014-15 Budget: Analysis of the Human Services Budget.* Sacramento: 2014. s.v. "Community Care Licensing Quality Enhancement and Program Improvement."

- **Increased licensing fees.** Currently, all facilities, except for foster family homes, must pay application and annual fees set by statute. The budget proposes a ten percent increase in licensing and application fees, which could result in $1 million additional revenues in the first year. The fees would then be adjusted annually with the Consumer Price Index. The proposal requires the department to analyze initial application fees and annual fees, at least every five years, to determine whether the appropriate fee amounts are charged.

Proposed Application Fee and Annual Fee, by Facility Type
(as of March 7, 2014)

Facility Type	Capacity	Initial Application Fee		Annual Fee	
		Current	Proposed	Current	Proposed
Foster Family and Adoption Agencies	N/A	$2,750	$3,025	$1,375	$1,513
Adult Day Programs	1–15	$165	$182	$83	$91
	16–30	$275	$303	$138	$152
	31–60	$550	$605	$275	$303
	61–75	$689	$758	$344	$378
	76–90	$825	$908	$413	$454
	91–120	$1,100	$1,210	$550	$605
	121+	$1,375	$1513	$688	$757
Other Community Care Facilities	1–3	$413	$454	$413	$454
	4–6	$825	$908	$413	$454
	7–15	$1,239	$1,363	$619	$681
	16–30	$1,650	$1,815	$825	$908

Facility Type	Capacity	Initial Application Fee		Annual Fee	
		Current	Proposed	Current	Proposed
	31–49	$2,064	$2,270	$1,032	$1,135
	50–74	$2,477	$2,725	$1,239	$1,363
	75–100	$2,891	$3,180	$1,445	$1,590
	101–150	$3,304	$3,634	$1,652	$1,817
	151–200	$3,852	$4,237	$1,926	$2,119
	201–250	$4,400	$4,840	$2,200	$2,420
	251–300	$4,950	$5,445	$2,475	$2,723
	301–350	$5,500	$6,050	$2,750	$3,025
	351–400	$6,050	$6,655	$3,025	$3,328
	401–500	$7,150	$7,865	$3,575	$3,933
	501–600	$8,250	$9,075	$4,125	$4,538
	601–700	$9,350	$10,285	$4,675	$5,143
	701+	$11,000	$12,100	$5,500	$6,050
Residential Care Facilities For Persons with Chronic Life-Threatening Illness	1–6	$550	$605	$275 plus $10 per bed	$303 plus $11 per bed
	7–15	$689	$758	$344 plus $10 per bed	$378 plus $11 per bed
	16–25	$825	$908	$413 plus $10 per bed	$454 plus $11 per bed
	26+	$964	$1,060	$482 plus $10 per bed	$530 plus $11 per bed
Residential Care Facilities for the Elderly	1–3	$413	$454	$413	$454
	4–6	$825	$908	$413	$454
	7–15	$1,239	$1,363	$619	$681
	16–30	$1,650	$1,815	$825	$908
	31–49	$2,064	$2,270	$1,032	$1,135
	50–74	$2,477	$2,725	$1,239	$1,363
	75–100	$2,891	$3,180	$1,445	$1,590
	101–150	$3,304	$3,634	$1,652	$1,817
	151–200	$3,852	$4,237	$1,926	$2,119
	201–250	$4,400	$4,840	$2,200	$2,420
	251–300	$4,950	$5,445	$2,475	$2,723
	301–350	$5,500	$6,050	$2,750	$3,025
	351–400	$6,050	$6,655	$3,025	$3,328
	401–500	$7,150	$7,865	$3,575	$3,933
	501–600	$8,250	$9,075	$4,125	$4,538

Facility Type	Capacity	Initial Application Fee		Annual Fee	
		Current	Proposed	Current	Proposed
	601–700	$9,350	$10,285	$4,675	$5,143
	701+	$11,000	$12,100	$5,500	$6,050
Family Day Care	1–8	$66	$73	$66	$73
	9–14	$127	$140	$127	$140
Day Care Centers	1–30	$440	$484	$220	$242
	31–60	$880	$968	$440	$484
	61–75	$1,100	$1,210	$550	$605
	76–90	$1,320	$1,452	$660	$726
	91–120	$1,760	$1,936	$880	$968
	121+	$2,200	$2,420	$1,100	$1,210

- **Establish a Temporary Manager and Receivership Process.** The budget authorizes DSS to appoint a temporary manager or receiver to act as the provisional licensee, if DSS determines that residents of a facility are likely to be in danger of serious injury or death, and the immediate relocation of clients is not feasible. The temporary manager or receiver assumes operation of a facility to bring it into compliance; to facilitate a transfer of ownership to a new licensee; or, to assure the transfer of residents, if the facility is required to close. Facilities that serve less than six residents and are also the principal residence of the licensee are exempt. The budget sets forth language which specifies the following:

    - A process to appoint a temporary manger or receiver;
    - A process by which a licensee may contest the appointment of the temporary manager;
    - A temporary manger or receiver's authorized responsibilities;
    - A receiver's salary and length of appointment; and,
    - Circumstances wherein a facility's owner can sell, lease, or close the facility.

- **Specialized complaint hotline.** Currently, 462 LPAs in 26 licensing offices throughout the state review incoming complaints. Depending on workload, a LPA may remain in the office instead of in the field performing licensing visits. Additionally, every LPA must spend two days a month conducting intake and assessing complaints and incidences, as well as respond to general inquiries. The budget establishes a specialized and centralized toll-free public complaint hotline, which can help acquire better initial information, conduct consistent prioritization, and dispatch incoming complaints to regional offices.

- **Centralized application processing.** As of January 10, 2014, 779 Adult and Senior Facility applications for licensure are pending. Applications can take from six months, up to a year or more, to process. The budget proposes centralizing applications for Adult and Senior Care facilities, which is expected to increase inspections of licensed facilities to at least once every two years.

- **Establish a statewide Quality Assurance Unit.** The current information technology system does not allow for documents and reports to track information statewide, including complaints, actions, or performance. It also does not provide aggregate data to review and identify patterns. The budget proposes to establish a Quality Assurance Unit to identify immediate health and safety risks to clients, develop a statewide quality assurance review model, coordinate licensing case file responses to Public Record Act requests, and identify training needs for quality assurance review. The unit will also assist DSS in ensuring that regional offices have the support necessary to ensure that licensed care facilities are monitored, and that systemic noncompliance is detected and addressed at the appropriate organizational level.

- **Establish an Emergency Client/Resident Contingency Account.** The accounts, which would be within the Technical Assistance Fund, would be used at the discretion of the Director of DSS for the care and relocation of clients and residents, when a facility's license is revoked or temporarily suspended. The money in the account must cover costs, such as transportation expenses, expenses incurred in notifying family members, costs associated with providing continuous care and supervision.

The budget provides for an accompanying trailer bill that proposes language to implement the provisions discussed above.

LAO Comments. The LAO makes the following comments and recommendations:

- Changing needs of clients at RCFEs. Due to the changing medical conditions of RCFE residents, and the changing profiles of those applying for licenses to operate RCFEs, the LAO finds merit in the department's proposal to have a public health nurse and the establishment of a mental health populations unit and corporate accountability unit for CCL.

- Increased application and annual licensing fees, and civil penalties. The LAO finds it reasonable to increase the maximum penalty for serious violations. However, citing uncertainty surrounding the appropriate level of civil penalties, and the variations in these levels across states, LAO suggests that the Legislature consider a more gradual ramp up of civil penalty levels to allow evaluation of the appropriateness of the penalties in a year and whether additional increases should be implemented. In addition, the LAO recommends the Legislature require DSS to report annually with information to help evaluate the appropriateness of penalties.

- Centralize specified activities. The LAO finds the proposal in centralizing application processing and complaint intake could increase state oversight and efficiency. By providing a statewide complaint hotline, the public would have one number to call for any complaint and the state could improve consistency in complaint intake and response. Further, LAO notes that by creating a centralized application processing unit, CCL could ensure that a single licensee with multiple applications would get one reviewer and one set of instructions.

- Temporary manager and receivership. The LAO notes that the new enforcement tool makes sense in concept, but recommends the Legislature to ask DSS the differences between the CCL proposal and how DPH currently administers its temporary manager and receivership process for Skilled Nursing Facilities (SNFs).

Staff Comment & Recommendation. Hold open. With demand for health delivery in a home-care, non-institutional setting, the state is at a crossroads to update CCL's current regulatory framework and to ensure that residential care for individuals, including dementia or mental health care, is provided safely. It is recommended to hold this item open to continue discussions with the Administration.

Questions

1. Please briefly summarize the proposal, including the need for the requested positions, the proposed civil penalty structure, the temporary manager and receivership process, and how inspectors can identify widespread problems or patterns across a single licensee

2. Please briefly describe how the KIT will be used within the proposal. Do facilities, which have demonstrated success in meeting the key indicators assessment over time, continue to receive a KIT assessment or a full assessment?

3. How does the proposal address inspection frequency?

4. Please briefly summarize the stakeholder process and involvement.

3. Sacramento County Caseload Transfer

Budget Issue. On September 30, 2013, Sacramento County terminated its contract with DSS and returned the licensing of 1,752 FCCHs to CCL. The Governor's budget requests to redirect funding, from local assistance to state operations, to support 10.5 permanent positions that would manage the workload, specifically:

- Seven licensing program analysts;
- One licensing program manager;
- Two office assistants; and,
- 0.5 associate governmental program analyst.

Background. The CCL Division in DSS oversees the licensure or certification of approximately 66,000 licensed community care facilities, including FCCHs. Staff in CCL regional offices directly license and monitor FCCHs in accordance with mandated minimum licensing standards and Title 22 regulations. For fiscal year 2014-15, CCL projects that it will license and monitor about 29,550 FCCHs, which serve around 297,082 children.

State law authorizes CCL to contract with counties to license FCCHs. Currently, Inyo and Del Norte Counties license FCCHs. If a county chooses to no longer perform the licensing, approval, or consultation responsibilities, the workload is returned to CCL. Last September, Sacramento County terminated its contact with DSS, and returned the licensing of 1,752 FCCHs to CCL. For current budget year, CCL redirected funding from local assistance to state operations to hire temporary staff to handle the workload.

Staff Comment & Recommendation. Approve. It is recommended to approve the requested resources and positions, as no concerns have been raised.

Questions

1. Please briefly summarize the need for the requested positions.

4. Home Care Services Consumer Protection Act

Budget Issue. The budget requests $1,472,000 in General Fund for vendor contract funding ($251,000) and ten positions (seven permanent; two one-year limited-term; and, one two-year limited-term) to establish, and maintain, the operational and administrative components of the Home Care Services Consumer Protection Act (AB 1217, Lowenthal). The positions and related divisions include:

- Community Care Licensing: one staff services manager; two associate governmental program analysts; and, one office technician.
- Legal Division: one attorney.
- Information Systems Division: two staff programmer analysts; two one-year limited term staff programmer analyst; and, one senior information systems analyst.

Initial funding to implement the program will be provided through a General Fund loan, which will be repaid from fees paid by home care organizations and home care aides once the program is operational. The department also intends to submit a FY 2015-16 BCP for resources to ensure that licensing and registration functions are performed.

The Administration also includes a trailer bill, which contains the following provisions:

1. Deletes language that exempts specified individuals from registration requirements for home care aides, and expands the list of individuals and entities that are not considered home care aides or home care organizations.
2. Requires the chief executive officer, or another person serving in a similar capacity, in a home care organization, to consent to a background examination.
3. Prohibits the department from issuing a provisional license to any corporate home care organization applicant that has a member of the board of directors, executive director, or officer who is not eligible for licensure.
4. Revises license renewal requirements, including insurance and workers' compensation policies.
5. Revises a home care organization's licensure requirements to require proof of an employee dishonesty bond.
6. Authorizes the department to cease review on an application if it is determined that the home care applicant was previously issued a license and that license was revoked.
7. Requires home care organization licensees to report suspected or known dependent adult, elder, or child abuse to the department. Upon receipt of these reports, the department must cross-report the suspected or known abuse to local law enforcement and Adult Protective Services or Child Protected Services.
8. Authorizes home care organization applicants and home care aide applicants, who submit applications prior to January 1, 2016, to provide home care services without meeting the tuberculosis examination requirements, provided that those requirements are met by July 1, 2016.

Background. In response to concerns that home care organizations (HCOs) are not required to be licensed, and that home care aides are not required to meet minimum qualifications or screenings, AB 1217 (Lowenthal), Chapter 790, Statutes of 2013, enacted the Home Care Services Consumer Protection Act, effective January 1, 2016, per the Governor's signing message. The Act requires DSS to:

- Develop licensing requirements to regulate organizations that hire aides;
- Obligate licensee and aide applicants of the HCOs to submit to state and federal criminal background checks; and,
- Maintain a public Web-based registry, which will list aides who have passed a criminal background check and which home care organization(s) an aide is affiliated, if applicable.

Aides, who are employed by a HCO as of January 1, 2016, will have until July 1, 2016, to complete their background check. The department estimates that around 70,000 background checks need to be conducted. AB 1217 also provides that DSS has no responsibility for the oversight of home care aides. Independent home care aides, who are not employed by a licensed home care organization, are not subject to regulatory oversight, but may voluntarily apply to be listed on the registry.

Finally, AB 1217 required that the Administration of the Act be fully supported by fees paid by the HCO and home care aides.

Staff Comment & Recommendation. Hold open. It is recommended to hold this item open to continue discussions on this proposal.

Questions.

1. Please briefly summarize the need for the requested positions.

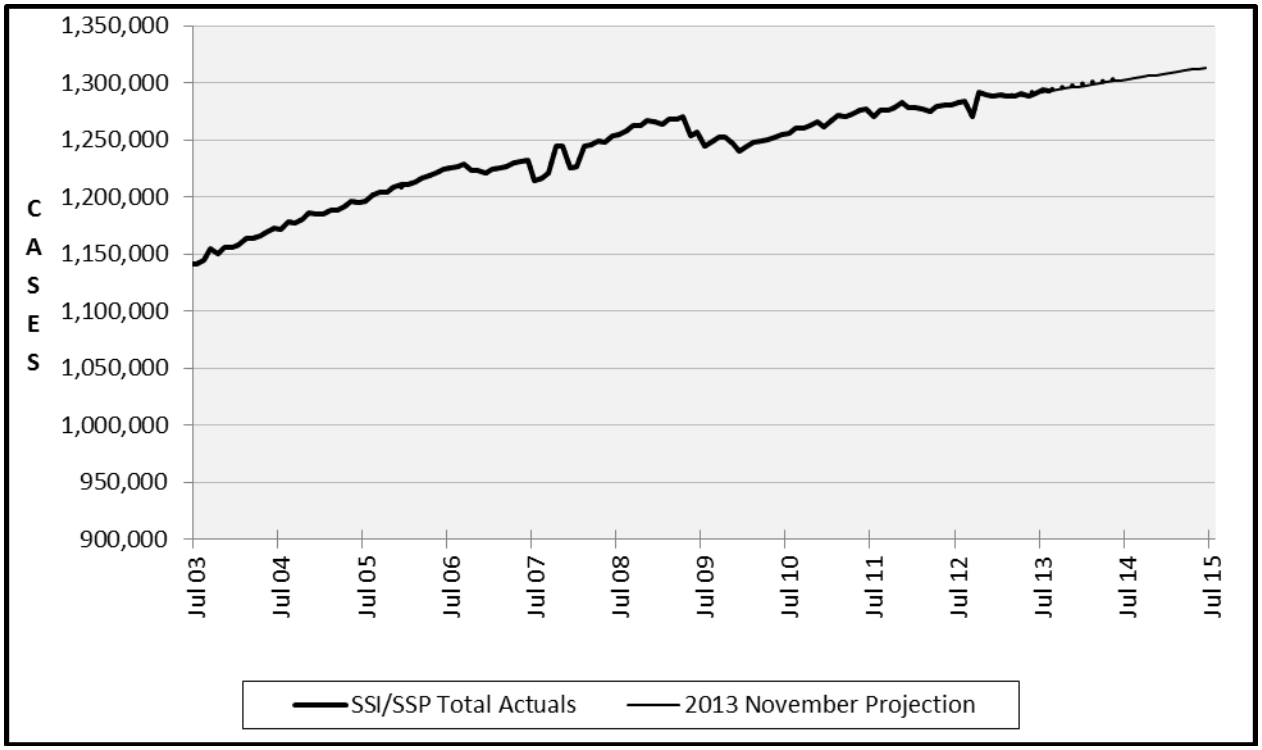
2. How has the Administration involved stakeholders in the development of this proposal?

5180 Department of Social Services, Supplemental Security Income/State Supplemental Payment (SSI/SSP)

1. Overview

The SSI/SSP programs provide cash assistance to around 1.3 million Californians, aged 65 or older (28 percent), who are blind (one percent), or who have disabilities (78 percent), and meet federal income and resources limits. Grants under SSI are 100 percent federally funded, while the state pays SSP, which augments the SSI benefit. The SSI/SSP program is primarily administered by the federal Social Security Administration.

Funding and Caseload. The budget proposes expenditures of $9.6 billion ($2.5 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $184 million in for 2014-15. Effective October 2013, the administrative fee is $11.32 per benefit issuance. The budget projects SSI/SSP average monthly enrollment will grow by 0.9 percent, from 1,297,289 in 2013-14 to 1,308,166 in the budget year.



Maximum and Average Grant Amounts. The maximum grant amount for individuals is $877.40 per month ($721 SSI + $156.40 SSP), which is roughly 90 percent of the federal poverty level (FPL). For couples, the maximum grant amount is $1,478.20 per month ($1,082 SSI + $396.20 SSP), which is equal to 113 percent of FPL .[10] The federal government has established a maintenance of effort (MOE) for the amount of SSP paid by California. The current SSP grant for individuals and couples is the state's March 1983 payment level. Violating this MOE would risk all of the state's Medicaid funding. In addition, California's SSI/SSP beneficiaries are ineligible for Food Stamps benefits, due to the state's "cash-out" policy.

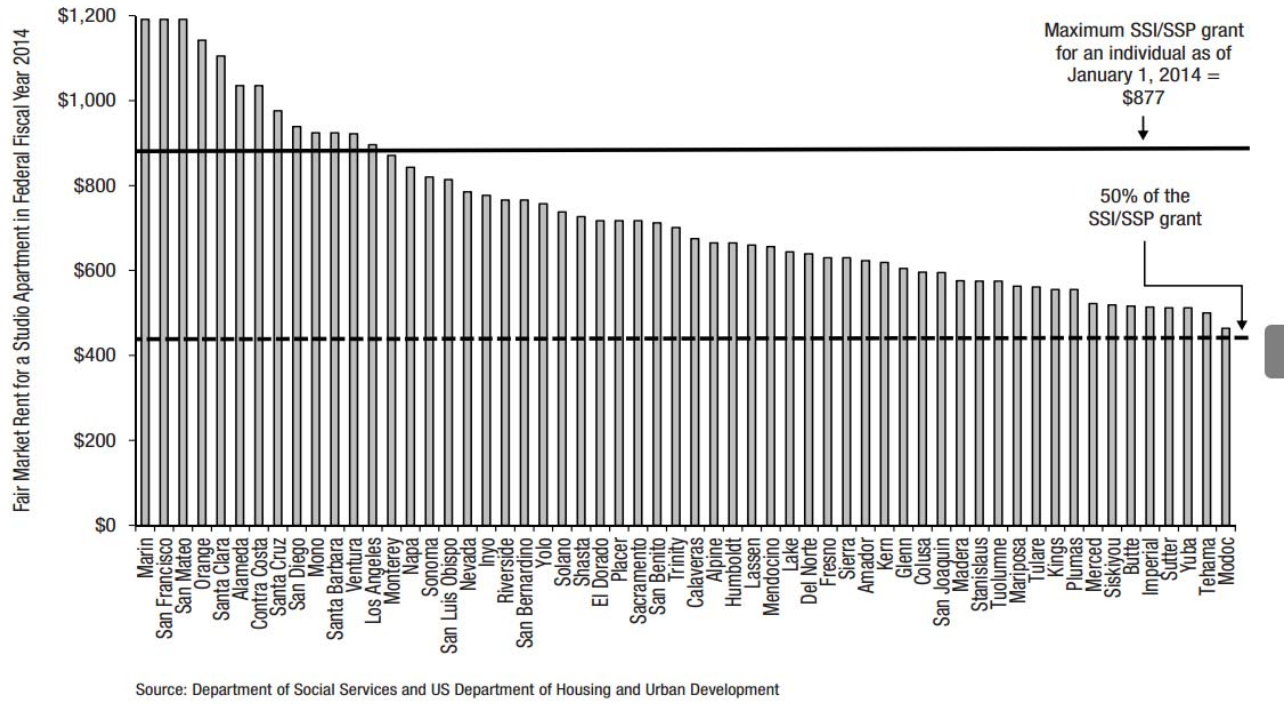
[10] The department projects the 2015 SSI/SSP payment for an individual to be $884.40 (91 percent of FPL); for couples, $1,488.20 (114 percent of FPL).

Average SSI/SSP Grants for Individuals
(as of January 10, 2014)

	SSI	SSP
Individuals aged 65+	$347.93	$159.36
Individuals who are blind	$445.28	$204.24
Individuals with disabilities	$493.69	$157.56

Cost-of-Living Adjustment (COLA). Under current law, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January through Cost-of-Living Adjustments (COLAs). Federal law provides an annual SSI COLA based on the Consumer Price Index, and state law provides an annual SSP COLA based on the California Necessities Index. A 2009 human services budget trailer bill (SB 6 X3) eliminated the statutory requirement to provide a state COLA for SSI/SSP grants. Without the COLA, recipients face pressure to reduce spending on food or utilities, as housing costs increase. Below is a figure from the California Budget Project, which demonstrates that fair market rent for a studio apartment exceeds one-half of the current SSI/SSP grant for an individual in all 58 counties, and is higher than the entire grant amount in 13 counties.

Figure 1: Studio Apartment Rent Exceeds One-Half of the SSI/SSP Grant in All 58 Counties and Is Higher Than the Entire Grant in 13 Counties



Source: Department of Social Services and US Department of Housing and Urban Development

Source: California Budget Project. "SSI/SSP in the Governor's Proposed 2014015 Budget: Assistance for Seniors and People with Disabilites is Left Below the Poverty Line." 4 March 2014. http://www.cbp.org/pdfs/2014/140304_SSI_SSP_Governor_Proposed_Budget_BB.pdf

Staff Comment & Recommendation. This is an informational item, and included for discussion. No action is required.

Questions.

1. Please briefly summarize the changes to SSI/SSP grant levels in recent years.

5180 Department of Social Services, In-Home Supportive Services (IHSS)

1. Overview

Budget Issue. The budget proposes $6.2 billion ($1.8 billion GF) for services and administration, a 4.9 percent increase over expenditures in 2013-14. In response to recent federal labor regulations effective January 1, 2015, (to be discussed further below), the budget increases $209 million ($99 million GF) to comply with new federal regulations. IHSS Basic Services also increases $68 million ($35 million GF) because of a 1.3 percent caseload growth, and higher cost per hour, due to the increase in the hourly minimum wage from $8 to $9, effective July 1, 2014. As a result of implementing the seven percent reduction in IHSS authorized hours (to be discussed further below), the budget estimates $181 million in GF savings.

Background. The IHSS program provides personal care services to approximately 420,000 qualified low-income individuals who are aged (over 65), blind, or who have disabilities. Services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings. The average annual cost of services per IHSS client is estimated to be around $13,248 ($1,104.08 per client per month) for 2014-15.

Service delivery. 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. In general, most social workers reassess annually recipients' need for services. The department indicates that the statewide reassessment compliance is around 90 percent through FY 2010-11 to FY 2012-13. Based on authorized hours and services, IHSS recipients are responsible for hiring, firing, and directing their IHSS provider(s). If an IHSS recipient disagrees with the hours authorized by a social worker, the recipient can request a reassessment, or appeal their hour allotment by submitting a request for a state hearing to the Department of Social Services (DSS). According to DSS, around 73 percent of providers are relatives or "kith and kin."

In 2013, IHSS providers' combined hourly wages and health benefits vary by county, and range from $8.00 to $15.38 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 -- Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara -- participating in Coordinated Care Initiative (CCI) will shift to an IHSS Authority administered by the state (to be discussed further below).

Funding. The average annual cost of services per IHSS client is estimated to be around $12,000 for 2012-13. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. Prior to July 1, 2012, the state and counties split the non-federal share of IHSS funding at 65 and 35 percent, respectively. A 2012-13 budget trailer bill changed this structure as of July 1, 2012, to base county IHSS costs on a maintenance of effort (MOE) requirement. The change was related to enactment of the CCI, also called the Duals Demonstration project.

Other policies. Several recent policies have also impacted the IHSS program, including:

- **Reductions in IHSS recipient hours.** A legal settlement from *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an 8 percent reduction to authorized hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours will be reduced to 7 percent.

- **Minimum wage increases.** AB 10 (Alejo), Chapter 351, Statutes of 2013, increased the minimum wage from $8 per hour to $9 per hour in July 2014, with gradual increases until the minimum wage meets $10 per hour by January 2016. 17 counties will be impacted by the minimum wage increase for this fiscal year: Alpine, Amador, Butte, Colusa, Glenn, Humboldt, Lake, Lassen, Modoc, Mono, Nevada, Plumas, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne. All non-federal IHSS provider wage costs will be funded by the General Fund, around $5.7 million total for this year.

Staff Comment & Recommendation. This is an informational item, and no action is required.

Questions.

1. Please briefly summarize the IHSS program.

2. Coordinated Care Initiative (CCI), IHSS – Update

Background. As discussed in greater detail during the joint Senate Budget and Fiscal Review Committee and Senate Health Committee hearing on February 6, 2014 (background materials available online at: http://sbud.senate.ca.gov/fullcommitteehearings), the Coordinated Care Initiative, requires Cal Medi-Connect to coordinate medical, behavioral health, long-term institutional, and home and community-based services; and, to administer IHSS according to current program standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings. As IHSS becomes a Medi-Cal managed care benefit in the eight counties, the county is responsible for paying a MOE amount, not a percentage of program costs. Approximately 65 percent of IHSS recipients reside in the demonstration counties.

Service delivery. All current regulations pertaining to the governance and operation of IHSS, such as assessments, notices, maintenance of a registry by the county IHSS Public Authority, remains the same. Further, IHSS recipients will continue to hire, fire, and supervise IHSS providers under the self-directed model. Under CCI, managed care plans must include County IHSS social workers in their interdisciplinary team care planning process. Upon their own determination, CCI plan enrollees may also include their IHSS providers in this care coordination team process. This care coordination team is intended to improve the communication, quality of care plans, and 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.

Funding. Related to CCI, a 2012-13 budget trailer bill (Chapter 45, Statutes of 2012) created IHSS Maintenance of Effort (MOE) funding requirements for counties, which replaced the previously existing county share of non-federal funding of 35 percent, and an inflation factor of 3.5 percent beginning this budget year. Under the county MOE financing structure, the GF assumes all nonfederal IHSS costs above a counties' MOE level. As a result, the LAO estimates the county MOE to be $994 million.

Statewide Authority. SB 1036 (Senate Budget and Fiscal Review Committee), Chapter 45, Statutes of 2012, also shifted collective bargaining responsibilities from local county public authorities (PAs), or non-profit consortia in the demonstration counties, to a new California IHSS Authority (Statewide Authority), with specified members and an advisory committee. The department indicates that 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.

Universal Assessment Tool. Under CCI, IHSS will continue to be the major home and community based services for seniors and persons with disabilities. The Department of Health Care Services, DSS, and Department of Aging must develop a Universal (or Uniform) Assessment Tool to assess a Medi-Cal beneficiary's need for Home and Community-Based Services. The goal is to enhance personalized care planning under CCI, and 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.

DSS indicates that DHCS is working closely with it and CDA, creating a stakeholder workgroup -- comprised of advocates; consumers; county IHSS; CBAS; MSSP; legislative staff; health plans; and UCLA, USC, and UCSF researches -- and a process that facilitates the development of this tool. The workgroup intends 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.

Staff Comment & Recommendation. This is an informational item, and no action is required.

Questions

1. Please briefly summarize the recent changes to IHSS financing and collective bargaining, and the impacts of those changes in 2014-15.

2. Please briefly provide an update on the Universal Assessment Tool, and the department's engagement with stakeholders.

3. Litigation Settlement Related to Prior Reductions

Budget Issue. As summarized in the chart below, several reductions to the IHSS program made in the last four state budgets were enjoined by federal courts from taking effect.

Policy	Name of Lawsuit Under Which Policy Is Enjoined from Taking Effect
Loss of eligibility for individuals with assessed needs below specified thresholds.	*Oster (V.L.) v. Lightbourne, et al. (Oster I)*
Across-the-board cut of 20% of authorized hours, with exceptions (impacts about 300,000 recipients).	*Oster (V.L.) v. Lightbourne, et al. (Oster II)*
Reduction in state participation in provider wages (from maximum of $12.10 to $10.10 per hour).	*Dominguez v. Schwarzenegger, et al.*

In March 2013, the Administration and plaintiffs in those cases (labor unions and disability rights advocates) announced that they had reached a comprehensive settlement agreement. The repeal of the reductions described above and replacement with the policies is described in the chart and summary below:

Policy Included in Settlement	Effective Date
Across-the-board cut of 8% (no exceptions)	July 1, 2013
Across-the-board cut of up to 7% (no exceptions)[11]	July 1, 2014

The settlement agreement also includes a provision to "trigger off" the ongoing reduction of up to seven percent–in whole or in part–as a result of enhanced federal funding received pursuant to an "assessment" (likely a fee or tax) on home care services, including IHSS. The Department of Health Care Services (DHCS) must submit a proposal for its implementation to the federal government by October 2014.

Appeals and Reassessments under the Settlement. If an IHSS recipient appeals the eight or seven percent reductions on their face, his or her request can be administratively denied. At the same time, the settlement agreement reiterates that IHSS recipients retain their rights under existing law to request a reassessment of service hours based on a change in personal circumstances. For FY 2013-14, the

[11] The department notes that current methodology results in a net impact of 6.41 percent reduction across all IHSS hours. There is no excluded population, and reassessments are only granted for changes in circumstances or health condition. The seven percent reduction is first applied to any documented unmet need, excluding protective supervision.

department estimated that in response to the eight percent reduction proposed, ten percent of IHSS recipients would appeal the reduction itself and have their requests administratively denied. However, the department indicates that appeals submitted for the eight percent reduction were not tied to recent assessments regarding a change in circumstance or health condition; rather, hearings were tied to challenges to the law that required the reduction, not the eight percent reduction impact itself.

Panel. The Subcommittee has requested the following panelists present on the topic:

- Terry Walker-Dampier, Provider in Stanislaus County, Member of UDW/AFSCME
- Michelle Rousey, Consumer in Alameda County, Member of the IHSS Coalition
- Gary Passmore, Vice President, Congress of California Seniors

Staff Comment & Recommendation. This is an information item, and included for discussion. No action is required.

Questions

1. Please briefly summarize the prior reductions at issue and the terms of the settlement agreement.

2. When can we expect to hear more details about the "assessment" on home care services included as part of the settlement agreement? How might it work?

4. Federal Fair Labor Standards Act (FLSA)- Final Rule

Budget Issue. The budget recognizes the new FLSA regulations, effective January 1, 2015, and provides that implementation of federal requirements will cost $208.9 million ($99 million General Fund) in 2014-15 and $327.9 million ($153.1 million General Fund) annually thereafter. The $208.9 million breakdown is as follows:

- Approximately $68.6 million ($32 million GF) for FLSA regulations and creating a provider backup system (around $7.5 million would be allocated to modify CMIPS-II data software to maintain workweek agreements; track provider hours; update policies, instructions, and provider timesheets; and, add new activities, such as wait time during medical accompaniment and mandatory training);[12]
- $87 million ($40 million GF) for FLSA compliance[13] ($81 million [$37 million GF] for medical accompaniment wait time; $6 million [$3 million GF] for travel time; and, mandatory provider training); and,
- $53 million ($27 million GF) to implement overtime restrictions (social workers in county welfare departments work with IHSS recipients to create and review workweek agreements for all recipients).

Prohibits providers from working overtime. The budget prohibits providers from working overtime, except for documented emergency circumstances. Providers who work beyond work week limitations are subject to disciplinary action. After the first instance of overtime claim on a timesheet, the IHSS provider would receive a warning notice. After the second instance, the IHSS provider would be suspended for the program for one year. The budget assumes that unauthorized overtime costs $6.17 per hour.

Establishes a Provider Backup System. The budget assumes that a notification must be mailed to current IHSS providers and recipients, explaining the new policy and workweek agreement. The recipient must monitor his or her workweek agreement, so that IHSS providers do not exceed 40 hours per week. If a recipient's regular provider exceeds, or is approaching, the limitation on hours, a recipient should contact his or her substitute backup provider. If the recipient's substitute backup provider is unavailable, the recipient is authorized to contact the provider Backup System for assistance. Services provided by a backup provider would be deducted from the recipient's authorized hours. The cost of adding providers to the Public Authority registry and backup is $34.50 per provider.

The budget estimate assumes that the cost of compensating the backup provider will be, on average, 25 percent higher than the estimate 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.

[12] Due to a technical budget error, the Administration overestimated the cost associated with paying for authorized services delivered by a backup provider by $22 million GF in 2014-15 and $48 million GF in 2015-16. After correcting the error, the Administration estimates that the proposal to restrict overtime for all IHSS providers, including administrative activities to prevent overtime and maintain the Provider Backup System would cost $52 million ($25 million GF) annually.

[13] The budget provides that 85 percent of recipients will have a provider accompany them to medical visits, where providers will spend three hours per month waiting for recipients to complete their appointments. Each month new providers will attend a two-hour mandatory orientation training.

The budget provides for an accompanying trailer bill that proposes language to implement the provisions discussed above.

Background. FLSA is the primary federal statute dealing with minimum wage, overtime pay, child labor, and related issues. Under current law, some provisions of the FLSA do not apply to certain employees, including the "Companionship Services Exemption" for domestic service employees who: 1) provide babysitting services on a casual basis, or 2) provide "companionship services" to individuals who are unable to care for themselves. Federal regulations define "companionship services" as services that provide fellowship, care, and protection for a person who, because of advanced age or physical or mental disability, cannot care for his or her own needs. These services may include household work, such as meal preparation, bed making, washing of clothes, and other similar services that can be provided through IHSS. General housework may also be included, subject to some limitations. Current regulations exempt employees of third-party agencies and live-in domestic service employees who provide companionship services from overtime regulations in FLSA.

In September 2013, the U.S. Department of Labor (US-DOL) issued a Final Rule, effective January 1, 2015, which redefines "companionship services;" limits exemptions for "companionship services" and "live-in domestic service employees" to the individual, family, or household using the services (not a third party employer); and, requires compensation for activities, such as travel time between multiple recipients, wait time associated with medical accompaniment, and time spent in mandatory provider training. Under the Final Rule, employers must pay at least the federal minimum wage ($7.25) and overtime pay at one and a half times the regular pay if a provider works over 40 hours per work week.

The department estimates that 385,425 individuals will work as IHSS providers in 2014-15. About 49,000 providers (12.7 percent of the workforce), work more than 160 hours per month, and will be impacted by the prohibition on overtime. Further, some providers work for more than one recipient. The department also estimates that 453,417 eligible individuals receive IHSS services. About 37,000 recipients (8.2 percent of the estimated caseload) are expected to receive more than 160 hours per month from a single IHSS provider. About 317,000 recipients (70 percent) receive care from a family member or relative provider; about 222,000 recipients receive care from a live-in provider.

LAO Comments. The LAO makes the following comments and recommendations:

- Consumer choice. For recipients who receive care from a live-in provider, or family member or relative, the restriction and potential to hire a second provider may be undesirable. Some recipients will have to switch to a provider who can accommodate their care, or hire a second provider. Further, for recipients with certain disabilities, there may be challenges in adjusting and finding an appropriate provider to meet needs.

- Back-up provider. Because the Provider Backup System is only intended for unforeseen circumstances, an IHSS recipient who regularly needs more than 40 hours of assistance per week would need to retain at least two providers. It is uncertain if a sufficient number of IHSS providers would be available to meet this demand, and if the Backup System will be able to successfully pair all consumers with providers who meet the consumer's individual needs (e.g., geographically isolated, language other than English) and to preserve the consumers' right to hire a provider of his or her choosing. In addition, the proposed one-year suspension of IHSS providers who claim overtime on two occasions could reduce the pool of available providers.

- Lacks flexibility. By prohibiting all overtime exceeding 40 hours in a week, the proposal could impede consumers' access and disrupt care. The LAO also finds that suspending a provider after claiming two instances of overtime to be unduly punitive to both the provider and recipient. A provider could submit two timesheets in close succession before receiving a warning notice, or may not have received the warning due to a change of address. As such, the LAO recommends adding a suspension of one month, prior to the one-year suspension. A suspension shorter than one-year may produce the same deterrent, and would not force a recipient to go without his or her preferred provider for an extended period.

- Overtime restriction**.** The Governor's proposal to restrict overtime would cost $51 million ($25 million GF) annually. This is significantly less than the estimated cost of paying for the overtime $401 million ($186 million GF) annually.

- Provide targeted exemption**.** The Legislature could consider a targeted exemption for recipients who would be in particularly disruptive situations if the overtime restriction applied to their providers. Examples of a targeted exemption include: individuals with developmental disabilities, who may face challenge in adjusting to a new provider; or, individuals in rural counties who may face difficulty in finding and securing a suitable second provider. Because of federal Medicaid rules, there is significant uncertainty whether this modification would receive approval.

- Provide limited allotment of overtime hours to certain providers. The Legislature could allow a limited allotment – for example, 48 hours in a year (4 overtime hours each month) – to IHSS providers of high-hour recipients, to allow some flexibility to work hours for special circumstances, such as a recipient's fall or a long doctor's visit.

- Authorize overtime when other providers are unavailable. The Legislature may also authorize overtime for a recipient until a second provider, or backup provider, is identified.

- Consider "cash and counseling" model. Under the Cash-and-Counseling Model, consumers receive a monthly sum of available funds, based on the cost of hours of in-home services, to set wage levels, hire a provider, and purchase permissible goods that make it easier to remain at home. A counselor helps the consumer craft spending plans and monitors the use of available funds; and, a financial management services agency assists the consumer with paperwork. The LAO notes that this model could have the effect of classifying the consumer as the sole employer of the live-in provider, which could authorize a consumer to claim the live-in domestic service worker exemption.

Panel. The Subcommittee has requested the following panelists present on the topic:

- Rebecca Malberg, SEIU-UHW
- Earnie Spencer, Provider in Solano County, Member of SEIU-ULTCW
- Mark Beckwith, Consumer in Alameda County, Member of the IHSS Coalition
- Deborah Doctor, Disability Rights California
- Frank Mecca, Executive Director, County Welfare Directors Association

Staff Comment & Recommendation. Hold open. It is recommended to hold the item open for further discussion. In deliberating this proposal, the Legislature may wish to consider the following:

- **Increased workforce.** According to the Department of Finance (DOF), between 30,000 to 40,000 additional providers and workers are needed to meet the needs of the over 160 hours per month population. County workers would help IHSS recipients develop a workweek agreement and would monitor compliance with the agreement. The budget assumes wage cost per hour for social workers of $60.55 per hour, and for clerks, $16.80 per hour. Consistent with the intent of an 8-hour workday/40-hour work week, the new federal regulations attempt to protect the health and safety of providers for IHSS recipients, ensuring that providers are rested and able to care for and supervise the health of IHSS recipients.

- **Impact on family caregivers and providers.** About 37,000 recipients (8.2 percent) of the estimated caseload are expected to receive more than 160 hours per month from a single IHSS provider. About 317,000 recipients (70 percent) receive care from a family member or relative provider. If California were to implement FLSA regulations, as well as fund current allotments, the budget estimates full implementation to cost over $620 million ($288 GF). The Legislature may wish to consider whether limiting overtime is appropriate, as well as the impact of a second provider entering a home on the recipient.

- **Provider Backup System.** Los Angeles County currently operates a Back-Up Attendant Program (BUAP), which matches eligible IHSS recipients with homecare workers to assist on a short-term basis when a recipient's long-term provider and designated substitute provider are unavailable. There are currently 59 providers in the BUAP. The program provides a wage of $12 per hour for providers listed on the registry as backup providers, and $9 per hour for all other providers. The BUAP phone line is available Monday through Friday, 8 a.m. to 5 p.m. When a consumer calls, BUAP operators use a computer database to identify a backup provider who can best meet the consumer's needs. In 2013, only 142 IHSS recipients were enrolled. The phone line received 254 calls, and provided 1,342 backup service hours.

- **A broader perspective.** The IHSS program was created in 1973 to enable elderly, blind, and individuals with disabilities the ability to live independently in the community, not intentionally designed as financial support for caregivers -- though it has evolved as such. Further, as more individuals age in place and prefer home-like, independent, and non-institutional care, the program's recipients and needs continue to change. As more IHSS recipients select in-home care, California's IHSS program may experience a programmatic shift in formalizing care for a family member as employment, as well as a shift in the types of services provided to recipients.

- **Stakeholder process.** The budget proposal assumes a stakeholder process to inform providers and recipients of the impending changes to implement federal regulations, as well as in developing the workweek agreement. The Legislature may wish to consider the timing of conducting a stakeholder process, given the state's required implementation of federal regulations by January 1, 2015.

- **Other states.** Some states, such as New Mexico, Kentucky, and Pennsylvania, have contracted with organizations for counseling services and fiscal agents; and use a "cash and counseling" model, also known as "participant direction." In a Cash-and-Counseling program, the government provides recipients a monthly monetary allowance, based on an assessment of needs. Recipients prepare a plan for spending the allowance on permissible goods and services, hire and pay the providers, and receive counseling to help make decisions about developing back-up plans. The

Legislature may wish to consider whether allocating its resources to create a provider back-up system to comply with FLSA regulations may be better spent on a new delivery system altogether.

Questions.

1. Please briefly summarize the Fair Labor Standards Act Final Rule and how the Governor's proposal responds to the new requirements.

2. Please briefly explain the proposed Provider Backup System and what happens if a provider works over 40 hours per week on at least two occasions.

3. Please briefly describe the "Cash and Counseling" model. Could this model work for California? Why or why not?

4. Please briefly describe the stakeholder process.

5180 Department of Social Services
0530 Health and Human Services Agency: Office of Systems Integration (OSI)

1. Case Management, Information, & Payrolling System II (CMIPS II)

Budget Issue. The budget requests to align the Office of Systems Integration (OSI) spending authority with the CMIPS II system rollout and transition to Maintenance and Operations (M&O) in 2013-14 and 2014-15. Specifically, the budget proposes an increase of $115,000 in OSI spending authority and a corresponding increase of $2.9 million in the DSS Local Assistance for FY 2013-14, and a net decrease in OSI spending authority of $33.7 million for the budget year. The proposal also includes authority for ten new permanent state staff ($1.48 million) and a corresponding decrease of $36.7 million in the DSS Local Assistance.

Correspondingly, the DSS budget requests six permanent positions to support the CMIPS II project in its maintenance and operations (M&O) phase. This proposal has a corresponding reduction to its Local Assistance budget as it was originally budgeted within OSI. DSS will assume the lead role for the service and support activities that were formerly outsourced. Duties in this role include system enhancements, inputting of legislatively mandated changes, validation and testing, data extraction, research, analysis, and reporting. CMIPS II will provide monthly and quarterly system updates during the M&O period that will necessitate DSS oversight, leadership, support and approval.

Background on Case Management, Information, and Payrolling System II (CMIPS II). CMIPS is the automated, statewide system that handles payroll functions for all IHSS providers. The current vendor (formerly Electronic Data Systems, now Hewlett Packard) has operated the CMIPS system since its inception in 1979. The state has been in the process of procuring and developing a more modern CMIPS II system since 1997. The contract was awarded to Hewlett Packard, formerly EDS, in March 2008. Development commenced and in July 2012, Merced and Yolo counties began implementation of CMIPS II. San Diego County joined in September 2012, eight additional counties implemented in March 2013 and Los Angeles County implemented in September 2013. The final counties implemented November 2013, concluding the Design, Development and Implementation (DD&I) phase with associated conclusion activities into 2014.

The CMIPS II system will provide, according to the department, an enhanced Interface system to support the IHSS programs, including the IHSS program transition into managed care. As CMIPS II transitions into the M&O phase, the department will take a management role of the CMIPS operations, in partnership with OSI. The department will assume ongoing service and support activities that were once outsourced to contractors.

The schedule for the CMIPS II roll-out is summarized in the chart below:

Completed Project Milestones

Milestone Phase	End Date
Design, Development, and Implementation (DD&I)	
• Project Initiation Phase	Oct. 2008
• System Requirement Validation Phase	Dec. 2008
• General System Design Phase	Apr. 2009
• Detailed System Design Phase	Jul. 2009
• Coding and Documentation Phase	Jan. 2010
• System Test and Evaluation Phase	Jun. 2012
• Pilot Phase	Sept. 2012
o Pilot 1 go-live	Jul. 2012
o Pilot 2 go-live	Sep. 2012
• Group #1 go-live (8 counties)	Mar. 2013
• Group #2 go-live (22 counties)	May 2013

Rationale for Position Requests. The Administration indicates that the requested budget adjustment in 2013-14 reflects the need for additional infrastructure resources in support of implementation activities. The net decrease in OSI spending authority and DSS Local Assistance for 2014-15 reflects the scheduled completion of system implementation and the commencement of ongoing costs for the M&O phase of CMIPS II. To support ongoing CMIPS II support functions, the OSI budget proposal includes $98,000 for temporary help in 2013-14 and $1.7 million in 2014-15 for new state staff.

Currently, the CMIPS II Project lacks state staff to provide system support activities, such as monitoring and overseeing technical issues, application anomalies, and testing system defects. In the interim, the CMIPS II Project is utilizing contracted resources and loaned county staff. CMIPS II implementation began on July 30, 2012 and will continue through December 2013. CMIPS II M&O will start the following month in January 2014. The temporary help, legal consultant, and additional data center services storage capacity will be implemented in 2013-14 upon release of the Governor's Budget. Additional state positions for 2014-15 will be filled as soon as possible after the Budget Act is enacted. Given the need to ensure the transition of knowledge from consultants and county staff to State staff, CMIPS II plans to begin recruitment activities for these positions as soon as possible to fill the positions in July and August 2014.

OSI's requested ten permanent IT positions for M&O activities will support the program standards, program system enhancements, CMIPS II data sharing requirements, and CMS Medicaid business processes. Further, these staff will ensure that the application is updated with regulatory changes. The department also indicates as the state is now responsible for system analysis and end-user testing of the system, these staff will reduce risk to the state and provide resources to ensure that the system is functioning as designed.

Staff Comment & Recommendation. Hold open. It is recommended to hold this item open.

Questions

1. Please briefly summarize the need for the requested positions, and provide update on the CMIPS II transition.

2. Does this proposal address the adjustments required to implement FLSA overtime regulations?