Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, Chair
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Senator Jeff Stone

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Consultant: Theresa Pena

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4170 DEPARTMENT OF AGING (CDA)

Issue 1: Overview

With a proposed 2018-19 budget of $201.5 million ($34 million General Fund), 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.

California Department of Aging
Authority by Program

* Dollars in thousands

Grand Total By Fund	Fiscal Year	
General Fund	29,538	29,538
State HICAP Fund	2,246	2,246
Federal Fund	150,382	142,766
State Health Facility Citations Penalty Account	2,094	1,094
State Department of Public Health Licensing and Certification Program Fund	400	400
Skilled Nursing Quality & Accountability Fund	1,900	1,900
Reimbursements	5,442	5,442
Total All Funds	**192,002**	**183,386**

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.

Overview of Programs.

Senior Nutrition. The Senior Nutrition Program is the largest OAA program in terms of funding and the most well-known. The Congregate Nutrition Program provides nutritionally-balanced meals and education to individuals age 60 or older at congregate meal sites. Approximately 27,000 meals a day were served at these sites; 6.9 million a year -- and 35% of the participants were at high nutritional risk.

The equally well known other program is the Home Delivered Meal Program, that serves older adults who are not able to attend congregate programs. Approximately 44,000 home delivered meals are provided at home for each day; 11 million annually.

A one-time $2 million General Fund augmentation for additional home-delivered meals for seniors was provided in the 2016-17 budget.

Supportive Services. Provides assistance to older individuals to help them live as independently as possible and access services available to them. Services include: information and assistance, transportation services, senior centers, in-home and case management and legal services for frail older persons.

Senior Legal Services. Assess legal service needs and assists older adults with disabilities in their community with a variety of legal problems. This is a priority service under Title IIIB and each AAA must include it as one of their funded programs. There are 39 legal services projects in California.

Family Caregiver Support. Provides support to unpaid family caregivers of older adults and grandparents (or other older relatives) with primary caregiving responsibilities.

Long-Term Care Ombudsman. Investigates and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities.

All General Fund local assistance funding for the Ombudsman program was eliminated during FY 2008-09. Between FY 2009-10 and FY 2011-12, several one-time appropriations and funding solutions were utilized to partially backfill lost General Fund and federal Citation Penalties Account monies. In 2012-13 and 2013-14, the implementation of federal sequestration reduced federal Ombudsman funding by about $0.2 million. Local Assistance funding for the Ombudsman in the Current Year is $8.4 million and for the Budget Year is $7.3 million and includes federal and State funds from the Skilled Nursing Facility Quality Assurance Fund and the State Citation Penalties Account funds. The 2017-18 budget included a one-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account. These funds were used to increase staffing hours and/or limited-term appointments for local Ombudsman programs, support volunteers through additional training classes and mileage reimbursement, purchase office equipment, and outreach to consumers.

Elder Abuse Prevention. Develops, strengthens, and implements programs for the prevention, detection, assessment, and treatment of elder abuse.

Health Insurance Counseling and Advocacy (HICAP). Provides personalized counseling, outreach and community education to Medicare beneficiaries about their health and long-term care (LTC) coverage options. In 2016, the program provided in person counseling to 185,000 beneficiaries, provided telephone help (quick calls) to 54,000 individuals and 4,000 consumer presentations.

This program utilizes 770 trained and supervised volunteers who provide this assistance under the direction of the paid program staff. Like the Ombudsman Program and other Older Americans Act programs, trained and well supervised volunteers are key in increasing the capacity of these programs beyond the limited government funding.

Senior Community Service Employment Program (SCSEP). Provides part-time, subsidized work-based training and employment in community service agencies for low-income persons, 55 years of age and older, who have limited employment prospects. Currently there are 14 AAAs providing Senior Community Employment, however, based on the Department of Labor's updated Equitable Distribution of slots by County, CDA is in the process of issuing a Request for Proposals (RFP) to solicit proposals for services in four existing counties.

Funding. Between July 2007 and June 2012, the CDA budget was reduced by approximately $30.1 million in General Fund. 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. Below is a historical recap of budget changes:

- Senior Community Employment. All General Fund for the Senior Community Employment Program (SCSEP) was eliminated in FY 2008-09. Since that time the program has been funded solely by the federal government. In FY 2011-12, SCSEP suffered a 25 percent cut in its Department of Labor baseline funding, a loss of approximately $2.6 million.

- Sequestration - Federal Fiscal Year (FFY) 2013 and ongoing. CDA lost approximately $9.8 million in federal funding in FFY 2013 for its senior programs due to the federal sequestration. The nutrition sequestration reduction was partially offset in FY 2013-14 and FY 2014-15 with $2.7 million received from the Assembly Speaker's Office. In 2014, nutrition federal funding was restored to the 2012 funding levels. Sequestration cuts have continued for Supportive Services, Preventive Health, Family Caregiver, Ombudsman, and Elder Abuse Prevention in the FFYs 2014 and 2015.

- Ombudsman Funding Changes. All General Fund local assistance funding for the Ombudsman program was eliminated during FY 2008-09. Between FY 2009-10 and FY 2011-12, several one-time appropriations and funding solutions were utilized to partially backfill lost General Fund and federal Citation Penalties Account monies. In 2012-13 and 2013-14, the implementation of federal sequestration reduced federal Ombudsman funding by about $0.2 million. Local Assistance funding for the Ombudsman currently amounts $6.3 million and includes federal and state funds from the Skilled Nursing Facility Quality Assurance Fund and the state Citation Penalties Account funds. According to the department, this is $2.3 million lower than the 2008-09 funding level. The 2016-17 budget included a one-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account. These funds were used to increase staffing hours and/or limited-term appointments for local Ombudsman programs, support volunteers through additional training classes and mileage reimbursement, purchase office equipment, and outreach to consumers.

The President's Proposed Budget. On February 12, 2018, President Trump released his proposed budget for the upcoming fiscal year. These recommendations cover Federal Fiscal Year 2019 which runs from October 1, 2018 through September 30, 2019. The President's budget largely proposes level-funding or slight increases in many Older American's Act (OAA) programs, such as the Nutrition Services

Programs, Home and Community-Based Supportive Services, and Family Caregiver Support Services. However, the President's proposed budget also includes the elimination of the State Health Insurance Assistance Program (SHIP), known as HICAP in California, and the SCSEP.

Continuing Resolutions. In the absence of a full federal fiscal year budget, CDA has been operating under a series of Continuing Resolutions (CR) since October 1, 2017. This has resulted in federal funding coming to the states in smaller increments as opposed to a full year funding award. CDA kept the Area Agencies on Aging (AAA) up-to-date on the status of the federal funds awarded and the current available balance of each AAA's funds. With each CR, CDA and the AAAs continued to receive funding at the 2017 federal grant level. However, for the CRs that were less than 30 days, the Administration for Community Living (ACL) did not provide funding until the CR period exceeded 30 days.

For AAAs operating under tight fiscal constraints, CDA has been proactive and working closely with the AAA network to identify options to assist those AAAs most impacted by the delayed federal funding.

CDA continues to release funds based on the contracts with the AAAs, the request for funds and expenditure reports submitted by the AAAs, and their current available balance of funding.

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

Questions.

1. Please provide an update of the department's programs and services and current funding levels.

2. Please discuss how federal funding uncertainties are affecting programs in CDA.

Issue 2: Update: Multi-Purpose Senior Services Program (MSSP)

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 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. The current FY 2017-18 MSSP budget is approximately $39.8 million and the proposed FY 2018-19 MSSP budget remains unchanged.

MSSP as Part of the Coordinated Care Initiative. Under California's Coordinated Care Initiative (CCI), most Medi-Cal beneficiaries in CCI counties were to be enrolled in a participating Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MSSP. MSSP sites in a CCI county had entered into contracts with the participating managed care health plans to deliver MSSP waiver services to eligible plan members and were reimbursed by the health plans. In six of the seven CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara; excluding San Mateo, which fully transitioned to a managed care benefit), MSSP continued to be a 1915(c) Home- and Community-Based Services waiver benefit until it transitioned to being a fully integrated managed care health plan benefit that is administered and authorized by the plan. However, the 2017-18 Governor's Budget found that the CCI was no longer cost-effective and did not meet the statutory savings requirements, and the CCI was discontinued.

In the remaining six counties, the MSSP sites will continue to contract with the managed care health plans participating in the Cal MediConnect program, which continues mandatory enrollment of dual eligibles, and integrates long-term services and supports (LTSS) (except In-Home Supportive Services) into managed care. MSSP will continue to operate as a waiver program in CCI counties until no sooner than January 2020. In addition, all current MSSP Waiver policies and program standards remain in effect during the transition period. After December 2019, services formerly available under the MSSP waiver will transition from a federal 1915(c) waiver to a fully integrated Medi-Cal managed care LTSS benefit in the CCI counties.

Until the MSSP transition is complete in the remaining six CCI counties, Medicare/Medicaid plans (MMPs) and managed care plans (MCPs) pay the 12 MSSP sites in these six counties a monthly all-inclusive rate of $357.08 for each MSSP Waiver participant who is enrolled with the MMP or MCP. MSSP Waiver participants in these six counties who are not enrolled with a MCP or MMP currently are receiving MSSP Waiver services from MSSP sites that are reimbursed through the Fee for Service (FFS) model.

Supplemental Reporting Language Update. Pursuant to the Supplemental Report of the 2017-18 Budget Act, the Department of Health Care Services (DHCS) and CDA provided its first biannual update to the Legislature in February. Per the MSSP SRL, items to be discussed with the Legislature include:

- A list and brief summaries of stakeholder and transition meetings to date;
- Status updates on the transition work that has been completed or is in the process of being completed by each CMC demonstration county;
- List of future tasks and activities that need to take place to effectively transition MSSP into managed care plans in all and each of the CMC demonstration counties by January 1, 2020, with estimated start and end dates and list of necessary stakeholders;
- Discussion of how the coordination and management of care will be conducted for various populations, including but not limited to individuals enrolled in a CMC plan, dual eligible beneficiaries that have opted out of CMC, Medi-Cal only seniors and persons with disabilities, and dual eligible that are ineligible for CMC, following the transition of MSSP into managed care;
- Any foreseen or potential issues or risks that may jeopardize the transition of MSSP into managed care or result in delays; and
- A discussion of the Administration's long-term vision of MSSP in the CMC demonstration counties if the pilot is discontinued, and how integration achieved thus far would be unwound without an adverse effect on the MSSP participants, as of December 31, 2019 and if the pilot continues on a more permanent basis.

Early last fall, DHCS and CDA also started the Stakeholder and Transition meetings that included the following activities:

- October 6, 2017, DHCS publically released two transition documents to the California Collaborative for Long-Term Services and Supports for public comment.
    - The *Archive Document for the Multipurpose Senior Services Program Transition: Target Updated from 2018 to 2020* is an archive document that was meant to memorialize the activities conducted and policy guidance developed during 2015 and 2016.
    - The *Transition Plan Framework and Major Milestones* document is more of a living document intended to document the activities and policy guidance developed in 2018-19, in preparation for the 2020 transition
- DHCS has also continue to hold quarterly CCI Stakeholder calls with stakeholders, advocates, health plans, MSSP sites, and other interested parties. The next call is scheduled for March 2018.

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

Questions.

1. Please provide a brief overview of the MSSP program, and discuss any impacts of the discontinuance of CCI on the MSSP program.

2. Please provide a summary of the information provided in the SRL meeting.

Issue 3: Proposals for Investment

The subcommittee has received the following aging-related proposals for investment.

1. Senior Nutrition Program Augmentation

Budget Issue. The California Association of Area Agencies on Aging and other advocates request $12.5 million General Fund ongoing to augment existing senior nutrition programs. Area Agencies on Aging operate these programs, including Congregate Mealsites and Home-delivered Meals (known as Meals on Wheels). The increase in funds would provide an additional one half-million meals to California seniors.

Staff Comment and Recommendation. Hold open. The 2016-17 Budget included a one-time augmentation of $2 million General Fund specifically for the Home-delivered Meals.

2. Long-Term Care (LTC) Ombudsman Augmentation

Budget Issue. The California LTC Ombudsman Association requests $7.3 million General Fund ongoing for the local LTC Ombudsman Programs. The breakdown of the requested funds is as follows: 1) $3.5 million to enable local programs to conduct quarterly unannounced visits to long term care facilities; 2) $420,000 to enable the program to focus on volunteer recruitment; 3) $1.1 million to enable programs to investigate and resolve additional complaints; and 4) $2.3 million to adjust the local annual program base to $100,000 (an additional $65,000 per program).

Staff Comment and Recommendation. Hold open. This program saw various cuts throughout the recession and has struggled under a growing workload. In both 2016-17 and 2017-18, the program received a one-time augmentation of $1 million from the State Health Facilities Citation Account. In 2017-18 budget bill language was also added so that program would receive up to $1 million in additional funds from the State Health Facilities Citation Account if funds were in excess of $6 million. This year, however, no additional funds are available.

3. Supplemental Rate Adjustment for MSSP sites

Budget Issue. The MSSP Site Association (MSA) requests $4.7 million General Fund ongoing to provide a supplemental rate adjustment for MSSP sites. MSA points out that MediCal funding for MSSP has been flat and was reduced during recession years, while the cost of professional staff and operations has continued to increase. The requested funds would increase the per client rate to $5,356.

Staff Comment and Recommendation. Hold open.

4. Funds for Alzheimer's disease education campaign

Budget Issue. The Alzheimer's Association requests $2.2 million General Fund one-time for the Department of Aging to build local capacity to promote early detection and diagnosis of Alzheimer's disease through a public outreach initiative. These funds would be available to use for two years.

Staff Comment and Recommendation. Hold open

4185 CALIFORNIA SENIOR LEGISLATURE (CSL)

Issue 1: Overview and Update

Background. SCR 44 (Mello), Chapter 87, Statutes of 1982, established the CSL. The CSL is a nonpartisan, volunteer organization comprised of 40 senior senators and 80 senior assemblymembers, who are elected by their peers in elections supervised by the Advisory Councils in 33 Planning and Services Areas. The CSL's mission is to gather ideas for state and federal legislation and to present these proposals to members of the Legislature and/or Congress. Each October, the CSL convenes a model legislative session in Sacramento, participating in hearing up to 120 legislative proposals.

Since 1983, the CSL has been funded through voluntary contributions received with state income tax returns, appearing as the California Fund for Senior Citizens. State law allows taxpayers to contribute money to voluntary contribution funds (VCFs) by checking a box on their state income tax returns. With a few exceptions, VCFs remain on the tax form until they are repealed by a sunset date or fail to generate a minimum contribution amount. For most VCFs, the minimum contribution amount is $250,000, beginning in the fund's second year. In 2013 the CSL did not meet the minimum contribution amount, and it fell off the tax check-off for the 2014 tax return. The CSL managed to maintain their funding status through VCF by establishing the new California Senior Legislature Fund through SB 997 (Morrell), Chapter 248, Statutes of 2014, and repealing the California Fund for Senior Citizens. But in 2015, the new VCF revenue was only $60,000. In 2016, the California Senior Legislature Fund was removed from the tax check-off list once again for not meeting the minimum requirement. The Legislature included a one-time $500,000 General Fund appropriation in the Budget Act of 2016 to keep the CSL operative. CSL spent $235,000 of this in the past year, and the remaining $265,000 were reappropriated and carried into 2017-18. Combined with the 2017-18 General Fund appropriation of $375,000, CSL has approximately $640,000 to spend in the current year. Additionally, as of January 1, 2018, CSL has approximately $71,000 from the tax check off fund. CSL has estimated their current year expenditures to be $324,000.

Three-Year Financing Plan. The Budget Act of 2017 also called for the CSL to work with the Department of Finance on a longer-term financing plan. This plan was released at the beginning of March 2018. The financing is meant to discuss ways to reduce the Department of General Services' (DGS) state contracting costs, identify ways in which organizational and program activities can be streamlined, and develop additional funding sources.

The report identified that fixed costs of Consolidated and Professional Services (C&PS) (accounting, administration, legal, etc.) Pro Rata fees, and salary and benefits make up a large and increasing portion of the CSL's budget. If current trends continue, CP&S is projected to double within the next five years, and when these are combined with salary and benefits, will consume the CSL budget in outyears.

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

Questions.

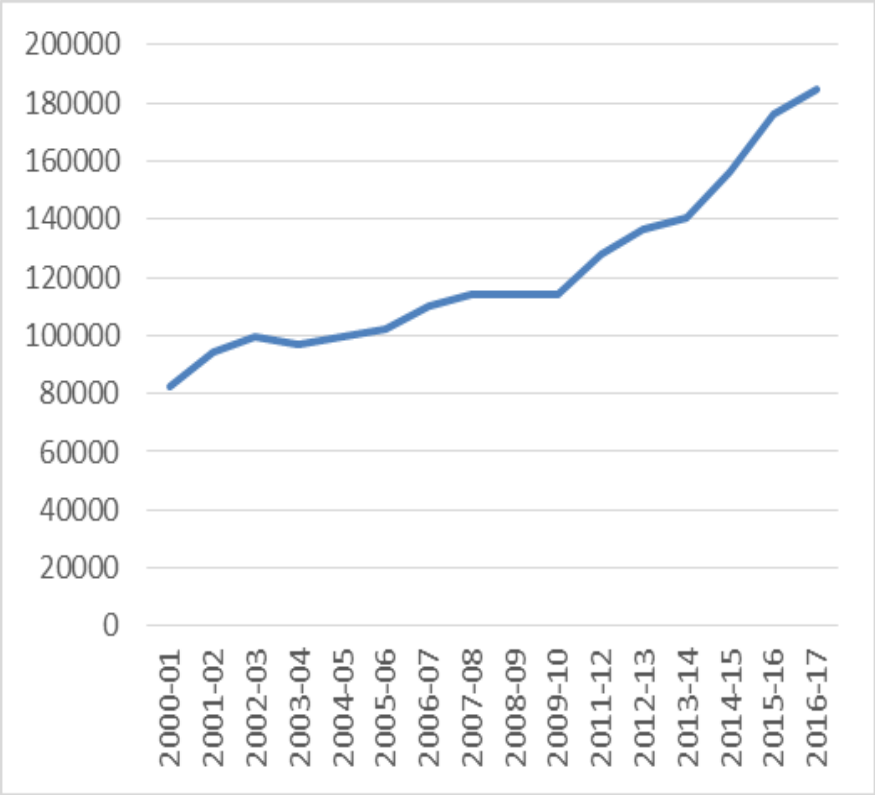
1. Please provide an overview of the three-year financing plan and important takeaways from the report.

5180 – DEPARTMENT OF SOCIAL SERVICES – ADULT PROTECTIVE SERVICES (APS)

Issue 1: Overview – Adult Protective Services

Background. Each of California's 58 counties has an APS agency to help adults aged 65 years and older and dependent adults who are unable to meet their needs, or are victims of abuse, neglect, or exploitation. The APS program provides 24/7 emergency response to reports of abuse and neglect of elders and dependent adults who live in private homes, apartments, hotels or hospitals, and health clinics when the alleged abuser is not at staff member. APS social workers evaluate abuse cases and arrange for services such as advocacy, counseling, money management, out-of-home placement, or conservatorship. APS social workers conduct in-person investigations on complex cases, often coordinating with local law enforcement, and assist elder adults and their families navigate systems such as conservatorships and local aging programs for in-home services. These efforts often enable elder adults and dependent adults to remain safely in their homes and communities, avoiding costly institutional placements, like nursing homes.

APS reports have risen by 124 percent between 2000-01 and 2016-17. The chart below shows the upward trend of reports of abuse and neglect received by APS:



Realignment. In 2011, Governor Brown and the Legislature realigned several programs, including child welfare and adult protective services, and shifted program and fiscal responsibility for non-federal costs to California's 58 counties.[1] The Department of Social Services, (DSS) retains program oversight and regulatory and policy making responsibilities for the program, including statewide training of APS workers to ensure consistency. DSS also serves as the agency for the purpose of federal funding and administration.

Training. In 2015-16, $176,000 ($88,000 General Fund) was allocated to DSS for APS training. Funding for statewide APS training had not increased in 11 years, even as APS reports have risen by 124 percent between 2000-01 and 2015-16.

The 2014 Budget Act included $150,000 in funding for one staffing position within the Department of Social Services to assist with APS coordination and training. In 2015, trailer bill language was adopted that codified the responsibilities of this staff person. The 2016 Budget Act included one-time funding of $3 million General Fund for APS training for social workers. So far, the funding has been used to:

- Add three new (2017-2019) contracts with the three Regional Training Academies (RTAs) (San Diego State University, UC Davis, and Cal State Fresno) to provide "APS Core Competency Academies" in each region, provide tracking and documentation for national APS certification, and five advanced trainings and three supervisor trainings.
- Provided funding to the Public Administrators (PA), Public Guardians (PG) and Public Conservators (PC) Association to support their need to train their employees.

Federal Grants. APS has received a federal Administration for Community Living grant of $250,000 to study and develop an improved comprehensive data collection system in line with the National Adult Maltreatment Reporting System (NAMRS). DSS has been working with the counties to develop a new data reporting methodology. The department will begin collecting the new data in October 2018 and will be able to report state level data on client and perpetrator demographics in the future.

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

Questions.

1. Please provide a brief update on the APS program and funding.

2. Please discuss the rising APS reports.

[1] AB 118, (Committee on Budget), Chapter 40, Statutes of 2011, and AB 16 x 1 (Committee on Budget), Chapter 13, Statutes of 2011, First Extraordinary Session, realigns funding for Adoption Services, Foster Care, Child Welfare Services, and Adult Protective Services, and programs from the state to local governments and redirects specified tax revenues to fund this effort.

Issue 2: Proposals for Investment

The subcommittee has received the following proposal for investment.

- Adult Protective Services Home Safe

Budget Issue. The County Welfare Directors Association of California (CWDA), California Elder Justice Coalition, and California Commission on Aging, request $15 million General Fund in 2018-19 to establish Home Safe, a homelessness prevention demonstration grant for victims of elder and dependent adult abuse and neglect. The proposed one-time funding would allow approximately 15 county APS programs to demonstrate over three years how providing short-term housing crisis intervention can help reduce the incidence and risk of homelessness among California's older and dependent adults.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING (CCL)

Issue 3: Overview – Community Care Licensing

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of approximately 72,000 licensed community care facilities that include child care, children's residential, adult and senior care facilities, and home care services. CCL is responsible for protecting the health and safety of individuals served by those facilities. Approximately 565 licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. Current year funding is displayed in the chart below:

California Department of Social Services
Community Care Licensing Division
Fiscal Year 2017-18 Funding

		2017-18*
	State Operations Total ($000s):	**$154,957**
	GF	$69,168
	FF	$47,891
	Reimb.	$6,496
	Special Funds:	$31,402
0163	Continuing Care Provider Fee Fund	$938
0270	Technical Assistance Fund	$19,999
0271	Certification Fund	$1,590
0279	Child Health And Safety Fund	$3,272
3255	Home Care Fund (AB 1217)$_1$	$5,603

The table below lists the facilities licensed by CCL.

Facility Type	Description
Child Care Facilities	
Family Child Care Home	Provides care, protection and supervision of children, in the caregiver's own home, for periods of less than 24 hours per day, while the parents or authorized representatives are away.
Child Care Center	Provides care, protection and supervision of children in a group setting, usually in a commercial building, for periods of less than 24 hours per day. Includes infant centers, preschools, extended day care facilities, and school age child care centers
Children's Residential Facilities	
Adoption Agency	Nonprofit organizations licensed to assist families with the permanent placement of children with adoptive parents.
Community Treatment Facility	24-hour mental health treatment services for children certified as seriously emotionally disturbed with the ability to provide secure containment.
Crisis Nursery	Short-term, 24-hour non-medical residential care and supervision for children under 6 years of age, who are placed by a parent or legal guardian due to a family crisis or a stressful situation, for no more than 30 days.
Enhanced Behavioral Supports Home (Group Home)	24-hour nonmedical care, in a residential facility or group home, for individuals with developmental disabilities requiring enhanced behavioral supports, staffing, and supervision in a homelike setting.
Foster Family Agency	Organizations that recruit, certify, train and provide professional support to foster parents and Resource Families; and identify and secure out-of-home placement for children.
Group Homes	24-hour non-medical care and supervision provided to children in a structured environment
Out of State Group Home	24-hour non-medical care provided to children in out-of-state group homes identified by counties to best meet a child's specific and unique needs.
Runaway and Homeless Youth Shelter (Group Home)	Provides voluntary, short-term, shelter and personal services to runaway or homeless youth.
Short Term Residential Therapeutic Program	Provides short-term, specialized, and intensive therapeutic and 24-hour non-medical care and supervision to children.
Foster Family Home	A home where a licensed foster parent provides care for six or fewer foster children.
Small Family Homes	A residential facility that provides 24-hour care licensee's home for 6 or less children, who have mental disorders or developmental or physical disabilities.
Transitional Housing Placement	Provides supervised transitional housing services to foster

Provider	children who are at least 16 years old to promote their transition to adulthood.
Certified Family Homes	Foster parents certified by foster family agencies to provide care for six or fewer foster children in their own home.
Resource Family Home	Individual or family that meets both the home environment assessment and the permanency assessment criteria necessary for providing care for a child who is under the jurisdiction of the juvenile court, or otherwise in the care of a county child welfare agency or probation department.
Temporary Shelter Care Facilities	Owned and operated by the county or by a private, nonprofit agency on behalf of a county providing 24-hour care for no more than 10 days for children under 18 years pending placement.
Transitional Shelter Care Facilities	County owned and operated (or non-profit organization under contract with the County) facilities providing short term non-medical care for children to a maximum of 72 hours pending placement.
Private Alternative Outdoor Programs	A group home operating a program to provide youth with 24-hour, nonmedical, residential care and supervision, which provides behavioral-based services in an outdoor living setting to youth with social, emotional, or behavioral issues.
Private Alternative Boarding Programs	A group home operating a program to provide youth with 24-hour, nonmedical, residential care and supervision, which, in addition to providing educational services to youth, provides behavioral-based services to youth with social, emotional, or behavioral issues.
Adult & Senior Care Facilities	
Adult Day Programs	Community based facility/program that provides care to persons 18+ years old in need of personal services, supervision, or assistance essential for sustaining activities of daily living or for the protection of these individuals on less than a 24-hour basis.
Adult Residential Facilities (ARF)	24-hour non-medical care and supervision for adults, either 18-59 years old or 60+ years old.
Adult Residential Facility for Persons with Special Healthcare Needs	Any adult residential facility that provides 24-hour health care and intensive support services in a homelike setting that is licensed to serve up to five adults with developmental disabilities.
Community Crisis Homes (ARF)	A facility that operates as an adult residential facility providing 24-hour non-medical care to individuals with developmental disabilities receiving regional center service, in need of crisis intervention services, and who would otherwise be at risk of admission to an acute crisis center, at a maximum capacity of eight (8) clients.
Continuing Care Retirement Communities (RCFE-CCRC)	A Residential Care Facility for the Elderly that offers a long-term continuing care contract; provides housing, residential services, and nursing care.
Enhanced Behavioral Supports Home (ARF)	A facility that operates as an adult residential facility providing 24-hour non-medical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike

	setting, at a maximum capacity of four (4) clients.
Residential Care Facilities for the Chronically Ill	A facility that provides care and supervision to adults who have a terminal illness, AIDS or HIV.
Residential Care Facilities for the Elderly (RCFE)	A residential home for seniors aged 60 and older who require or prefer assistance with care and supervision. RCFEs are also known as Assisted Living facilities, retirement homes and board and care homes.
Social Rehabilitation Facilities	A facility that provides 24-hour-a-day non-medical care and supervision in a group setting at a total capacity that shall not exceed 16 adults recovering from mental illnesses who temporarily need assistance, guidance, or counseling.

As of January 2017, CCL has 1,266 authorized positions and 142 vacancies. There are 110 positions currently in the interview process with an additional 27 appointments in the final approval process.

Background Checks. 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. 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.

Continuum of Care Reform. AB 403 (Stone), Chapter 773, Statutes of 2015, is a multi-year effort to reduce the reliance on group home placements and develop a more robust supply of home-based family settings for foster youth, while providing families with the resources necessary to support foster youth as much as possible. In support of the CCR, the Children's Residential Program drafted or assisted with the drafting of two regulatory packages providing the framework for Foster Family Agencies and Short Term Residential Therapeutic Programs, four versions of written directives guiding the implementation of the Resource Family Approval (RFA) Program, conducted 10 orientations with provider groups on these new requirements and continued to support the 13 early implementing RFA counties through technical assistance and monitoring visits.

Home Care Services Consumer Protection Act. AB 1217 (Lowenthal), Chapter 70, Statutes of 2013, requires DSS to regulate Home Care Organizations and provide for background checks and a registry for affiliated Home Care Aides, as well as independent Home Care Aides who wish to be listed on the registry. This bill implemented on January 1, 2016.

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. Approximately 1.4 million Californians rely on CCL enforcement activities to ensure that the care they receive is consistent with standards set in law.

DSS conducts pre- and post-licensing inspections for new facilities and unannounced visits to licensed facilities under a statutorily-required timeframe. The adopted 2015 proposal increased the frequency of inspections from at least once every five years to at least once every three years or more frequently depending on facility type. These reforms go into effect incrementally through 2018-19, and as of

January 2017, DSS has implemented the required increased visit protocol. Below is a table showing the ramp up of inspections by facility type:

Inspection Frequency: Prior Law and As Enacted in the 2015 Budget

Facility Type	Prior Law	As Enacted in the 2015 Budget		
		Stage 1: January 2017	Stage 2: January 2018	Stage 3: January 2019
	Inspections must occur at least once every. . .			
Child care facilities	5 years	3 years	3 years (unchanged from stage 1)	3 years (unchanged from stage 1)
Children's residential care facilities	5 years	3 years	2 years	2 years (unchanged from stage 2)
Adult and senior care facilities	5 years	3 years	2 years	1 year

Key Indicator Tool. After various changes in 2003, and because of other personnel reductions,[2] 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 contracted 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, as well as a workload study. The findings of the KIT analysis focused on various iterations and refinement of three versions of the KIT, and to some extent found that the third version was most effective in identifying the need for further inspections for half of the facility types. The workload study concluded that CCL will need 630 LPAs to cover the increased workload through 2018, and 678 LPAs to fully staff the changes that take place beginning 2019.

Last year, the Legislature approved Supplementary Reporting Language that required the department to meet with legislative staff and stakeholders to discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. A meeting with the department in the summer of 2017 revealed that they were in the early stages of designing a new, comprehensive inspection tool, informed by the KIT analysis. In September 2017 the department released a report detailing its planned approach for a new tool. This will be discussed further in the next agenda item.

[2] 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.

The chart below summarizes the total and type of inspections conducted in licensed facilities and how many inspections utilized the Key Indicator Tool (KIT) verses comprehensive inspections triggered after initiation of a KIT visit.

CCL Inspections in All Facilities
By Type of Inspection and Protocol
Fiscal Year 2016-17

Type of Inspection[1]	Total Number of Inspections	Percentage of inspections utilized the Key Indicator Tool (KIT)	Percentage of inspections that utilized the KIT triggered a comprehensive inspection
Annual Required Inspection	6,762	5,935 (87.8%)	1,148 (19.3%)
Random Inspection	22,163	21,260 (95.9%)	1,828 (8.6%)
Required Five-Yr. Visit[1]	667	541 (81.1%)	201 (37.2%)
Required Three-Yr. Visit[2]	1,853		

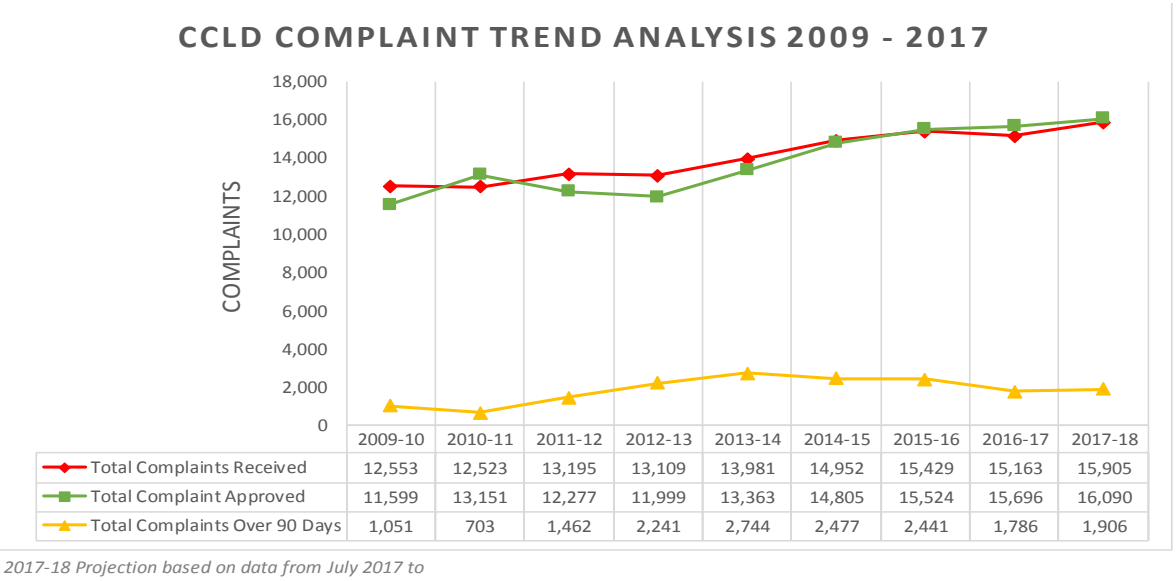
1 - In January 2017 the inspection protocol changed from 5 Years to 3 Years

2 - Data for comprehensive and triggered comprehensive inspections for Required 3 Year Inspections were not collected by FAS from January – July 2017.

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 is required to respond to complaints within 10 days. During 2016-17, CCL received over 15,000 complaints. The information below provides an analysis of DSS' complaint activity for the years of 2009-10 through 2017-18.

COMMUNITY CARE LICENSING DIVISION COMPLAINT ANALYSIS 2009 - 2017						
Fiscal Year	Total Complaints Rolled Over From Prior Year(s)	Total Complaints Received	Total Complaints Received + Prior Year(s) Rollover	Total Complaint Approved	Current Year Net Loss/gain	Total Complaints Over 90 Days
2009-10	2,508	12,553	15,061	11,599	3,462	1,051
2010-11	3,462	12,523	15,985	13,151	2,834	703
2011-12	2,834	13,195	16,029	12,277	3,752	1,462
2012-13	3,752	13,109	16,861	11,999	4,862	2,241
2013-14	4,862	13,981	18,843	13,363	5,480	2,744
2014-15	5,480	14,952	20,432	14,805	5,627	2,477
2015-16	5,627	15,429	21,056	15,524	5,532	2,441
2016-17	5,532	15,163	20,695	15,696	4,999	1,786
2017-18[1]	4,999	15,905	20,904	16,090	4,814	1,906

1 - Projection based on data from July 2017 to January 2018



	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Total Complaints Received	12,553	12,523	13,195	13,109	13,981	14,952	15,429	15,163	15,905
Total Complaint Approved	11,599	13,151	12,277	11,999	13,363	14,805	15,524	15,696	16,090
Total Complaints Over 90 Days	1,051	703	1,462	2,241	2,744	2,477	2,441	1,786	1,906

2017-18 Projection based on data from July 2017 to

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 deposited into the Technical Assistance Fund (TAF) and is expended by the department to fund administrative and other activities in support of the licensing program. In addition to these annual fees, facilities are assessed civil penalties if they are found to have committed a licensing violation. Civil penalties assessed on licensed facilities are also deposited into the TAF, and are required to be used by the department for technical assistance, training, and education of licensees.

Budget actions. In 2014-15, the budget included $7.5 million ($5.8 million General Fund) and 71.5 positions for quality enhancement and program improvement measures. In 2015-16, the budget included an increase of 28.5 positions (13 two-year limited-term positions) and $3 million General Fund in 2015-16 to hire and begin training staff in preparation for an increase in the frequency of inspections for all facility types beginning in 2016-17. In 2016-17, in order to further comply with the increased frequency of inspections including annual random inspections, and various other legislative requirements related to caregiver background checks, licensing and registration activities, and appeals and Residential Care Facility for the Elderly (RCFE) ownership disclosure, the budget includes new funding of $3.7 million General Fund for 36.5 positions. In 2017-18, an additional $3.3 million from the Technical Assistance Fund (TAF) was approved to help complete timely complaint allegations, address the growing backlog of RCFE and Adult Residential Facilities (ARF), continue implementation efforts related to the RCFE Reform Act of 2014, and 5.5 permanent LPAs and one-half Attorney III.

Staff Comment and 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 discuss the complaint backlog. Has the department seen an impact from additional staffing resources?

Issue 4: Development of New Inspection Tools

Background. CCL conducts pre- and post-licensing inspections for new facilities and unannounced visits to licensed facilities under a statutorily-required timeframe. Prior to 2003, these routine visits were required annually for almost all facilities. In 2003, budget cuts resulted in significantly reduced funding for CCL. By 2010, the cuts had taken a toll and CCL fell behind in meeting visitation frequency requirements. In an effort to increase the number of routine inspections CCL could perform each year, DSS proposed moving from the comprehensive inspections required by state law to the use of a key indicator tool (KIT). The KIT was proposed to be a standardized, shortened protocol for measuring compliance with a small number of rules. Under the proposal, if the KIT inspection revealed concerns, a comprehensive visit would be triggered.

Since that time, the department implemented the KIT for inspections of its licensed programs. CCL also contracted with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development, refinement, and validation of the KIT. The findings of the reports focus on three iterations of the KIT, and to some extent point to the third KIT as the most effective in identifying the need for further inspections for half of the facility types. However, there were no definitive findings as to whether the use of the KIT ultimately saves time and allows for more inspections to take place, nor was there a comparison of the KIT to the traditional comprehensive inspection. Further, it was revealed that there was no standardized statewide tool for the comprehensive inspection; LPAs draw upon their own knowledge of statute and regulations, or use an informal tool developed at a regional office.

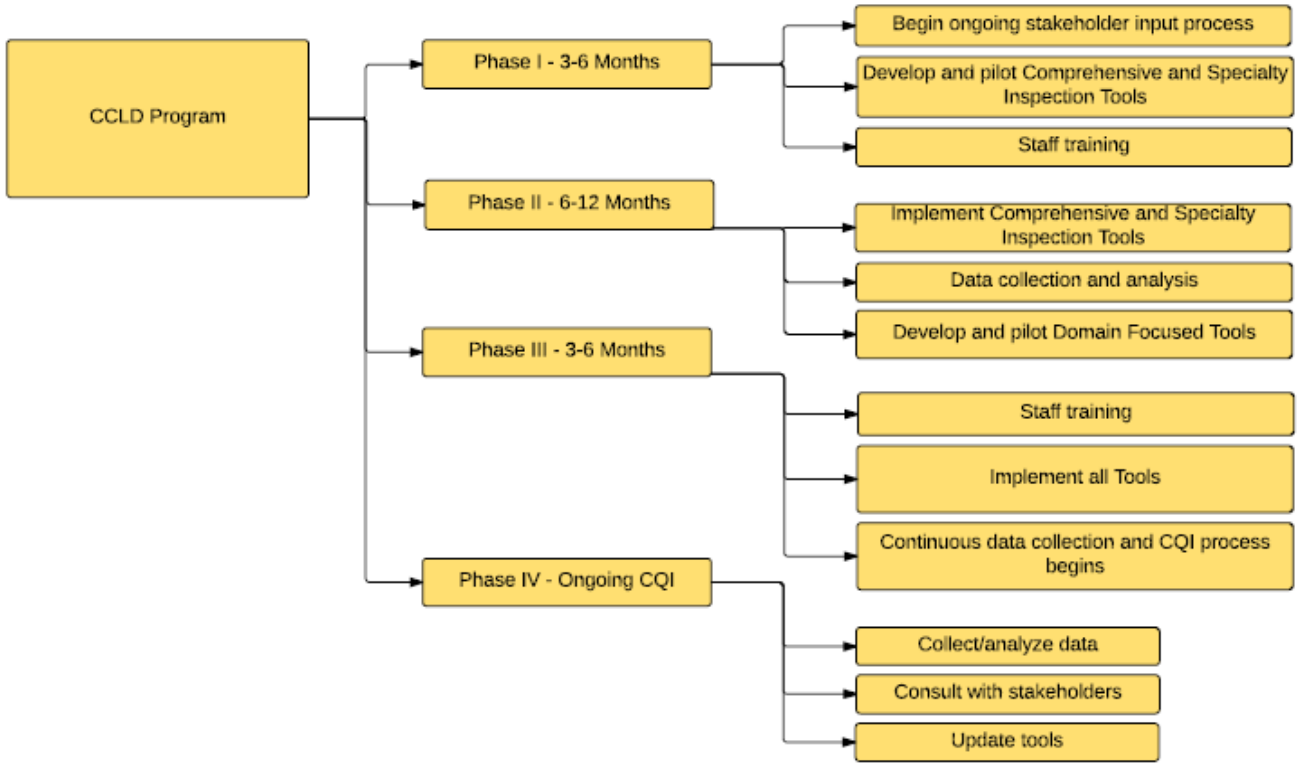
Last year, the Legislature approved Supplementary Reporting Language that required the department to meet with legislative staff and stakeholders to discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. A meeting with the department in the summer of 2017 revealed that they were in the early stages of designing a new, comprehensive inspection tool, informed by the KIT analysis. In September 2017 the department released a report detailing its planned approach for a new tool. During the development of the new tool, all three versions of the KIT will remain in use. The KITs will be replaced on a flow basis when the standard tools for each licensing category are developed.

New Inspection Tools. In light of the absence of a standardized inspection tool, CCL has committed to developing a variety of standardized inspection tools for LPAs to improve the effectiveness and quality of the inspection process. In particular, the department will focus on prevention, and enhancing technical support to licenses from LPAs. These tools will also be developed differently for the various licensing categories, understanding that different facility types will have different statutory requirements and indicators of compliance to meet. CCL intends to adapt an Agile project management style and incorporate continuous quality improvement into the tool development process.

The department proposes three different types of tools: 1) comprehensive tools, 2) domain-focused tools, and 3) specialty tools. Comprehensive tools will be used for pre-licensing inspections, post-licensing inspections, and required annual inspections, and will contain extensive requirements in all domain areas that are relevant to the time of visits. Domain-focused tools will be developed after and based on data from comprehensive tools. These tools will replace the KITs as shortened tools for LPAs, designed for each CCL program type. Specialty tools will be used with both comprehensive and domain-focused tools if a deeper dive into a specific area is identified.

The department has indicated that the new tool may require additional resources for staffing and training.

Below is a timeline provided by the department showing the various phases of development for the development and implementation of the tools.



CCL has begun efforts to develop Comprehensive and Specialty Tools for RCFEs and ARFs, to pilot in the spring of 2018. The department has also held stakeholder meetings to gather initial input from Children's Residential and Child Care and Adult and Senior Care facility advocates. CCL will also contract with an independent entity in developing quality measurement and compliance tools.

Currently, tools are being developed with LPAs and stakeholders for the RCFE pilot. These tools will be piloted on a portion of RCFEs due for their annual inspection to allow for its effectiveness to be evaluated before a statewide implementation. The pilot will test process measures, such the duration of the inspection or the learnability of the tools, and to a lesser degree will look at the validity and reliability of the tool, particularly inter-rater reliability.

Below is a timeline of the RCFE pilot:

Target Completion Date	Milestone
March 2018	Release pilot information and draft tools for stakeholder review
June 2018	Train LPAs participating in the pilot
July 2018	Conduct pilot visits and licensee surveys
September 2018	Pilot period concludes
October 2018	Conduct focus groups with LPAs
December 2018	Present and publish pilot report to stakeholders
January 2019	Integrate feedback into tools

Staff Comment and Recommendation. Hold open.

Questions.

1. Please discuss the genesis for creating a new comprehensive tool, and provide an update on current and upcoming activities in the development of this tool.

2. How do the KIT analysis and workload study inform your development of the new tools?

3. Does the department intend to require the use of the newly developed tools in statute?

4. How does the department intend to measure the new tool, and what kind of data does the department plan to collect to evaluate the effectiveness of the tool?

Issue 5: Budget Change Proposal: Private Alternative Boarding Schools and Outdoor Programs Oversight and Policy Development

Governor's Proposal. The Administration requests 12.5 positions and $591,000 General Fund ongoing in order to implement SB 524 (Lara), Chapter 864, Statutes of 2016, which established Private Alternative Boarding Schools and Private Alternative Outdoor Programs as two new subcategories of Group Homes to be overseen by the department. Specifically, the positions requested are eight full-time Licensing Program Analysts (LPAs), one Licensing Program Manager (LPM), one and a half Office Assistant positions, and one Associate Governmental Program Analyst (AGPA). The Information Systems Division also requests $450,000 for contracts to make updates to the Licensing Information System.

Background. In response to the absence of state oversight for facilities and outdoor programs that advertise services and care for troubled teens, SB 524 established "private alternative boarding schools" and "private alternative outdoor programs" as two new types of licensed community care facilities under the purview of DSS beginning January 1, 2018, and January 1, 2019, respectively. The 2017-18 Governor's Budget proposed to modify implementation of SB 524 by making funding for its requirements contingent upon appropriation in the budget act and delaying implementation by 18 months after the appropriation of funds. The Subcommittee rejected this trailer bill, and the 2017 Budget Act provided $750,000 General Fund to begin implementation activities for SB 524.

The department estimates that there are 90 facilities (75 private alternative boarding schools and 15 private alternative outdoor programs; however, the proposal provides for a scaled-back alternative based on 60 facilities, given that it is difficult to estimate the number of these types of facilities currently operating.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. How did the department get to its estimate of numbers of facilities? Is the department confident in the higher or lower estimate?

5180 – DEPARTMENT OF SOCIAL SERVICES, SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT (SSI/SSP)

Issue 6: Overview – SSI/SSP

The Supplemental Security Income/State Supplemental Payment (SSI/SSP) programs provide cash assistance to around 1.3 million Californians, who are aged 65 or older (28 percent), are blind (one percent), or have disabilities (71 percent), and in each case meet federal income and resource limits. A qualified SSI recipient is automatically qualified for SSP. SSI grants are 100 percent federally funded. The state pays SSP, which augments the federal benefit.

Funding. The budget proposes $11.2 billion total funds ($2.8 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $188 million for the budget year. Costs for SSI/SSP include the Cash Assistance Program for Immigrants and the California Veterans Case Benefit Program and (to be discussed below).

Cash Assistance Program for Immigrants (CAPI). In 1998, the Cash Assistance Program for Immigrants (CAPI) was established as a state-only program to serve some legal non-citizens who were aged, blind, or had disabilities. After 1996 federal law changes, most entering immigrants were ineligible for SSI, although those with refugee status are allowed seven years of SSI. CAPI benefits are equivalent to SSI/SSP program benefits, less $10 per individual and $20 per couple. The CAPI recipients in the base program include 1) immigrants who entered the United States prior to August 22, 1996, and are not eligible for SSI/SSP benefits solely due to their immigration status; and 2) those who entered the U.S. on or after August 22, 1996, but meet special sponsor restrictions (have a sponsor who is disabled, deceased, or abusive). The extended CAPI caseload, which is separate from the base CAPI caseload, includes immigrants who entered the U.S. on or after August 22, 1996, who do not have a sponsor or have a sponsor who does not meet the sponsor restrictions of the base program. In 2018-19, the estimated monthly average caseload is 869 cases for CAPI and 13,632 for extended CAPI.

California Veterans Cash Benefit Program (CVCB) Program. The California Veterans Cash Benefit Program (CVCB) program is linked to the federal Special Veterans Benefit (SVB) Program, which was signed into law in 1999 and provides benefits for certain World War II veterans. The SVB application also serves as the CVCB application, and payments for both programs are combined and issued by the SSA. CVCB program benefits are specifically for certain Filipino veterans of World War II who were eligible for CA SSP in 1999, who are eligible for the SVB program, and who have returned to live in the Republic of the Philippines. For 2018-19, the department estimates that the caseload is around 252 cases. Grant levels are identical to the SSP portion for individuals.

Caseload. The SSI/SSP caseload has generally experienced slow and steady growth over the last decade. However, since 2014-15, caseloads have shown a steady decline. For the 2018-19 Governor's Budget, DSS projects that the caseload for 2017-18 will decrease by 0.5 percent and the caseload for 2018-19 will decrease by another 0.1 percent. The department attributes this slowing growth largely to program attrition and less income eligible individuals, as asset limits have not changed since 1989.

Maintenance-of-Effort. 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 CalFresh benefits, due to the state's "cash-out" policy.

SSI Cash-out. State policy provides SSI/SSP recipients an extra $10 payment in lieu of their being eligible to receive federal food benefits through California's CalFresh program. The Legislative Analyst's Office (LAO) was directed by the 2017-18 Budget Act to assess the effects of ending the cash-out. The analysis weighs the potential benefits and risks of this course of action, and ultimately illustrates how, due to serious data limitations, it is complicated in its impacts on various populations that receive SSI.

Cost-of-Living Adjustment (COLA). Under current law, the federal SSI and grant payments for SSI/SSP recipients are adjusted for inflation each January through cost-of-living adjustments (COLAs). The state COLA for the SSP grant was suspended periodically throughout the 1990s and into the 2000s. The SSP COLA was permanently repealed in 2011 through statute. However, in 2016-17, the Administration proposed and the Legislature approved a one-time SSP COLA of 2.76 percent, which provided an additional $4.63 for individuals and $11.73 for couples per month.

Grant Levels. The chart below displays the maximum monthly SSI/SSP grant for individuals and couples in 2008–09, as compared to grant levels for 2018–19. Reflecting SSP grant reductions and the suspension of the state COLA, the combined SSI/SSP maximum monthly grant for individuals and couples has declined as a percentage of federal poverty level (FPL) over this period. Current grants are at 92 percent of the FPL.

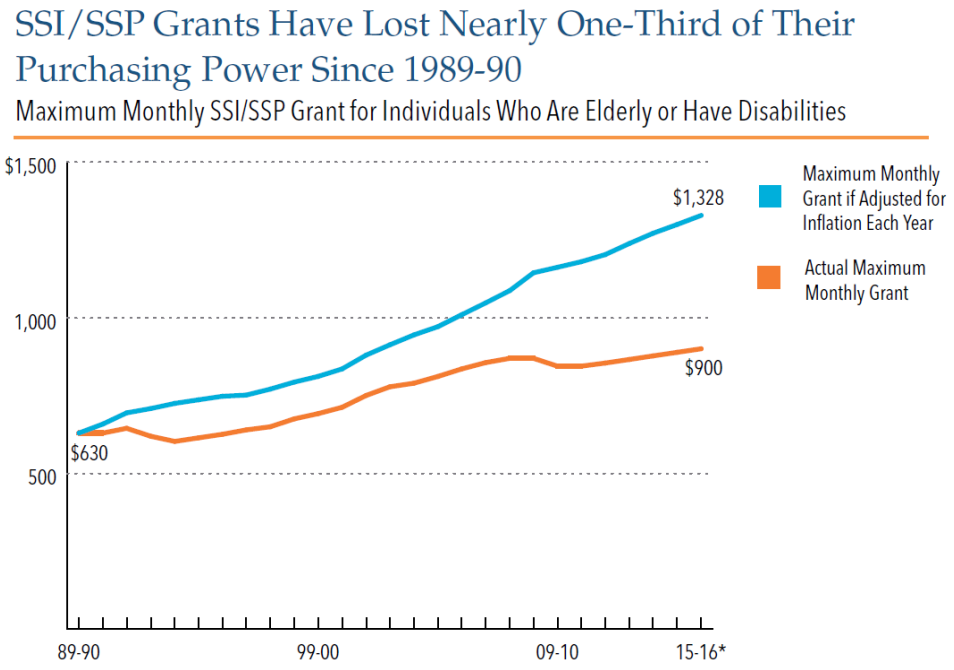
SSI/SSP Maximum Grants: Then and Now

	2008-09	2018-19 Governor's Estimates	Change From 2008-09
Maximum Grant—Individuals[a]			
SSI	$674	$770	$96
SSP	233	161	-72
Totals	**$907**	**$931**	**$24**
Maximum Grant—Couples[a]			
SSI	$1,011	$1,155	$144
SSP	568	407	-161
Totals	**$1,579**	**$1,562**	**-$17**

[a] Reflects the maximum monthly grants for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective budget year.

According to LAO, after using the California Consumer Price Index to adjust for inflation, the proposed maximum combined SSI/SSP grant for 2017-18 has declined in purchasing power since 2008-09. They estimate that if the 2008-09 maximum grant levels for individuals and couples had increased annually with inflation, they would be roughly $240 and $480 higher than 2018-19 levels.

The chart below compares an individual's SSI maximum grant amount as a percentage of the federal poverty level and demonstrates its loss of purchasing power since 1989.



Source: California Budget and Policy Center. "California Budget Perspective 2015-16." March 2015. http://calbudgetcenter.org/wp-content/uploads/Budget-Perspective-2015_16-03.04.2015.pdf

Other grant increase options. Other methodologies can be used to provide an adjustment to the SSI/SSP COLA. 2016-17's COLA applies the CNI to only the SSP portion. However, in prior SSI/SSP grant increases, the CNI was applied to the entirety of the grant. Additionally, last year's COLA is a one-time increase. Prior to 2011, the Legislature had the ability to provide annual COLA adjustments to SSP portion of the grant.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the SSI/SSP program and budget.

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

Staff Comment. Hold open.

Issue 7: Housing Disability and Advocacy Program (HDAP)

Governor's Proposal. In 2016-17, the Senate "No Place Like Home" package of homelessness initiatives included a one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible poor people enrolled in the SSI/SSP program. $45 million General Fund was approved for this purpose, and named the Housing and Disability Advocacy Program (HDAP). $513,000 of the $45 million was carved out to staff the program and get it up and running as soon as possible. HDAP has a dollar-for-dollar county match requirement. The implementation of HDAP was delayed, however, as the 2017-18 Governor's budget proposed to halt implementation. HDAP was eventually included in the final budget for 2017-18, and the $45 million is now available from July 1, 2017 through June 30, 2020.

Background. Applying to SSI is a complicated and challenging process, particularly for applicants that are homeless or have severe mental disabilities. Some studies have indicated that there may be a significant population of individuals who qualify for SSI who are not currently receiving benefits from the program[3]. In fact, many applicants are denied when they first apply, and it is only upon appeal that they receive assistance. In the meantime, which can range from months to year, they must subsist on General Assistance/General Relief (GA/GR) payments from the county, which are substantially less than an average SSI/SSP grant, and utilize emergency services at a high cost to state and local governments.

Some counties are currently investing in SSI advocacy programs to proactively assist applicants with the application process and helping them stabilize in the interim. Best practices include providing modest housing subsidies, transportation and other supportive services, case management, outreach to participants, and collaboration with medical providers.[4] In particular, for individuals approved for SSI, housing subsidies can be recouped through the Interim Assistance Reimbursement (IAR), and these funds can then be applied toward another applicant in need of a housing subsidy. The federal government covers 72% of the total costs of the SSI/SSP program.

Implementation Update. In July of 2017, DSS released a request for proposals to county welfare departments. Proposals were due in the fall of 2017, and as of December 2017 a total of 41 counties applied. Currently, $41 million has been allocated to 39 counties during Phase 1, and there is an additional $3 million left for allocation in Phase 2 to be distributed among the 39 counties on a competitive basis..

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

Questions.

1. Please provide an update on HDAP implementation, and when you expect to hear feedback from counties.

2. Will the department be facilitating the spread of best practices among counties?

[3] http://economicrt.org/publication/all-alone/
[4] http://healthconsumer.org/SSIAdvocacyBestPracticesRpt.pdf

Issue 8: Proposals for Investment

The subcommittee has received the following SSI/SSP-related proposals for investment.

1. Restore the SSI/SSP Grant Cuts and the COLA

Budget Issue. California's for SSI, a statewide coalition of over 200 organizations, requests that SSI/SSP grant cuts and the COLA be restored.

Staff Comment and Recommendation. Hold open. California periodically provided an SSI/SSP COLA until it was repealed in 2009. The 2016-17 budget included a one-time COLA that provided an additional $4 to individuals and $11 to couples per month.

2. SSI Cash-Out report

Budget Issue. Western Center on Law and Poverty requests that the Legislature direct the Department of Social Services to work with stakeholders on developing a plan to 1) enroll SSI recipients in SNAP; 2) develop specific "hold harmless" options; 3) identify legal steps necessary to end cash-out; and 4) identify any technology hurdles that must be solved before enrollment can begin.

Staff Comment and Recommendation. Hold open. Advocates note that according to the LAO report on the cash-out, if the cash-out were ended the state would potentially see a net gain of $205 million in federal SNAP benefits. However, given the potential for some households to lose benefits, it may be that more information is needed before a decision should be made.

5180 – DEPARTMENT OF SOCIAL SERVICES, IN-HOME SUPPORTIVE SERVICES

Issue 9: Overview - IHSS

The In-Home Supportive Services (IHSS) program provides personal care services to approximately over 500,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. Services include feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services help program recipients avoid or delay more expensive and less desirable institutional care settings.

Budget Issue. The budget proposes $11.2 billion ($3.6 billion General Fund) for services and administration. Of that amount, $3.5 billion ($1.8 billion General Fund) is for IHSS Basic Services. While estimates from last year to this year have decreased somewhat, primarily due to lower than anticipated Fair Labor Standards Act (FLSA) costs, costs have increased from year to year. Overall, the increased costs for IHSS in 2018-19 are due to growth in caseload of 5.1 percent, an increase in paid hours per case, the increase in the hourly minimum wage from $10.50 to $11.50, effective January 1, 2018, and county wage increases. Caseload growth and wage increases for IHSS providers continue to be two primary drivers of increasing IHSS service costs.

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. 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 DSS. According to DSS, around 73 percent of providers are relatives, or "kith and kin."

In the current year, IHSS providers' combined hourly wages and health benefits vary by county. 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 seven counties – Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara – participating in Coordinated Care Initiative (CCI) shifted to an IHSS Authority administered by the state. With the ending of the CCI, however, collective bargaining was returned to counties, and various new provisions related to collective bargaining were added in the 2017-18 budget, to be discussed further in the next item.

Program Funding. The average annual cost of services per IHSS client is estimated to be approximately $18,000 Total Funds for 2018-19. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. Before the CCI, the county IHSS share-of-cost (SOC) was determined by 1991 Realignment. When the state transferred various programs from the state to county control, it altered program cost-sharing ratios and provided counties with dedicated tax revenues from the sales tax and vehicle license fee to pay for these changes. Prior to realignment, the state and counties split the non-federal share of IHSS program costs at 65 and 35 percent, respectively.

With the enactment of the CCI, the funding structure changed as of July 1, 2012, with county IHSS costs based on a maintenance-of-effort (MOE) requirement. When the CCI ended in 2017-18, a new MOE was established, which will increase annually by the county share of costs from locally negotiated wage increases and an annual adjustment factor. The new MOE will be discussed further in the next item.

Other Policy Changes. Several recently enacted policies have also impacted the IHSS program, including:

- **Restoration of the seven percent reduction in service hours.** A legal settlement in *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an eight percent reduction to authorized IHSS hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours was changed to seven percent. The 2015 Budget Act approved one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours. Starting in 2016, the seven percent restoration was funded using a portion of the revenues from a restructuring of the existing Managed Care Organization (MCO) tax. The 2018-19 Governor's Budget uses $300 million General Fund to restore the seven percent across-the-board reduction. Restoration of the seven percent reduction is tied to the MCO tax, which is up for renewal in 2019.

- **Minimum wage increases and paid sick leave.** Assembly Bill 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 reached $10 per hour by January 2016. SB 3 (Leno), Chapter 4, Statutes of 2016, will move the state's current $10 per month for minimum wage to $10.50 at the beginning of 2017, and schedules annual increases to $15 for most employers by 2022. As of January 1, 2018, the minimum wage is set at $11.50. The budget includes $260.3 million ($119.4 million General Fund) to reflect the impact of the increasing state minimum wage.

  SB 3 also provides eight hours of paid sick leave to IHSS providers who work over 100 hours beginning July 1, 2018. When the state minimum wage reaches $13, IHSS providers will accrue 16 hours, and when the state minimum wage reaches $15 they will receive 24 hours. $30 million General Fund is included in 20170-18 for this purpose, assuming all providers use their eight hours. Another crucial component of implementing sick leave is the provider back-up system for recipients. The department indicates it has initiated conversations with counties to ensure that recipients know how to find a back-up provider if their regular provider is sick.

- **Fair Labor Standards Act (FLSA)—Final Rule.** FLSA is the primary federal statute dealing with minimum wage, overtime pay, child labor, and related issues. In September 2013, the U.S. Department of Labor issued a final rule, effective January 1, 2015, which redefined "companionship services" and 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). The rule also 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 and overtime pay at one and a half times the regular pay if a provider works more than 40 hours per work week. The final rule began implementation in California on February 1, 2016.

SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, established a limit of 66 hours per week for IHSS providers based on the statutory maximum of 283 hours a month for IHSS recipients and limited travel time for providers to seven hours a week. DSS or counties may terminate a provider in the event of persistent violations of overtime or travel limitations. $274 million General Fund is included in the current year, and $297 million General Fund is included in the budget year, for these purposes.

- **Ending of the Coordinated Care Initiative.** The CCI required health plans to coordinate medical, behavioral health, long-term institutional, and home and community-based services, and set up a MOE and collective bargaining protocol for the counties. However, if the Department of Finance found that the CCI was not cost-effective, all components of CCI and the county MOE agreement would cease operation. The 2017-18 Governor's Budget found that the CCI was no longer cost-effective and did not meet the statutory savings requirements. The Administration discontinued the CCI, which ended the IHSS MOE and returned to the prior state-county sharing ratio, and shifted collective bargaining responsibility back to demonstration counties. SB 90 (Senate Committee on Budget and Fiscal Review), Chapter 25, Statutes of 2017, enacted negotiated changes between the state, counties and labor to the MOE structure and collective bargaining, and the 2017-18 budget allocates funding to counties to mitigate costs incurred due to the ending of the CCI.

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, or escalating penalties will be incurred. Below is an estimate from the department on what the IHSS program could face in penalties if noncompliant:

FY 2018-19	$13,175,000
FY 2019-20	$29,480,000
FY 2020-21	$50,087,000
FY 2021-22	$93,898,000
FY 2022-23	$144,181,000
FY 2023-24	$179,718,000

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. IHSS consumers and stakeholders have expressed great trepidation around the prospect EVV, as it has the potential to be extremely disruptive, depending on how prescriptive federal guidance ends up being. The department has been communicating with stakeholders, and will hold a call on March 9, 2018 to discuss the results of the Request for Information (RFI) that was sent out in the fall of 2017.

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. In an effort to streamline timesheet processing, and in response to requests from IHSS stakeholders, DSS implemented online IHSS timesheets in three pilot counties in June 2017. A four-wave rollout to all counties began in August 2017 and was completed in November 2017. The online timesheet system uses technology that

is easy to use on PCs, smartphones and tablets and provides real-time data validation, which means timesheet errors can be corrected before the timesheet is submitted. Providers and recipients are 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. So far, reception of the electronic timesheets has been positive and the department is seeing participation grow. As of February 19, 2018, 90,000 providers and 99,855 recipients are enrolled to use electronic timesheets, which is a provider adoption rate of 18.6 percent. The department is also working on plans to increase the use of direct deposit as well as other electronic funds transfer options.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview for the IHSS program, including caseload and funding levels.

2. Please provide an update on the status of EVV. What are the options DSS is exploring around implementation? Can you share any information about the RFI?

3. Please summarize current implementation of electronic timesheets. What is the department doing to encourage providers and recipients to enroll?

4. Is the department still working to increase the use of direct deposit? If so, how are these efforts going?

5. Does the department have a statewide approach to a provider back-up system for the implementation of paid sick leave?

Issue 10: Update: IHSS MOE Changes

Budget Issue. The 2017-18 budget ended the Coordinated Care Initiative (CCI) funding structure, which in turn automatically ended the In-Home Supportive Services (IHSS) Maintenance-of-Effort (MOE) and returned to the prior state-county cost-sharing ratio, and shifted collective bargaining responsibility back to demonstration counties. SB 90 (Senate Committee on Budget and Fiscal Review), Chapter 25, Statutes of 2017, enacted negotiated changes between the state, counties and labor to the MOE structure and collective bargaining, and the 2017-18 budget allocates funding to counties to mitigate costs incurred due to the ending of the CCI.

End of the Coordinated Care Initiative. CCI required health plans to coordinate medical, behavioral health, long-term institutional, and home and community-based services. The intent of CCI was to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings by reducing institutional care. A 2012-13 budget trailer bill related to the enactment of the CCI, changed the funding in IHSS from a state and county split of the non-federal share of IHSS program costs at 65 and 35 percent to a MOE requirement as of July 1, 2012. Starting July 1, 2014, a 3.5 percent annual inflation factor was applied to each county's funding base along with any adjustments for approved county negotiated wage and health benefit increases. The state assumed responsibility for any additional costs that would have historically been paid under the previous county share of cost, although with a $12.10 cap on state wage and benefit participation.

Language embedded in the CCI required the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI was not cost-effective, all components of CCI and the county MOE agreement would cease operation. The 2017-18 Governor's Budget found that the CCI was no longer cost-effective and did not meet the statutory savings requirements. The Administration discontinued the CCI, which ended the IHSS MOE and returned to the prior state-county sharing ratio, and shifted collective bargaining responsibility back to demonstration counties.

MOE Changes. The new MOE increased county IHSS costs to reflect estimated 2017-18 IHSS costs, creating a new MOE base that includes both services and administration costs. The county MOE will increase annually by an inflation factor and the counties' share of costs associated with locally negotiated wage increases. Beginning July 1, 2018, the inflation factor be five percent, and for 2018-19 is estimated to be $86,987,000. Beginning July 1, 2019, and annually thereafter, the inflation factor will be seven percent. These amounts may also change depending on 1991 realignment revenues in any given year, as they did in the current year.

The IHSS MOE for 2017-18 was established at $1,769,443,000, based on the estimated county share of IHSS services and administration costs in the 2017 May Revision budget. The Governor's Budget updates this to $1,739,753,000 based largely on lower than anticipated Fair Labor Standards Act (FLSA) costs. Below is a chart provided by the Legislative Analyst's Office displaying the difference in these numbers.

Increase in IHSS County MOE Costs

(In Millions)

	2017–18		2018–19 Governor's Budget	Change From Revised 2017–18
	Appropriation	Revised		
Total IHSS County MOE Costs[a]	**$1,768**	**$1,740**	**$1,835**	**$95**
Share of IHSS service costs	1,672	1,630	1,720	90
Share of IHSS administrative costs	96	110	115	5

[a]Total IHSS county MOE costs are partially offset by General Fund assistance provided to counties to assist them in meeting their increased IHSS MOE costs in 2017–18 ($400 million) and 2018–19 ($330 million).

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

Changes in Administration Costs. SB 90 directed DSS, the Department of Finance, and the counties to examine the workload and budget assumptions related to the administration of the IHSS program for 2017-18 and 2018-19.While the General Fund is now expected to pay all nonfederal IHSS service costs above the counties' MOE expenditure level, the amount of General Fund that can be used for county IHSS administrative costs is capped at $220 million in 2017-18 and $208 million in 2018-19. The table above shows the county share of administration costs in 2017-18 as $110 million and in 2018-19 as $115 million. Total funding in the Governor's Budget for IHSS administrative costs in 2018-19, including federal funding, is $640 million. This includes automation costs, public authority costs, and direct service-related and fixed administrative costs. These administrative cost estimates are based on updated assumptions about average county wages and the average number of county workers needed to fulfill required activities at current caseload levels. In future years, it is expected that administrative costs will be increased according to the yearly growth in IHSS.

Counties and Public Authorities are still in conversations with the department regarding the development of budgeting methodology.

Panel. The subcommittee has requested the following panelists, in addition to the Department of Social Services, to provide comment on the changes to IHSS Administration costs and developing methodology:

- Frank Mecca, California Welfare Director's Association (CWDA)
- Karen Keeslar, California Association of Public Authorities (CAPA)

County Cost Mitigation. To help mitigate the impact of the ending of the CCI and the transition to the new IHSS MOE, the 2017-18 budget appropriates $400 million for 2017-18, $330 million for 2018-19, $200 million for 2019-20, and $150 million in 2020-21 and ongoing. These funds are a combination of General Fund and a temporary redirection of realignment funds (Vehicle License Fee growth from the Health, County Medical Services Program, and Mental Health Subaccounts). For 2017-18, the IHSS

county mitigation is $351 million General Fund, and the redirection from realignment funds is $48 million. For 2018-19, the IHSS county mitigation is $285 million General Fund, and the redirection from realignment funds is $44 million.

Below is a chart provided by the Department of Finance to provide further detail on the County IHSS Mitigation costs:

2018-19 Governor's Budget

County IHSS Mitigation
($ millions)

	2017-18	2018-19	2019-20	2020-21	2021-22
Increased County IHSS Costs[1/]	$563.9	$657.7	$786.1	$923.5	$1,070.6
Carryover of Excess Realignment Funds from Prior Year			-$13.3		
Increased County IHSS Costs Before Offsets	$563.9	$657.7	$772.8	$923.5	$1,070.6
Offsets:					
Realignment Growth Funds[2/]					
Available Sales Tax Growth	-$84.3	-$250.6	-$355.9	-$470.8	-$564.9
Redirect Mental Health VLF Growth	-$40.1	-$72.0	-$99.9	-$112.7	-$125.2
Redirect Health/CMSP VLF Growth	-$16.7	-$31.2	-$43.9	-$49.7	-$55.4
Redirect AB 85 VLF Savings	-$16.9	-$31.7	-$44.5	-$50.4	-$56.2
State General Fund[3/]	-$351.4	-$285.5	-$149.6	-$93.8	-$150.0
Total Offsets	-$509.4	-$671.0	-$693.8	-$777.4	-$951.7
Net Increase/Decrease in County Costs[4/]	$54.5	-$13.3	$79.0	$146.1	$118.9
Net Increase in County Costs at 2017 Budget Act	$141.0	$128.6	$229.8	$251.0	N/A
Change in Net County Costs from 2017 Budget Act to 2018-19 Governor's Budget	**-$86.5**	**-$141.9**	**-$150.8**	**-$104.9**	**N/A**
Total GF Impact	-$400.0	-$330.0	-$200.0	-$150.0	-$150.0

[1/] Resets county IHSS base costs in 2017-18 using historical state/county cost-sharing ratios. 5-percent growth factor applied in 2018-19 and 7-percent growth factor applied annually thereafter.
[2/] Reflects year growth is allocated and paid to counties instead of accrual year.
[3/] Amounts adjusted to reflect accrual of AB 85 growth in year prior to county allocation.
[4/] Negative amount in 2018-19 indicates reserve funds that would be available in subsequent fiscal years.

Collective Bargaining Changes. Currently, collective bargaining is conducted at the county-level. SB 90 maintains that counties pay 35 percent of the nonfederal share of costs associated with negotiated wage increases, with 65 percent state participation. The state will pay its 65 percent share in county negotiated wages up to $1.10 above the hourly minimum wage set in SB 3 (Leno), Chapter 4, Statutes of 2016. For counties at or exceeding the current state participation cap of $12.10, the state would participate at its 65 percent share of costs up to a ten percent increase in wages until the state minimum wage hits $15. All wage increases will result in an adjustment to the county's IHSS MOE requirement. Total county service costs that exceed the county IHSS MOE are shifted to General Fund.

Additionally, beginning July 1, 2017, if a county does not conclude bargaining with its IHSS workers within nine months, the union may appeal to the Public Employment Relations Board (PERB). Currently, no appeal has been made to the PERB concerning IHSS bargaining.

Recent Clarifications. AB 110 (Senate Budget and Fiscal Review Committee) makes several clarifications in order to provide further guidance to counties as they begin the negotiation process for increasing wages or benefits for IHSS providers including outlining that the wage supplement will be subsequently applied when the state minimum wage equals or exceeds the county provider wage absent the wage supplement amount, and how the wage supplement will work if a county shifts the existing amounts it pays for wages and health benefits, which was not addressed previously.

Long-term implications for Realignment. Given the complexities of realignment, layered now with the temporary redirection of a portion of these funds, the Department of Finance, in consultation with the counties and other affected parties, is statutorily required to reexamine the funding structure within 1991 Realignment and to report findings and recommendations regarding the IHSS MOE and other impacts on 1991 Realignment programs, as well as the status of collective bargaining for IHSS programs in each county, by no later than January 10, 2019.

Stakeholder Perspectives. The counties and labor organizations were actively involved in negotiating the various MOE and collective bargaining changes last year and clarifications this year. So far, no concerns have been raised with current year implementation.

Staff Comment and Recommendation. This is an informational item, and no action is required. However, the changes made to 1991 Realignment funding overall were comprehensive and it may take some time to fully understand the consequences not only to the IHSS Program but other programs that draw from the redirected realignment funds. With the required reporting due next year, the Legislature should continue to monitor implementation closely. Similarly, the Legislative Analyst's Office points out that the Legislature should consider what additional data may need to be collected to further inform efforts to modify the budget assumptions regarding IHSS administration costs for next year.

Questions.

1. Please provide a summary of the changes to the IHSS MOE and collective bargaining and an update regarding implementation. In particular, please discuss the assumptions and changes relating to the IHSS administration methodology.

2. How have stakeholders been involved in current year implementation, and what has their feedback been on the process?

3. Please share if there have been any preliminary discussions on what kind of information will be included in the report due next year.

Issue 11: Oversight – Fair Labor Standards Act (FLSA) Overtime Implementation

Governor's Proposal. The 2018-19 Governor's Budget provides $533.2 million ($246.4 million General Fund) in 2017-18 and $582.2 million in FY 2018-19 ($268.9 million General Fund) for the implementation of the federal requirements. Funding for 2017-18 is less than originally estimated, as fewer providers are working overtime, and those that are claim less additional hours. However, there is a year over year increase from current year to budget year. The Governor's budget estimates that 13 percent of providers with a single recipient and 8.2 percent of providers with multiple recipients typically work more than 40 hours per week. The total funding is allocated as follows:

- FLSA Overtime: $478.5 million in FY 2017-18 and $522.3 million in FY 2018-19
- FLSA Travel: $27.2 million in FY 2017-18 and $29.6 million in FY 2018-19
- FLSA Provider Exemptions: $14.4 million in FY 2017-18 and $17.9 million in FY 2018-19
- FLSA Administration: $8.0 million in FY 2017-18 and $8.3 million in FY 2018-19
- CMIPS II FLSA changes: $4.0 million in FY 2017-18 and FY 2018-19
- CMIPS II FLSA Provider Exemptions System Change: $1 million in FY 2017-18

Background. The new FLSA overtime regulations require states to pay overtime compensation, and to compensate 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 overtime at one and a half times the regular pay if a provider works more than 40 hours per work week.

SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, established a limit of 66 hours per week for IHSS providers based on the statutory maximum of 283 hours a month for IHSS recipients and limited travel time for providers to seven hours a week. DSS or counties may terminate a provider in the event of persistent violations of overtime or travel limitations. The final rule was implemented in California effective February 1, 2016.

Exemptions. Beginning May 1, 2016, two exemptions were established for limited circumstances that allow the maximum weekly hours to be exceeded:

- Exemption 1 – Live-In Family Care Provider: Is granted for live-in care providers residing in the home for two or more minor or adult children or grandchildren or step-children with disabilities for whom they provide IHSS services and who meet specified requirements on or before January 31, 2016. The projected average monthly caseload is 1,300 providers in 2016-17 and 2017-18. Providers who meet the specific criteria for this exemption will be allowed to work up to 12 hours per day, or 90 hours per week, not to exceed 360 hours per month.
- Exemption 2 – Extraordinary Incurable Circumstances: Is granted on a case-by-case basis for providers who work for two or more IHSS recipients that have extraordinary circumstances including complex medical and behavioral needs, living in a rural or remote area, or language

barriers that place the recipient(s) at imminent risk of out-of-home institutionalized care. The projected average monthly caseload is 135 in 2016-17 and 385 in 2017-18. It is estimated that the number of providers who qualify for this exemption will reach 250 by the end of 2016-17 and 500 by the end of 2017-18. Providers who meet the specific criteria for this exemption will be allowed to work up to 12 hours per day, or 90 hours per week, not to exceed 360 hours per month.

The 2017 Budget Act codified these exemptions, and required that as part of an initial IHSS assessment and any subsequent reassessments, county social workers evaluate IHSS recipients to determine if their provider is eligible for either exemption. The department is also required written notification to the provider and recipients of its approval or denial of an exemption, and to establish an appeals process through the State Hearings Division. The department is working with stakeholders on this process, and a draft All-County Letter should be sent out in March.

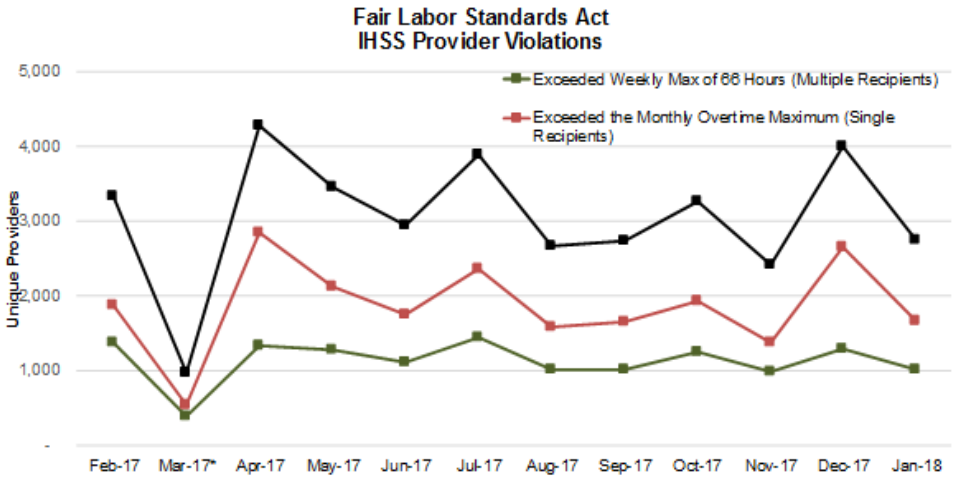
Violations Process. The first time a provider exceeds the work or travel limits, they receive a written notice. For second violations, providers will be offered a one-time opportunity to voluntarily review the instructional materials and sign a certification form stating that they understand and agree to the requirements, and their violation will be rescinded. After a second violation that is not rescinded, county staff must contact the provider. The third violation results in a three-month suspension and a fourth violation results in the provider's termination for one year.

Exemptions and Violations Data. The department states that it has engaged in an extensive communication campaign in conjunction with stakeholders. This campaign included statewide informational mailings, a training video that was made available on the internet and for counties and public authorities to show locally, and trainings for trainers so that information could be disseminated to providers in the most personalized methods possible.

Exemption 1: As of 2/08/2018, there were 1,550 providers approved to date (1,390 have a current exemption), 755 denied, and zero pending.

Exemption 2: As of 2/08/2018, there were 121 providers approved to date (102 have a current exemption), 99 denied, and eight pending.

In 2017, an average of 3,000 providers per month received a violation. Below are two charts from DSS documenting violations data:



Violation Type	Feb-17	Mar-17*	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Exceeded Weekly Max of 66 Hours (Multiple Recipients)	1,372	386	1,342	1,274	1,119	1,447	1,010	1,018	1,258	985	1,298	1,017
Exceeded the Monthly Overtime Maximum (Single Recipients)	1,872	545	2,843	2,128	1,750	2,359	1,585	1,651	1,937	1,374	2,647	1,662
Exceeded the Travel Maximum1	93	47	96	64	77	84	69	69	63	57	57	76
Statewide Total	**3,337**	**978**	**4,281**	**3,466**	**2,946**	**3,890**	**2,664**	**2,738**	**3,258**	**2,416**	**4,002**	**2,755**
Providers with 2 violations2	772	151	787	629	596	823	498	543	530	472	681	506
Providers with 3 violations2	239	47	240	183	167	217	147	167	152	148	184	124
Providers with 4 violations2	0	8	22	16	23	12	15	18	17	14	23	14

Ongoing Implementation Monitoring. 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 was due in April 2017.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please describe what you are seeing with the two exemptions and violations data. Do you expect these current trends to continue?

2. How many providers have been terminated or are near termination? Please discuss continued efforts to train providers.

3. Please provide an update on the creation of an appeals process for exemptions in the State Hearings Division. What is the target date for implementation?

Issue 12: Budget Change Proposal: In-Depth Monitoring of the In-Home Supportive Services Program

Governor's Proposal. The Administration requests a total of six permanent positions (one Staff Services Manager I (SSM I) and five Associate Governmental Program Analysts (AGPAs) and $780,000 ($390,000 General Fund) in 2018-19 and $712,000 ($356,000 General Fund) annually thereafter to provide in-depth monitoring and technical assistance to help improve county administration of the IHSS program.

Background. The Quality Assurance (QA) Monitoring Unit within DSS currently consists of one SSM I and eight AGPAs who perform county monitoring reviews to oversee the administration of, and compliance with, approved Quality Assurance/Quality Improvement plans, and statutes and regulations of the IHSS program. The QA Monitoring Unit also provides technical support and consultation to county QA staff to assist counties. DSS claims that due to limited resources, the QA Monitoring Unit is unable to provide in-depth monitoring and increased technical assistance to all counties. Additionally, they do not currently have the capacity to identify and address IHSS program cost trends, as the average number of hours paid per case has seen an increase of 21 percent between 2012-13 (86.3 hours) and 2015-16 (105.3 hours). DSS also points to an increased workload for QA staff due to the increased IHSS caseload and implementation of the Fair Labor Standards Act administrative changes and related overtime exemption procedures.

The Administration posits that these additional positions will allow the QA Monitoring Unit to better meet its state and federal oversight mandates by enhancing their ability to conduct annual in-depth monitoring of all counties, evaluate county administration of the IHSS program, deal with increased workload, and help to identify which specific IHSS program components are driving overall program costs.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

2. Specifically, what has activities has the QA Monitoring Unit been unable to perform, or in how many counties has it been unable to meet its statutorily required duties, with current resources?

3. Please explain in further detail what increased monitoring and technical assistance will look like.

4. What are planned next steps after workers gather information on program cost trends?

Issue 13: Proposals for Investment

The subcommittee has received the following IHSS-related proposals for investment:

1. Rescind the seven percent across the board cut to IHSS service hours

Budget Issue. The UDW and AFSCME Local 3930 request that the seven percent across the board cut to IHSS services hours be fully and permanently restored, regardless of the state Managed Care Organization (MCO) tax, from which the restoration is currently funded.

Staff Comment and Recommendation. Hold open. Due to a legal settlement, IHSS service hours were reduced by eight percent for all recipients for one year in 2013, with a seven percent cut annually after the first year. The cut was restored in 2016-17 using proceeds from the MCO tax, which is up for renewal in 2019. Currently in statute, the restoration of the seven percent is tied to the MCO tax; the cut will be reinstated if the MCO tax becomes inoperable.

2. Oppose Electronic Visit Verification (EVV)

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU oppose the new federal requirement for personal care services programs like IHSS to implement EVV beginning January 2019 or lose federal funding for these programs.

Staff Comment and Recommendation. Hold open. Further federal guidance is forthcoming, and currently it is unclear how EVV would work. California would be at risk for approximately $13 million for noncompliance in 2018-19. It is unclear how much compliance would cost, given the lack of federal guidance.

3. Expedite IHSS Provider Enrollment

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU request a modest appropriation to expedite the provider enrollment process at the county level. It can take several weeks or even months before a new IHSS provider is enrolled into the program and they are mailed their first timesheet. This delay impacts the ability of IHSS consumers to recruit and retain new workers.

Staff Comment and Recommendation. Hold open. The Department of Social Services is in discussions with counties to work on remedies for this issue.

4. Fund Health Care Benefits and establish an Employer of Record for Waiver Personal Care Services (WPCS) Providers

Budget Issue. The California Association of Public Authorities (CAPA), UDW and AFSCME Local 3930 and the SEIU request $3.5 million General Fund to establish an employer of record and provide health care benefits for approximately 700 WPCS providers in California. Currently, WPCS providers cannot receive health benefits because their hours are not covered by existing collective bargaining agreements.

Staff Comment and Recommendation. Hold open.

5. Paid Sick Leave Implementation

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU request that the Administration develop a comprehensive provider back-up system by the time paid sick leave is implemented for providers in July 2018.

Staff Comment and Recommendation. Hold open.

6. Addressing the Automation Backlog in IHSS

Budget Issue. CWDA requests $2.5 million General Fund one-time to address the backlog of pending automation changes in CMIPS. CWDA asserts that counties have submitted numerous change requests to fix various problems and improve functionality in CMIPS, but these have not been implemented. Further, they claim that changes related to FLSA implementation and electronic timesheet have not been adequately funded, leaving some counties behind.

Staff Comment and Recommendation. Hold open.