# In-Home Supportive Services: Coordinated Care Initiative

## BACKGROUND

The passage of the Coordinated Care Initiative (CCI) in 2012 created some major changes in the In-Home Supportive Services (IHSS) program. With the Governor's proposal to repeal the IHSS provisions of CCI this year, the Legislature must address some important questions related to sharing of IHSS costs between the county and the state, whether or not the IHSS portion of the CCI had any merits that may be worth saving, and what long-term implications for programs other than IHSS may be.

The IHSS program provides personal care services to approximately 531,000 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. A proposed budget of $10.6 billion ($3.2 billion General Fund) for services and administration includes funding for compliance with federal overtime regulations and state minimum wage increases.

**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 the Department of Social Services (DSS). According to DSS, around 73 percent of providers are relatives, otherwise known as "kith and kin."

In the current year, IHSS providers' combined hourly wages and health benefits vary by county, and range from approximately $10.00 to $18.00 per hour. Prior to July 1, 2012, county public authorities or nonprofit consortia were designated as "employers of record" for collective bargaining purposes, while the state administered payroll and benefits. Pursuant to 2012-13 trailer bill language, however, collective bargaining responsibilities in seven counties participating in the Coordinated Care Initiative (CCI) – Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, shifted to an IHSS Authority administered by the state. The CCI is further discussed in the Health section of this document.

**Program Funding.** The average annual cost of services per IHSS client was estimated to be around $15,500 for 2015-16. 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.

A 2012-13 budget trailer bill, related to the enactment of the CCI, changed this structure as of July 1, 2012, with county IHSS costs based on a maintenance- of-effort (MOE) requirement. The MOE works differently depending on the county. For a select 15 smaller counties, the MOE levels are based either on the 2011-12 county allocations or county expenditures, whatever is lower. For the other 43 counties, the MOE levels are based on county expenditures in 2011-12. Starting July 1, 2014, a 3.5 percent annual inflation factor was applied to this 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 SOC. However, language embedded in the CCI requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI and the county MOE agreement would cease operation.

**Coordinated Care Initiative.** CCI requires health plans to coordinate medical, behavioral health, long-term institutional, and home and community-based services. Counties continue to administer the program under existing standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings by reducing institutional care.

**Universal Assessment Tool.** In 2012, the Legislature authorized the development and pilot implementation of a universal assessment tool (UAT). The Department of Health Care Services (DHCS), the Department of Aging (CDA), and DSS were tasked with developing a UAT to assess a Medi-Cal beneficiary's need for home and community-based services. The goal was to enhance personalized care planning under CCI, and create a common tool that can be used by all involved in the care of beneficiaries who need home and community-based, long-term care services.

As of last year, DSS, DHCS and CDA continued to work with a design team from the UCLA Boren School of Gerontology to prepare a draft UAT for focus group, pre-pilot and pilot testing. UAT focus group testing was expected to begin in May 2016, and pre-pilot testing was slated for early 2017.

**Evaluation of IHSS in the CCI.** While there is not robust data available on how the IHSS integration into managed care under the CCI is working, given the short duration of the pilot, a couple of preliminary studies provide some insight into the strengths and weaknesses of the program model. A recent report entitled "Evaluation of CalMediConnect: Results of Focus Groups with Beneficiaries"[1] found that several key stakeholders interviewed found that the program inspired better collaboration and communication between IHSS and plans. Those involved saw the potential for IHSS workers to become more involved and ensure that the number of IHSS hours authorized would be better aligned with the needs of IHSS beneficiaries. However, many IHSS recipients opted out of involvement in the program. Another recent report, "CalMediConnect: How Have Health Systems Responded?"[2] echoed these findings, and both

[1] University of California for the SCAN Foundation, *Evaluation of CalMediConnect: Results of Focus Groups with Beneficiaries* (March 2016): http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_focus_group_report_march_2016.pdf
[2] University of California for the SCAN Foundation, *CalMediConnect: How Have Health Systems Responded* (July 2016): http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf

reports emphasize that more outreach to communities with high opt-out rates, IHSS social workers, and IHSS providers, is needed.

**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 related to *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 $225.9 million in one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours. The 2016-17 Governor's budget uses a portion of the revenues from a restructuring of the existing Managed Care Organization (MCO) tax to restore the seven percent across-the-board reduction beginning July 1, 2016.

- **Minimum wage increases.** 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. 29 counties are impacted by the minimum wage increase in 2016-17.

  In addition, 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. SB 3 also provides three paid sick leave days to IHSS workers beginning July 2018, and requires DSS, in conjunction with stakeholders, to convene a workgroup to implement paid sick leave for IHSS providers and issue guidance by December 1, 2017.

- **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 started 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.

## GOVERNOR'S PROPOSALS:

The Governor's budget estimates that CCI will no longer be cost-effective and does not meet the statutory savings requirements. With this proposal, the IHSS MOE provisions would no longer be in effect and the IHSS program would return to the prior state-county sharing ratio. Responsibility for collective bargaining also returns to counties. The Administration estimates that eliminating the IHSS County MOE provides $665.6 million General Fund savings in 2017-18. The impact of the proposal on funding is shown in the figure below.

**Eliminate IHSS County MOE**

| Funding (In Millions) | FY 2016-17 Appropriation | FY 2016-17 Revised Budget | FY 2017-18 Governor's Budget | FY 2016-17 Change From Appropriation | FY 2017-18 Change From Appropriation |
|---|---|---|---|---|---|
| Total* | $0 | $0 | $0 | $0 | $0 |
| Federal | $0 | $0 | $0 | $0 | $0 |
| State | -$1,113.5 | -$1,117.4 | -$1,779.2 | -$3.8 | -$665.6 |
| County (Reimb) | $1,113.5 | $1,117.4 | $1,779.2 | $3.8 | $665.6 |

*Total TANF/GF impact prior to subaccount funds.

## ISSUES TO CONSIDER

**What are the effects of the Governor's proposal on recipients and providers who participated in the CCI? Can we learn from any successes of the pilot?** One of the goals of the CCI was to integrate long-term services and supports (LTSS) and, by extension, IHSS, into Medi-Cal managed care and improve overall health care coordination for beneficiaries. LTSS provides a type of preventative care that can reduce hospitalizations and help consumers better manage their health conditions in the long-term. While the IHSS model as a whole remains relatively untouched by the dissolution of the CCI, meaning that both recipients and providers are unlikely to notice any changes, it may be worth re-examining why IHSS was included as part of the CCI in the first place, considering if the problems the CCI was trying to solve still exist, and determining if in any way the CCI was able to mitigate some of those issues and improve care for the recipients involved in the program.

**What are we losing by ending the development of the Universal Assessment Tool?** The development of the UAT will also be halted with the Governor's proposal. The UAT has been in development since 2012, and was expected to pilot sometime in 2017. It is important for the Legislature to consider whether the UAT has any merits and meets larger goals for LTSS and home and community-based care outside of the CCI, and if it makes sense to halt the UAT along with the CCI.

**What are the county implications of ending the IHSS MOE and returning to a share-of-cost model?** If the MOE reverted to the prior state-county split, it is important for the Legislature to evaluate more closely how the MOE worked for both the county and state, and consider what will change under the Governor's proposal, given that the SOC ratio was established back during 1991 Realignment. The elimination of the MOE raises questions about whether the counties should pay for cost increases that were approved after 2012, including FLSA overtime (which was federally mandated), state minimum wage increases, and paid sick leave. In particular, counties estimate that with current law capping state wage and benefit participation at $12.10 per hour, if state minimum wage increases shift to the counties, costs could grow into the hundreds of millions in the out years.

It appears that the Administration expects that the counties will now pay a share in all of these cost increases. It is likely that counties will have to use 1991 Realignment dollars for this purpose; however, many of these funds are already used to pay for other programs at the county level, including health and mental health programs. Complicating the 1991 Realignment issue further is AB 85 (Assembly Committee on Budget) Chapter 24, Statutes of 2013, which established the Child Poverty and Family Supplemental Support Subaccount, and takes a portion of 1991 Realignment growth revenues. This subaccount currently funds CalWORKs grant increases and the 2016 repeal of the Maximum Family Grant Rule in out years (see CalWORKs discussion in this section for more information). While 1991 Realignment funding, including the subaccount, is currently expected to grow, it is unclear if it will grow enough to cover all of its current costs, in addition to rapidly increasing IHSS costs. Given the complex nature of Realignment funding, the Legislature will need to consider where funding for ending the IHSS MOE will come from and whether that action will have impacts beyond just the IHSS program.

**What are the implications of ending statewide bargaining for the seven CCI pilot counties?** The Legislature should also evaluate what impact, if any, the elimination of statewide bargaining has for the seven pilot counties and if there are any effects on non-pilot counties.