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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, Chair
Senator William W. Monning
Senator Jeff Stone

March 2, 2017
9:30 a.m. or Upon Adjournment the Joint Legislative Budget Committee
State Capitol, Room 4203

Consultant: Theresa Pena

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4170 DEPARTMENT OF AGING (CDA)

Issue 1: Overview

With a proposed 2017-18 budget of $200.6 million ($33.8 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.

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. Provides nutritionally-balanced meals, nutrition education and nutrition counseling to individuals 60 years of age or older at congregate meal sites or for those who are homebound due to illness, disability or isolation, at home. 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.

Ombudsman and Elder Abuse Prevention. Investigates and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities.

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.

Senior Community Employment. 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.

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.

Current Competitive Federal Demonstration Grants. CDA has been awarded several competitive federal demonstration grants, including:

- Chronic Disease Self-Management Demonstration Grant. Funding for this grant ended in June 2016. At the grant's conclusion, 17,732 Californians had participated in the six-week chronic disease self-management program workshops in various counties. Although federal funding has ended, these workshops continue to be offered in 22 counties by AAAs, County Public Health Departments, and other healthcare and community based organizations.

- Expanding Capacity to Serve Persons with Dementia in the Coordinated Care Initiative. This grant ended in September 2016. However, in September 2016, CDA received additional federal funding to expand the collaboration already underway in providing training and technical assistance to Cal MediConnect care managers to increase their ability to better identify and serve plan members with dementia and refer these individuals and family caregivers to community-based services. Under the original federal grant, these activities were provided in Los Angeles, San Mateo, and Santa Clara counties. With the new funding, these activities will be expanded to Riverside, San Bernardino, and San Diego counties. The Alzheimer's organizations serving those counties are the lead agencies in providing these activities and the federally required matching funds. The total funding for the 18-month expansion grant is $323,493. Although the CCI has been discontinued, CDA does not anticipate any changes to this grant.

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

Questions.

1. Please provide an overview of the department's programs and services, and discuss caseload and demographics of caseload.

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

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

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

MSSP as Part of the Coordinated Care Initiative. Under California's Coordinated Care Initiative (CCI), most Medi-Cal beneficiaries in CCI counties must 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 have entered into contracts with the participating managed care health plans to deliver MSSP waiver services to eligible plan members and are reimbursed by the health plans.

In six of the seven CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara), MSSP continues to be a 1915(c) Home- and Community-Based Services waiver benefit until it transitions to being a fully integrated managed care health plan benefit that is administered and authorized by the plan. In San Mateo County, the transition into managed care occurred on October 31, 2015. While the Department of Finance has informed the Legislature that the CCI is no longer cost-effective pursuant to Chapter 37, Statutes of 2013 (SB 94), 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 integrate long-term services and supports (except IHSS) into managed care. The proposed Governor's budget delays the MSSP transition into managed care in the six remaining counties until no sooner than January 1, 2020.

Beginning in 2018, the California Department of Aging will continue to work closely with the Department of Health Care Services DHCS, MSSP sites, and managed care health plans to address any operational issues and prepare for MSSP's transition to a fully integrated managed care plan benefit in all the designated counties by January 1, 2020. Continuation of Cal MediConnect and integration of long-term services and supports in the six formerly-CCI counties will affect 12 MSSP sites and approximately 4,856 participants. These MSSP sites will continue to contract with managed health care plans and receive payment from them.

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.

Issue 3: Proposals for Investment

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

- Senior Nutrition Program

Budget Issue. The California Association of Area Agencies on Aging and other advocates requests $12.5 million General Fund 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.

4185 CALIFORNIA SENIOR LEGISLATURE (CSL)

Issue 1: Budget Change Proposal: 2016 Budget Act General Fund Reappropriation

Governor's Proposal. The California Senior Legislature (CSL) requests a reappropriation of any unexpended General Fund appropriated in the 2016 Budget Act to be available for expenditure until the end of fiscal year 2017-18 in order to support state operations while the Senior Legislature pursues an ongoing revenue source. The amount projected to roll over is $175,000.

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.

Staff Comment. Given the instability of the tax check-off VCF as a funding source over the last several years and the many competing demands for General Fund resources, staff recommends that the CSL remain proactive in finding other funding sources.

Questions.

1. Please provide an overview of the proposal.

2. What are specific alternative funding sources the CSL is pursuing? When does the CSL anticipate having enough funding from these other sources of funding or the tax check-off?

Staff Recommendation. Hold open.

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

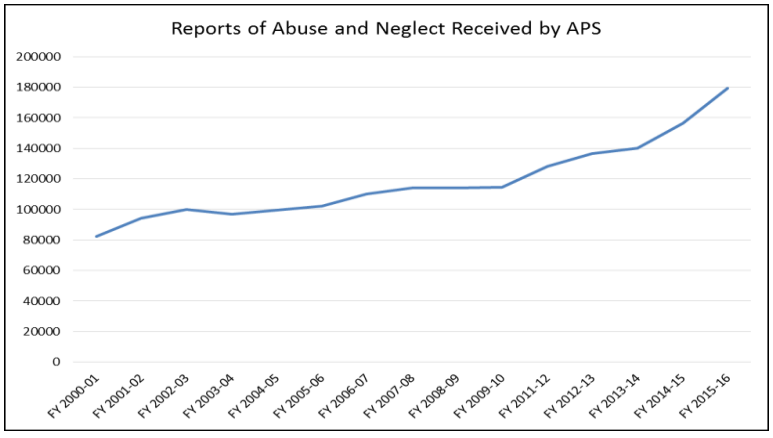
Issue 1: Overview – Adult Protective Services

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.

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 90 percent between 2000-01 and 2014-15.

The chart below shows the upward trend of reports of abuse and neglect received by APS:



[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.

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:

- Amend the current (2015-2017) contracts with the three Regional Training Academies (RTAs) (San Diego State University, UC Davis, and Cal State Fresno) to increase their delivery of core competency classes.

- Add three new (2017-2019) contracts with the same three RTAs 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).

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

Questions.

1. Please briefly summarize the program and services.

2. Please provide an update on how the one-time funds provided in 2016-17 are being used.

Issue 2: Proposals for Investment

The subcommittee has received the following proposal for investment.

- Adult Protective Services Home Safe

Budget Issue. The California Welfare Directors Association requests one-time funding of $10 million General Fund in 2017-18 to establish APS-Home Safe, a homelessness prevention and rapid re-housing demonstration grant program for victims of elder abuse and neglect. This competitive grant program would allow 10 participating counties or groups of counties to help clients maintain their housing through services such as short-term rental or utility assistance, legal assistance, and expanded case management services.

Background. Many elder abuse victims are at risk of losing their homes as a direct result of abuse, neglect, or exploitation. Adults who become homeless later in life have a higher risk of chronic health problems, and have a higher chance of visiting hospital emergency rooms or dying. APS programs have limited or no resources to prevent homelessness or rehouse victims.

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 73,000 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 589 licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. The table below indicates facilities licensed by CCL.

Facility Type	Description
Child Care Licensing	
Family Child Care Home	Less than 24 hour non-medical care in licensee's home.
Child Care Center	Less than 24 hour non-medical care in a group setting.
Children's Residential Facilities	
Adoption Agency	Assists families in the adoption process.
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 care for eligible children under 6 years of age.
Enhanced Behavioral Supports 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 identify and secure out of home placement for children.
Group Homes	24-hour non-medical care 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	A group home to provide voluntary, short-term, shelter and personal services to runaway or homeless youth.
Short Term Residential Treatment Program	Provide short-term, specialized, and intensive treatment and will be used only for children whose needs cannot be safely met initially in a family setting.
Foster Family Home	24-hour care for six or fewer foster children.
Small Family Homes	24-hr. care in the licensee's home for 6 or fewer children, who have disabilities.
Temporary Shelter	County owned and operated facilities providing 24-hour, short-term residential care and supervision to dependent children for up to 10 days after removal from their homes due to abuse or neglect.
Transitional Care Facilities for Children	County owned and operated (or non-profit organization under contract with the County) facilities providing

Facility Type	Description
	short term non-medical care for children to a maximum of 72 hours pending placement.
Transitional Housing Placement	Provides care for 16+ yrs. old in independent living.
Adult & Elderly Facilities	
Adult Day Programs	Community based facility/program for person 18+ years old.
Adult Residential Facilities (ARF)	24-hour non-medical care for adults, 18-59 years old.
Adult Residential Facility for Persons with Special Healthcare Needs	24-hour services in homelike setting, for up to 5 adults, who have developmental disabilities, being transitioned from a developmental center.
Community Crisis Home	24-hour nonmedical care to individuals with developmental disabilities in need of crisis intervention services.
Continuing Care Retirement Communities (CCRC)	Long-term continuing care contract; provides housing, residential services, and nursing care.
Enhanced Behavioral Supports Home	24-hour nonmedical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting.
Residential Care Facilities for the Chronically Ill	Facilities with maximum capacity of 25.
Residential Care Facilities for the Elderly (RCFE)	Care, supervision, and assistance with activities of daily living to eligible persons, usually 60+ yrs. old. Facilities range from 6 beds or less, to over 100 beds.
Social Rehabilitation Facilities	24-hour non-medical care in group setting to adults recovering from mental illness.
Special Agencies	
Certified Family Homes (CFH)	Homes certified by foster family agencies.

As of February 2017, CCL has 1,268 authorized positions and 147 vacancies. There are 140 positions currently in the interview 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. As of December 2016, DSS had licensed over 1,200 Home Care Organizations and registered over 77,000 Home Care Aides and maintains the Home Care Aids Registry.

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

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 2015-16			
Type of Inspection	**Total 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	5,827	5,182 (88.9%)	944 (18.2%)
Random Inspection	21,706	21,010 (96.8%)	1,610 (7.7%)
Required Five-Yr. Visit	1,281	1,135 (88.6%)	297 (26.2%)

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 department notes that the work is complete and DSS is in the process of distributing the results of this project and will consider recommendations moving forward. DSS has preliminarily shared a summary of findings for both studies. 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. The KIT analysis validated that the third iteration of the KIT was the most effective in identifying the need for further inspections for half of the facility types. However, staff is still waiting to receive the full reports to further understand these findings.

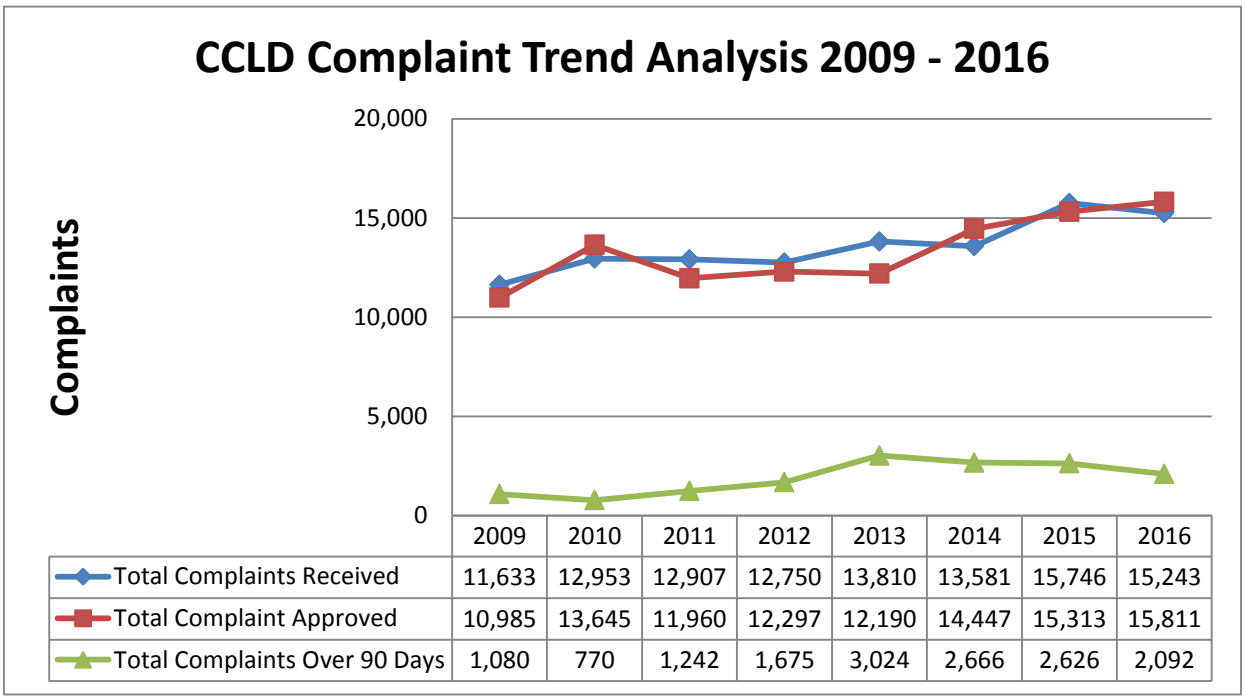
Complaints. Complaints are handled at regional offices. Licensing analysts, who would otherwise be conducting inspections, stay in the regional office two times a month, to receive complaint calls and address general inquiries and requests to verify licensing status from the public. CCL is required to respond to complaints within 10 days. During calendar year 2016, CCL received over 15,000 complaints. The information below provides an analysis of DSS' complaint activity for the years of 2009 through 2016.

[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.

COMMUNITY CARE LICENSING DIVISION COMPLAINT ANALYSIS 2009 - 2016									
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	Total Furlough Days [1]		Avg. Authorized Positions [2]
2009	2,456	11,633	14,089	10,985	3,104	1,080	2 - 5 mo.	3 - 6 mo.	515.4
2010	3,104	12,953	16,057	13,645	2,412	770	3 - 7 mo.	1 - 4 mo.	513.4
2011	2,412	12,907	15,319	11,960	3,359	1,242	1 - 8 mo.	0 - 4 mo.	514.9
2012	3,359	12,750	16,109	12,297	3,812	1,675	0 - 6 mo.	1 - 6 mo.	491.9
2013	3,812	13,810	17,622	12,190	**5,432**	**3,024**	1 - 6 mo.		491.3
2014	5,432	13,581	19,013	14,447	4,566	2,666			501.8 [3]
2015	4,566	15,746	20,312	15,313	4,999	2,626			516.8 [3]
2016	4,999	15,243	20,242	15,811	4,431	2,092			568.8 [4]

Bolded numbers represent highest complaint rollover to next year and total complaints over 90 days

1. Displays the total number of furlough days within the specified period of months for each calendar year. Current Year Net Loss/Gain and Total Complaints Over 90 Days increased annually during the years that furloughs were in effect.
2. Positions include Complaint Specialists.
3. The average authorized positions do not include the LPA positions allocated to the Central Complaint and Information Bureau (CCIB).
4. Total authorized LPA positions as of July 1, 2016. Positions do not include the LPA positions allocated to the CCIB.



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. The additional positions and resources seek to improve the timeliness of investigations; help to ensure the CCL division inspects all licensed residential facilities as statutorily required; increase staff training; establish clear fiscal, program, and corporate accountability; develop resources for populations with medical and mental health needs; and update facility fees. 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. The department filled all of the 70.5 positions within the first seven months of 2014-15 and has also filled all positions authorized in 2015-16. Currently, 70 percent of positions authorized in 2016-17 are filled.

The CCL division has utilized these additional resources to strengthen the infrastructure by implementing many programs which have enhanced best practices, improved resources for licensees and implemented several programs identified below:

Quality Assurance Unit. This unit has developed and implemented performance dashboards for the Adult and Senior Care and Child Care programs. Additionally, the unit has produced documentation of the Most Commonly Cited Deficiencies Analyses for a number of CCL facility types, provided field staff with information that is utilized in preparing for facility inspections, and identified field staff training needs by conducting quality reviews of fieldwork.

Technical Assistance Unit. This unit has re-instituted provider consultation visits and given provider technical assistance inclusive of training, sharing of best practices, and the identification of grant opportunities to assist licensees with physical facility issues such as necessary renovations and repairs. This unit has also published several resource guides that will be posted on CCL's website, available to licensees and utilized for plans of corrections.

Centralized Applications Unit. This unit was established in July of 2014 to centralize the processing of all new Adult and Senior Care applications removing the function from Regional Offices. The unit is focused solely on processing RCFEs and Adult Residential Facilities (ARFs) applications.

Centralized Complaint and Information Bureau. This unit handles all complaint intake as well as facility information calls. DSS developed and widely disseminated a toll free phone number as well as an email address and fax number that is available on CCL's website, and is posted in RCFEs. In 2015,

the contact center received 58, 267 incoming calls and in 2016 this number rose to 97, 052 calls. In 2016, the bureau created 13,770 complaint reports for investigation by the Regional Offices. Additionally, the call center received, reviewed and processed 9,814 faxed or emailed referrals from Child Protective Services, Adult Protective Services, the Long Term Care Ombudsman, Regional Centers, Law Enforcement, Consumers/Residents and the general public. The majority of these referrals resulted in complaint investigations.

Clinical Expertise. The 2014-15 and 2015-16 budgets included resources for a Nurse Practioner and three Nurse Consultants to afford CCL the critical medical expertise necessary to meet the increasing level of medical care of residents in RCFEs and ARFs. With immediate clinical knowledge, skills, and experience, these nurses have enhanced CCL's ability to quickly address the quality of care of residents, address poor performing facilities, and educate struggling operators. The clinicians have conducted two mental health symposiums with expert panels identifying best practices to educate and assist providers in dealing with resident needs. Additionally, they are currently in the process of developing educational guides for providers on addressing pressure ulcers which is a significant care issue in adult and senior care facilities.

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. When can the Legislature expect to see a full KIT analysis or workload study? Can the department share any high-level findings from these publications at this time?

Issue 4: Budget Change Proposal: Continuance of Community Care Licensing Staffing Resources

Governor's Proposal. The Administration requests increased expenditure authority of $3.3 million in the Technical Assistance Fund (TAF) to address various program and service delivery issues within the Community Care Licensing Division. The breakdown of requested funds is as follows:

- $1.4 million to complete timely complaint allegations.
- $1 million to address the growing backlog of RCFE and ARF applications.
- $125,000 to continue implementation of licensing reform efforts related to the RCFE Reform Act of 2014.
- $690,000 in FY 2017-18 and FY 2018-19 and ongoing to fund 5.5 permanent positions (five Licensing Program Analysts (LPAs) and one-half Attorney III) to continue providing functions mandated by AB 388 (Chesbro), Chapter 760, Statutes of 2014.

Background. All licensing fees are deposited into the TAF and are utilized to offset general fund expenditures of licensing functions. The Adult and Senior Care and Children's Residential Programs' civil penalties collected are deposited into the TAF and used only for technical assistance, training, and education of licensees and for emergency resident relocation and care when a license is revoked or temporarily suspended. TAF guidelines specify that the fund should only be used for administrative and other activities to support the licensing program. There is no negative impact to any other programs or departments, as only CCL may utilize these funds.

Complaint Investigations: The 2015 Budget Act approved 13 limited-term (LT) LPA positions to focus on the backlog of complaint investigations that had built up during recession years. At the time, the backlog consisted of 3,300 cases. Since then, DSS has investigated more than 15,500 complaints, resulting in 8,900 citations. The LT positions are set to expire in June 2017, while the amount of complaints continues to rise. Attached is a chart provided by DSS showing the growth of complaints over the last five years.

CCL Children's Residential Program Adult and Senior Care Program Complaints Data

Calendar Year	Total Complaints Rolled Over From Prior Year(s)	Total Complaints Received	Total Complaints Received + Prior Year(s) Rollover	Total Complaints Approved	Ratio of Complaints Approved to Complaints Pending	Current Year Net Loss/gain	Total Complaints Over 90 Days
2012	2,773	8,129	10,902	7,685	0.70	3,217	1,591
2013	3,217	9,228	12,445	7,619	0.61	4,826	2,971
2014	4,826	9,001	13,827	9,780	0.71	4,047	2,600
2015	4,047	10,673	14,720	10,333	0.70	4,387	2,565
2016	4,387	10,319	14,706	10,989	0.75	3,717	2,012

Centralized Application Unit (CAU): DSS states that since the establishment of the Adult and Senior Care Program CAU in 2014, increased statutory and regulatory changes have resulted in staff not being able to process applications in an efficient and timely manner, resulting in the delayed opening of facilities. Examples of increased statutory and regulatory changes include requirements to collect and verify additional information associated with past compliance and financial history. The CAU backlog as of June 2016 was over 691 applications.

RCFE Reform: The establishment of the RCFE reform act, which included nineteen chaptered bills, created a significant policy and regulatory development workload for DSS. The 2015 Budget Act gave DSS a two-year LT Associate Governmental Program Analyst (AGPA) to work with various stakeholders to shoulder this increased workload. While the development of regulations is mostly finished, policy guidance and training is still needed and the LT position is set to expire before this can be completed.

Group Home Oversight: The 2015 Budget Act established 4.5 LT LPAs to implement AB 388. These positions will expire in June 2017, as the workload was expected to decline with the implementation of CCR and phase-out of group homes. However, some group homes will now continue to operate until 2019, and Short-Term Residential Treatment Programs (STRTPs) have been added to the list of facilities required to report to the CCLD. As a result, the AB 388 workload will continue to be ongoing. The requested resources will staff the Regional Offices that conduct this work.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal and provide information on the current state of the TAF.

2. Does the department anticipate that with the resources requested in this BCP, combined with the resources provided over the last several years, it will be able to keep up with the growth in complaints?

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

Issue 5: 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 $10.2 billion total funds ($2.9 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $189 million for the budget year. From 2016-17 to budget year, the budget is projected to increase by $55.2 million General Fund due to a projected average monthly caseload growth and the full-year costs of the one-time 2017 SSP COLA.

Total spending for SSI/SSP grants—including General Fund and federal expenditures (which are not passed through the state budget)—has increased by about $1.1 billion— or 12 percent—between 2007–08 and 2015–16. 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 2017-18, the estimated monthly average caseload is 15,646 cases for both CAPI and 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 2017-18, the department estimates that the caseload is around 313 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 at an average of approximately 0.9 percent annually. However, for 2016-17, there is actually a 0.6 percent decline from the prior year. Caseload will increase slightly into 2017-18 by 0.1%. The department attributes this slowing growth to program attrition.

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.

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.

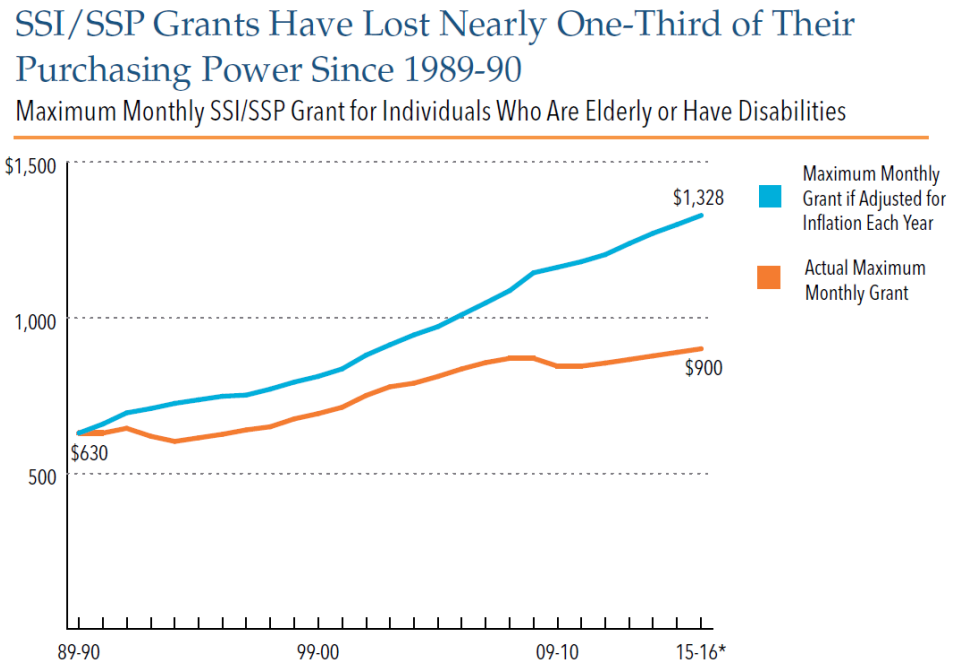
Grant Levels. The chart below displays the maximum monthly SSI/SSP grant for individuals and couples in 2007–08, as compared to grant levels for 2017–18. Reflecting SSP grant reductions and the suspension of the state COLA, the combined SSI/SSP maximum monthly grant for individuals and couples has declined as a percentage of federal poverty level (FPL) over this period.

	2007-08	**2017-18**
Maximum Grant—Individuals		
SSI	$637	$735
SSP	233	160
Totals	**$870**	**$895**
Percent of FPL	102.3%	89.1%
Maximum Grant—Couples		
SSI	$956	$1,103
SSP	568	407
Totals	**$1,524**	**$1,510**
Percent of FPL	133.6%	112.0%

According to the Legislative Analyst's Office (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 2007-08:

- Represents roughly $132 less purchasing power for individuals.
- Represents roughly $296 less purchasing power for couples.

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. Last year'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 6: Housing Disability and Advocacy Program (HDAP)

Governor's Proposal. Last year, 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. However, the Governor's budget proposes to halt implementation of the HDAP and scores the $45 million as savings in the budget year.

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.

Panel. The subcommittee has requested the following panelists, in addition to the Department of Social Services, to provide comment on SSI Advocacy:

- Mike Herald, Western Center on Law and Poverty
- Trent Rohrer, Executive Director at City and County of San Francisco - Human Services Agency
- Leepi Shimkhada, Director of Housing and Services, Housing for Health, LA County Department of Health Services

Staff Comment and Recommendation. Staff recommends that the Subcommittee not approve the Governor's proposal to halt implementation of the HDAP, and instead use the $45 million General Fund as intended in the 2016-17 budget to fund the HDAP in the current year. The HDAP was part of the Senate's "No Place Like Home" package, many components of which were also included in the 2016 Budget Act. While the rest of the "No Place Like Home" pieces were left in-tact in the Governor's Budget, the Administration chose to cut HDAP despite its potential to provide overall savings by maximizing federal dollars and to combat homelessness.

[3] http://economicrt.org/publication/all-alone/

[4] http://healthconsumer.org/SSIAdvocacyBestPracticesRpt.pdf

Questions.

1. Please discuss what efforts went into getting HDAP ready to implement in the fall of 2016.

2. Please provide insight into why implementation of HDAP halted.

3. Please discuss the department's current efforts to ensure that all eligible individuals are applying to SSI and what help is available to applicants who are denied.

Issue 7: Proposals for Investment

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

- Restore the SSI/SSP Grant Cuts and the COLA

Budget Issue. The CA4SSI coalition requests restoration on the SSP grant cuts and the COLA to bring individuals to at or above the federal poverty level (FPL). This would be a three-step process: 1) In January 2018, the SSP grant would be increased and equal to 96 percent of the FPL when combined with the SSI grant; 2) In January 2019, the SSP grant would be increased to equal 100 percent of the FPL when combined with the SSI grant; and 3) After 2019, the statutory COLA would be restored.

Background. Currently, the individual SSI/SSP grant is worth 89% percent of the FPL.

Staff Comment and Recommendation. Hold open.

- Restore HDAP SSI Advocacy for GA/GR Recipients

Budget Issue. The Western Center on Law and Poverty opposes the Administration's proposal to defund the HDAP program and urges a strategy that will aid a portion of Californians reliant on GA/GR by assisting them in the SSI application process and providing other services and supports while they are waiting to be approved for SSI.

Background. The Western Center on Law and Poverty notes that approximately 130,000 Californians receiving GA/GR may be eligible for SSI, and that it is in California's interest to maximize the number of people receiving these federal dollars.

Staff Comment and Recommendation. Hold open.

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

Issue 8: Overview - IHSS

The In-Home Supportive Services (IHSS) program provides personal care services to approximately 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 $10.6 billion ($3.2 billion General Fund) for services and administration. Of that amount, $3.5 billion ($1.8 billion General Fund) is for IHSS Basic Services, an overall increase due to growth in caseload of 5.3 percent, and higher cost per hour, due to the increase in the hourly minimum wage from $10 to $10.50, effective January 1, 2017, 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, 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 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.

Coordinated Care Initiative. CCI requires Cal Medi-Connect to coordinate medical, behavioral health, long-term institutional, and home and community-based services, and to administer IHSS according to current program standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings. As IHSS becomes a Medi-Cal managed care benefit in the seven counties, each county is responsible for paying a MOE amount, not a percentage of program costs. 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. Based on CCI costs, the Governor's budget discontinues the CCI, and along with it the IHSS MOE and statewide bargaining. This will be discussed in more detail later in the agenda.

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, DSS, and the Department of Aging were tasked with developing a UAT to assess a Medi-Cal beneficiary's need for Home and Community-Based Services. The goal is to enhance personalized care planning under CCI, and create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services. The development of the UAT was halted along with the CCI.

Program Funding. The average annual cost of services per IHSS client is estimated to be around $16,891.08 for 2016-17. 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.

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 $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 Budget Act uses $272.9 million General Fund and 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. 2017-18 costs are estimated to be $188.6 million General Fund. Restoration of the seven percent reduction is tied to the MCO tax, which is up for renewal in 2019.

- **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. 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. DSS began consulting with stakeholders in the fall of 2016, and will continue to meet with them on an ongoing basis as policies and procedures for implementation are developed. $17.2 million General Fund is included in the current year, and $41.4 million General Fund is included in the budget year, for these purposes.

- **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. $437.1 million General Fund is included in the current year, and $303.4 million General Fund is included in the budget year, for these purposes.

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

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

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

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

Staff Comment 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.

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

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

Issue 9: Update: Coordinated Care Initiative

Budget Issue. The Governor's budget estimates that CCI will no longer be cost-effective and does not meet the statutory savings requirements. Current law allows the Administration to discontinue the CCI if this is found to be the case. The Governor's proposal for the unwinding of the CCI includes ending the IHSS MOE and returning to the prior state-county sharing ratio, and shifting collective bargaining responsibility back to demonstration counties. The Administration estimates that eliminating the IHSS County MOE provides $622.6 million General Fund savings in 2017-18. Below is a timeline of the unwinding of the CCI provided by the Legislative Analyst's Office (LAO)[5].

Figure 3

Timeline of When Major CCI Policies Become Inoperative Under Current Law[a]

January 2017	Return of responsibility for bargaining for IHSS wages and benefits to the CCI counties.
	End of development of home and community–based services universal assessment tool.
July 2017	Elimination of IHSS Maintenance–of–Effort and return to historical IHSS state–county cost–sharing ratio.
January 2018	Disenrollment of members from Cal MediConnect.[b]
	End of mandatory managed care enrollment for dual eligibles.[b]
	Removal of IHSS financing from managed care.

[a]Given the January 2017 determination by the Department of Finance that the CCI does not generate net General Fund savings.

[b]These are elements we expect to be proposed for continuation under the Governor's proposal.

CCI = Coordinated Care Initiative and IHSS = In–Home Supportive Services.

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.

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 maintenance- of-effort (MOE) requirement as of July 1, 2012. 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, although with a $12.10 cap on state wage and benefit participation. 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

[5] Legislative Analyst's Office: 2017-18: The Coordinated Care Initiative: A Critical Juncture (February 2017): http://lao.ca.gov/reports/2017/3585/coordinated-care-022717.pdf

the county MOE agreement would cease operation.

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"[6] reported 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?"[7] echoed these findings, and both reports emphasize that more outreach to communities with high opt-out rates, IHSS social workers, and IHSS providers, is needed.

Bargaining implications. Pursuant to current law, the Statewide Authority immediately ceased to be the employer of record when the CCI was discontinued, as the Statewide Authority did not execute any contracts while the CCI was in effect.

There is concern among counties and labor organizations about the implications of ending statewide bargaining. Also, while counties have already received notification of the immediate return of collective bargaining, counties and IHSS workers are not clear about when bargaining should resume.

Realignment funding implications. With the elimination of the IHSS MOE and return to the prior state-county sharing ratio, the Administration expects that counties will now also contribute to costs increases that were incurred while the CCI was operative, including FLSA overtime, state minimum wage increases, paid sick leave, and the restoration of the seven percent in service hours. 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.

It is likely that counties will have to use 1991 Realignment dollars to pay for IHSS costs; however, many of these funds are used to pay for health and mental health programs, as well as public safety and transportation. Complicating the 1991 Realignment issues further is AB 85 (Assembly Committee on

[6] 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
[7] 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

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 eventually the repeal of the Maximum Family Grant Rule, which is currently being paid for with the General Fund. 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, particularly in the out years.

The subcommittee has requested the LAO present on 1991 Realignment funding in relation to the CCI.

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

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

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

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

Panel. The subcommittee has requested the following panelists, in addition to DSS and the LAO, to provide comment on the discontinuation of the CCI in relation to IHSS, and respond to the Administration:

- Frank Mecca, County Welfare Director's Association
- Kirsten Barlow, County Behavioral Health Director's Association
- SEIU Representative
- UDW Representative
- County Supervisor

Staff Comment and Recommendation. Hold open. In contemplating how the Administration has chosen to unwind the CCI, the Legislature must take into account the concerns that counties have shared regarding bearing the full brunt of IHSS costs in 2017-18, as well as growing out-year costs that could negatively impact many programs beyond just IHSS. The Legislature should continue to work with the Administration and stakeholders to identify a path forward that meets shared priorities and allows for the stability of critical programs for vulnerable Californians.

Questions.

1. Please describe the status of IHSS in the CCI before it was discontinued.

2. Please describe the status of the UAT before it was halted. Did you consider the UAT to be a valuable tool, outside of the CCI?

3. Do you expect counties to pick up all additional IHSS costs that have been added to the program since 2012, such as overtime, sick leave, and minimum wage increases?

4. How do you expect counties to pay for costs, both upfront and in the out years? How do you respond to counties saying that they cannot bear these costs?

5. Please respond to county concerns about the $12.10 state wage and benefit cap in current statute.

6. In the Governor's budget, the Administration expressed its willingness to work with counties to mitigate impacts of ending the IHSS MOE. What is the status of current conversations?

7. Please respond to the suggestions from the LAO, included in the agenda, to mitigate the situation with counties.

Issue 10: Oversight – Fair Labor Standards Act (FLSA) Overtime Implementation

Governor's Proposal. FLSA implementation, as set forth under SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, began on February 1, 2016. The 2017-18 Governor's budget provides $989 million ($465 million General Fund) in 2017-18 for the implementation of the federal requirements. The $989 million is allocated as follows:

- $580.7 million for FLSA Overtime.
- $385.3 million for FLSA compliance (medical accompaniment wait time, travel time, and mandatory provider training).
- $13.1 million for FLSA Provider Exemptions.
- $5 million for FLSA Administration.
- $4 million for the Case Management, Information and Payrolling System (CMIPS II) FLSA changes.

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. 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 disabililities 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 Governor's budget estimates that 14.1 percent of providers with a single recipient and 9.4 percent of providers with multiple recipients typically work more than 40 hours per week.

Current Status of Implementation. The department has provided the following table documenting milestone implementation activities:

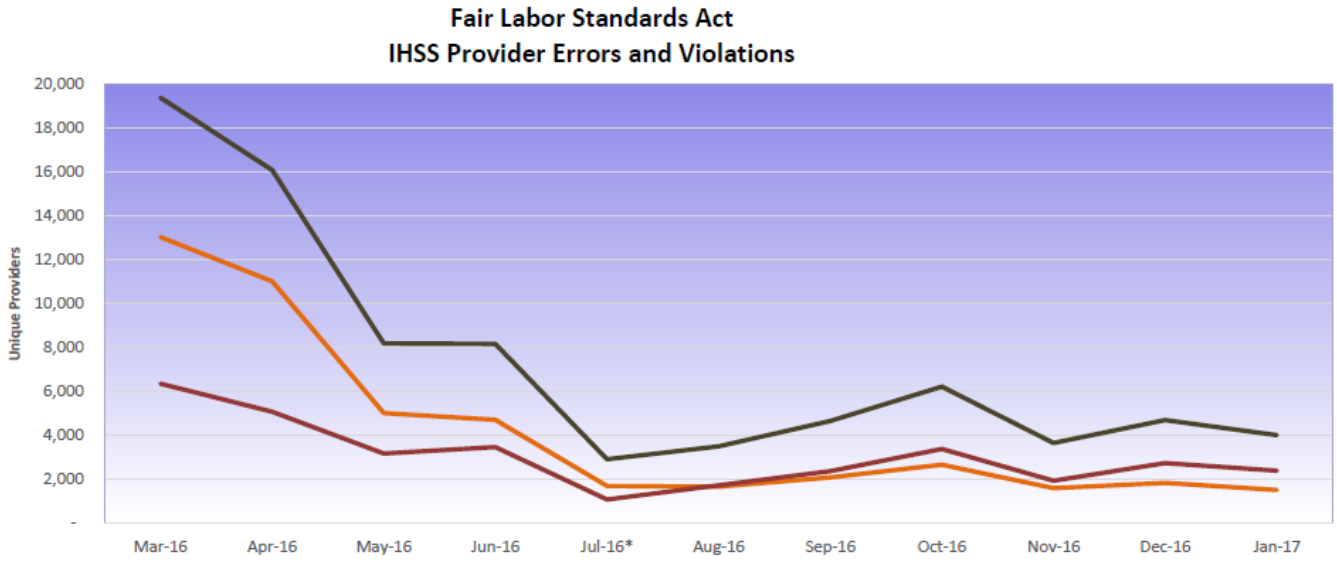
CDSS ADULT PROGRAMS DIVISION
OVERTIME (FLSA IMPLEMENTATION) TIMELINE

Completion Date	Milestone	State/County Activities
January 7, 2016	Implementation of overtime – Effective February 1, 2016	**All County Letter (ACL) Released for Implementation of FLSA requirements – SB 855 and SB 873 workweek and overtime provisions.** • CDSS released ACL 16-01 to provide counties with instructions, including the policies and procedures for implementation of the overtime, workweek requirements, (pursuant to SB 855 and SB 873). These included the revised forms and notices (including the workweek agreements for providers and recipients).
		Timesheets and Travel Claim Form - Timesheet (SOC 2261) and CMIPS modifications were made to accommodate the payment of overtime implemented on February 1, 2016 as well as claiming of travel time.
January 21, 2016	Overtime Exemption 1	**Overtime Exemption 1: Live-In Family Care Provider Overtime Exemption.** • CDSS released ACL 16-07 to provide counties with information for implementing Overtime Exemption 1.
Feb 9, - Feb 26, 2016	Training Sessions	**Training-for-Trainer (T4T) sessions commenced February 9, 2016, and concluded February 26, 2016.** • CDSS conducted the training sessions statewide to approximately 320 trainers at the counties, Public Authorities (PAs), and labor organizations.
April 1, 2016	Overtime Exemption 2	**Overtime Exemption 2: Extraordinary Circumstances.** • CDSS released ACL 16-22 to provide counties with information for implementing Overtime Exemption 2. • The Extraordinary Circumstances Exemption allows IHSS providers to work up to 360 hours per month.
April 15, 2016	Forms and Workweek Agreements	**Deadline for completed workweek agreements (SOC 2255 and SOC 2256) to be returned (completed) to counties for processing.** No consequences to recipients or providers who do not complete and return these forms by the deadline.
April 22, 2016	Violations	**Violations For Exceeding Workweek and/or Travel Time Limits -** CDSS released ACL 16-36 to provides counties with specific information and instructions related to the implementation of violations of the workweek and travel time limitations.
May 1, 2016	Effective date of Violations	**Violations (Non-Compliance with Workweek and Overtime Requirements) -** Grace period ends. While the grace period ended May 1st, no violations were issued until July 1st to allow time for counties to reach out and educate providers in order to avoid future violations.
May 10 and 16, 2016	Systems Modifications	**Modifications to CMIPS for Violations Processing, County Dispute and State Administrative Review Processes**

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.

For Exemption 1, as of February 3, 2017, there were 1,424 providers approved, 571 denied, and eight pending. For Exemption 2, as of January 1, 2017, there were 56 providers approved, 70 denied, and seven pending.

Below are two charts from DSS documenting violations data:



	Providers with Errors				Providers with Violations						
Violation Type	Mar-16	Apr-16	May-16	Jun-16	Jul-16*	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Exceeded Weekly Max of 66 Hours (Multiple Recipients)	13,043	11,025	5,019	4,706	1,694	1,657	2,081	2,660	1,599	1,834	1,510
Exceeded the Monthly Overtime Maximum (Single Recipients)	6,358	5,078	3,172	3,466	1,076	1,728	2,372	3,383	1,935	2,737	2,386
Exceeded the Travel Maximum**					142	113	204	175	117	128	115
Statewide Total	19,401	16,103	8,191	8,172	2,912	3,498	4,657	6,218	3,651	4,699	4,011
^Providers with 2 violations					0	1	526	912	796	1,114	812
^Providers with 3 violations					0	0	0	4	119	196	176
^Providers with 4 violations					0	0	0	0	0	1	13

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 is due in April 2017, and is currently undergoing administrative review. The report will include updated facts and figures used to build the May Revision.

Staff Comment and Recommendation. Hold open. As it has been just over one year of FLSA implementation, the department should share its data and findings with the Legislature and stakeholders, and all parties should continue to monitor how providers and recipients are faring under the new regulations and ensure that any unanticipated problems with implementation are addressed.

Questions.

1. Please provide an update on FLSA implementation.

2. Please describe what you are seeing with the two exemptions policies. Why do you think utilization of Exemption 2 is so low compared to what you were estimating last year?

3. Please describe what you are seeing with the violations policy. What preliminary data is the department seeing in terms of errors for those with violations? How many providers have been terminated or are near termination? Please discuss continued efforts to train providers.

4. Can you provide any insight into what the April 2017 FLSA report is showing about implementation?

Issue 11: Proposals for Investment

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

- FLSA Exemptions

Budget Issue. The IHSS Coalition requests that DSS expand IHSS exemption criteria, that consumers and providers receive notification about the criteria and process to request and exemption, and that DSS establish an appeals process.

Background. Beginning in May of 2016, DSS established two exemptions to weekly caps on hours for IHSS providers. Since the establishment of these exemptions, advocates have shared that they felt the exemptions were too narrow, and were concerned about the lack of notification and appeals process. Advocates are still developing a fiscal estimate.

Staff Comment and Recommendation. Hold Open.

- Oppose dismantling the CCI, the county IHSS MOE, and shifting IHSS collective bargaining to counties

Budget Issue. CSAC, CWDA, and various other advocates are opposed to the cessation of the CCI, the dismantling of the IHSS MOE, and shifting collective bargaining for IHSS workers from the Statewide Authority to the CCI counties.

Background. This year, CCI costs exceeded state savings, triggering the unwinding of the CCI. This also included ending the IHSS MOE and statewide bargaining for the CCI counties. In particular, CWDA estimates that shifting IHSS MOE costs back to the counties could cost upwards of $1 billion dollars by 2022-23, and will put a number of other programs at risk.

Staff Comment and Recommendation. Hold Open.

- Transfer collective bargaining for all IHSS providers from the county level to the state

Budget Issue. SEUI Local 2015 and UDW/AFSCME Local 3930 request to transfer the employer responsibility for collective bargaining for all IHSS providers from the county level to the state effective July 1, 2017. Costs, based on prior legislation, are estimated at approximately $3.5 million General Fund annually.

Staff Comment and Recommendation. Hold Open.