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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Andreas Borgeas
Senator Melissa Hurtado

Thursday, March 5, 2020
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Renita Polk

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4170 DEPARTMENT OF AGING (CDA)

DEPARTMENT OVERVIEW

Budget Summary. With a proposed 2020-21 budget of $254.9 million ($67.3 million General Fund), the CDA administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. As the federally designated State Unit on Aging, the department administers federal Older Americans Act (OAA) programs and the Health Insurance Counseling and Advocacy Program.

California Department of Aging
Expenditures by Fund Source
* Dollars in thousands

Grand Total By Fund	Fiscal Year	
	2019-20	2020-21 (Proposed Budget)
General Fund	$84,276	$67,282
State HICAP Fund	$2,506	$2,506
Federal Funds	$188,660	$168,731
Special Deposit Fund	$2,213	$1,213
Reimbursements	$14,892	$12,883
Department of Public Health Licensing and Certification Program Fund	$400	$400
Skilled Nursing Facility Quality and Accountability Fund	$1,900	$1,900
Total All Funds	$294,847	$254,915

2019 Budget Actions. The 2019 Budget Act provided significant investments in various programs at CDA, including:

- **Long-Term Care Ombudsman.** The 2019 budget increased funding for local Long-Term Care Ombudsman offices by $5.2 million annually. Additionally, the budget included trailer bill language requiring quarterly visits to Skilled Nursing Facilities and Residential Care Facilities for the Elderly by Long-Term Care Ombudsman staff. In 2019, local Ombudsman programs received an approximately 125 percent increase in General Fund support. Local Ombudsman programs reported being able to hire 36 new full-time equivalents, 20 new part-time staff, nine existing staff went from part-time to full-time and 12 existing part-time staff had an increase in hours.

- **Senior Nutrition.** The budget increased funding for senior nutrition programs by $17.5 million General Fund annually. The 2020-21 budget proposes to suspend this funding on July 1, 2023, unless there is sufficient General Fund revenue to support all programs proposed for suspension in the subsequent two fiscal years, as determined by the Department of Finance. Each Area

Agency on Aging (AAA) received a base of $150,00 for start-up and equipment costs. The remaining funding was allocated to each AAA using an interstate funding formula

- **Multipurpose Senior Services Program (MSSP).** The 2019 budget included a one-time increase of $29.6 million ($14.8 million General Fund) to be expended over three years to provide supplemental payments to MSSP providers. This resulted in a 25 percent supplemental payment increase for each MSSP site. The $4,285 per slot per year payment was increased to $5,356)

- **"No Wrong Door" Model**. The 2019 budget included $5 million General Fund annually to provide grants to local Area Agencies on Aging and Independent Living Centers to utilize the "No Wrong Door" model. The 2020-21 budget proposes to suspend this funding on July 1, 2023, unless there is sufficient General Fund revenue to support all programs proposed for suspension in the subsequent two fiscal years, as determined by the Department of Finance. Six local partnerships (jointly referred to as Aging and Disability Resource Centers (ADRCs)) have been approved as "State Designated ADRCs" and qualified for funding. Another ten local partnerships have been approved as "Emerging ADRCs" and also qualified for funding. Each designated ADRC will receive $180,000 base funding for each fiscal year. The table below shows funding allocations for 2019-20 and 2020-21. Each emerging ADRC will receive $90,000 in base funding. The remaining funding for both designated and emerging ADRCs will be allocated based on county population, county square mileage, and county geographic isolation.

Designated ADRCs	SFY 2019-20 Allocation[a]	SFY 2020-21 Allocation[b]
Marin County ADRC	$262,755	$239,380
Nevada County ADRC	$243,542	$225,594
Orange County ADRC[c]	$400,000	$781,322
Riverside County ADRC	$907,588	$702,073
San Francisco County ADRC	$410,632	$345,488
Ventura County ADRC	$425,483	$356,143
Total	$2,650,000	$2,650,000

Emerging ADRCs	SFY 2019-20 Allocation[a]	SFY 2020-21 Allocation[b]
Alameda County	$215,272	$215,272
Kern County	$180,824	$180,824
Monterey County	$133,919	$133,919
Amador, Calavera, Mariposa and Tuolumne Counties	$128,564	$128,564
Placer County	$131,596	$131,596
San Benito County	$98,172	$98,172
San Bernardino County	$279,757	$279,757

- **Dignity at Home Fall Prevention Program.** The budget includes $5 million General Fund one-time to provide grants to local Area Agencies on Aging for injury prevention education and

home modifications for seniors at risk of falling or institutionalization. The CDA allocated the funding equally among the 32 participating AAAs.

Overview of Programs.

Medi-Cal Programs. The department administers two Medi-Cal programs: it contracts directly with agencies that operate the Multipurpose Senior Services Program (MSSP) and provides oversight for the MSSP waiver and certifies Community-Based Adult Services (discussed further in next item) centers for participation in Medicaid. The department administers most of these programs through contracts with the state's 33 local AAAs. At the local level, AAA contract for and coordinate this array of community-based services to older adults, adults with disabilities, family caregivers, and residents of long-term care facilities.

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. CDA implements MSSP under the supervision of the Department of Health Care Services (DHCS) through an interagency agreement.

Senior Nutrition. This is the largest OAA program in terms of funding and the most well-known. It consists of the Congregate Nutrition Program and the Home Delivered Meal Program. The Congregate Nutrition program targets individuals age 60 or older with the greatest economic or social need. In 2016-17, approximately 28,694 meals a day were served at these sites; 7.2 million a year -- and approximately 27 percent of the participants were at high nutritional risk. The Home Delivered Meal Program serves older adults who are not able to attend congregate programs. In addition, programs provide nutrition education at least four times per year and nutrition counseling is available in some areas. In 2016-17, approximately 44,000 meals were delivered each day, 11 million annually.

Supportive Services. The Supportive Services Program assists 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. The Senior Legal Services Program assesses 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. The Family Caregiver Support Program provides support to unpaid family caregivers of older adults and grandparents (or other older relatives) with primary caregiving responsibilities for a child or individual with a disability. Each AAA is responsible for determining the array of services provided to unpaid family caregivers. Those services can include respite care, support services (such as support groups and training), supplemental services (such as assistive devices and home adaptations), access assistance, and information services.

Long-Term Care Ombudsman (LTCO). The LTCO identifies, investigates, and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities. These facilities include nursing homes, residential care facilities for the elderly, and assisted living facilities. The LTCO Program is a community-supported program, of which volunteers are an integral part. Approximately, 167 staff and 717 volunteers advocate on behalf of residents of long-term care facilities. These include 1,230 skilled nursing and intermediate care facilities and 7,300 residential care facilities for the elderly. The office also maintains a 24-hour, seven days a week crisis line to receive complaints by, and on behalf of, long-term care residents.

Elder Abuse Prevention. The Elder Abuse Prevention Program develops, strengthens, and implements programs for the prevention, detection, assessment, and treatment of elder abuse. Most programs educate the public about how to prevent, recognize, and respond to elder abuse

Health Insurance Counseling and Advocacy (HICAP). The HICAP Program provides personalized counseling, outreach and community education to Medicare beneficiaries about their health and long-term care (LTC) coverage options. In 2016-17, the program counseled approximately 79,000 clients, provided telephone help to 44,000 individuals and close to 3,700 interactive consumer presentations. This program utilizes 799 active counselors (volunteers and paid) who provide this assistance under the direction of the paid program staff.

Senior Community Service Employment Program (SCSEP). The SCSEP Program 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.

Aging and Disability Resource Connection (ADRC). The ADRC program's purpose is to improve consumers' experience by having a trusted point-of-contact that can provide reliable information and facilitate access to services for people of all ages, incomes, and disabilities. CDA collaborates with the DHCS to provide these services. However, the interagency agreement between the two is set to expire on June 30, 2019. The core partnership of an ADRC is between the regional Area Agency on Aging (AAA) and Independent Living Center (ILC). Neither CDA nor CHDS provide local assistance funding to ADRC. Since the federal ADRC demonstration grant funding ended in 2009, regional ADRCs have had to rely on either federal and state Older Americans Act and Older Californians Act funding, or the existing ILC funding.

Issue 1: Master Plan on Aging Update

Background. In June 2019, Governor Newsom issued an executive order calling for the creation of a Master Plan for Aging (MPA). This plan was spurred, in large part, by the projected growth of California's over-65 population to 8.6 million by 2030. This plan will serve as an outline for state and local governments, the private sector, and philanthropic organizations to promote health aging and prepare for demographic changes. The MPA will include key data indicators to support implementation and recommendations to better coordinate programs and services to older adults, families, and caregivers. The ultimate goal is to provide a person-centered, data-driven, ten-year California Master Plan for Aging by October 1, 2020. This includes a state plan, data dashboard, and best practice toolkit. The CDA has taken a lead role in developing the MPA.

As part of the MPA, the California Health and Human Services Agency (CHHS) convened a cabinet workgroup for aging. A stakeholder advisory committee and two subcommittees – research and long-term services and supports (LTSS) were also convened by CHSS. CHHS also convened an equity workgroup to provide advice on the MPA through an equity lens. The equity workgroup convened in February and is projected to meet four times between

Legislative/Budget Actions Advancing the MPA and Aging Issues. Within the past year, the Legislature has approved several measures to advance the MPA and to address other aging issues. These measures include:

- AB 1118 (Rubio), Chapter 820, Statutes of 2019. Requires the Secretary of CHHS to consider applying to join the AARP Network of Age-Friendly States and Communities on behalf of California.

- AB 1287 (Nazarian), Chapter 825, Statues of 2019. Requires the MPA to consider the efficacy of utilizing a "No Wrong Door" system and the use of a universal tool and process that is capable of assessing individual need and determining initial eligibility for programs and services available in the long-term services and supports delivery network.

- SB 228 (Jackson), Chapter 742, Statutes of 2019. Requires the director of the CDA to lead the development and implementation of the MPA.

- SB 453 (Hurtado), Chapter 850, Statutes of 2019. Requires the CDA to develop a core model of ADRC best practices and to develop a plan for and oversee implementation of the "No Wrong Door" system.

- 2019 Budget Act Investments. The 2019 Budget Act included several actions to advance the MPA and other aging issues.

    - "No Wrong Door" model. The 2019 budget provided $5 million to provide grants to local AAAs and Independent Living Center to utilize this model.

    - Dignity at Home Fall Prevention Program. The 2019 budget included $5 million to provide grants to local AAAs for injury prevention education and home modifications for seniors.

- Senior Nutrition programs. The budget provided $17.5 million ongoing for the expansion of Senior Nutrition programs at the CDA.

- Multipurpose Senior Services Program (MSSP). The 2019 budget included $29.6 million ($14.8 million General Fund) for supplemental payments to MSSP providers.

- Long-Term Care Ombudsman (LTCO). The 2019 budget included $5.2 million annually to aid in conducting quarterly visits to Skilled Nursing Facilities and Residential Care Facilities for the Elderly by LTCO staff.

- LTSS Actuarial Study. The 2019 budget included $1 million for the Department of Health Care Services to fund a feasibility study and actuarial analysis of LTSS financing and benefit options to meet the growing need for those services.

Update on Development. The CDA, as well as other departments and agencies with roles in the MPA, have provided consistent updates on the plan throughout its development. The CHHS agency has been releasing progress reports on the MPA every quarter. The agency has begun organizing "Webinar Wednesdays" where stakeholders can learn about and discuss various policy issues and their effects on seniors, as well as ways the MPA may address those issues. Final work is being conducted on the LTSS Subcommittee report from its stakeholder advisory committee. That report is due to the Governor in March 2020. During the winter and spring, recommendations for the MPA will continue to be gathered through the various processes mentioned above, with draft deliverables to be reviewed by the stakeholder advisory committee in the summer of 2020. The final MPA will be issued by the Administration no later than October 2020.

Next Steps. The LTSS subcommittee will submit a report to the Governor by March 2020. The research subcommittee will release a data dashboard in the spring/summer of 2020. During the rest of the year, recommendations for the MPA will continue to be gathered through the various processes mentioned above, with draft deliverables to be reviewed by the stakeholder advisory committee in the summer of 2020. The final MPA will be issued by the Administration no later than October 2020. CDA is also working on a new strategic plan that will be launched in July 2020.

Staff Comment and Recommendation. Informational item. No action is necessary.

Questions.

1. Please provide an update on the Master Plan for Aging.

2. One of the components of the Master Plan for Aging described in the most recent update is a transformation of the CDA. Please provide more information on what this entails.

Issue 2: BCP – Headquarters Relocation Funding

Governor's Proposal. The Administration requests $2.3 million General Fund in 2020-21 and $619,000 ongoing General Fund to relocate the department's offices. One-time costs include moving expenses, informational technology equipment and set-up, and furniture. Ongoing costs would be for facilities operations costs.

Background. Currently, the CDA and COA offices are located in the Natomas community of Sacramento. The departments have been in their current locations for the past 15 years. Recently, the building has had continuous ceiling leaks and problems with its heating, ventilation, and air conditioning system (HVAC), causing health and safety concerns for employees. The lessor of the building made modifications to the HVAC system in the spring of 2018, but problems with the system have persisted.

In addition to these concerns, the departments have outgrown the building's current capacity. As part of the Legislature's aging package in the Budget Act of 2019, the CDA was granted a total of approximately $65 million in additional investments to serve older Californians. With that additional funding came a need for expansion within the department. The CDA is also integrally involved in the development of the California Master Plan on Aging, creating additional growth at the CDA. With all these additional responsibilities and investments, the CDA has outgrown its current space.

The CDA has already identified a new location. The new building is much easier to access with public transit, contains spaces for large stakeholder meetings, and has space to allow for future growth within the CDA.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: Proposals for Investment

1. Statewide expansion of the Aging and Disability Resource Connections

Budget Issue. The California Association of Area Agencies on Aging requests $19 million in 2020-22, $30.1 million in 2021-22, and $51 million in 2022-23 for the expansion of the ADRC network. This request would expand the network from six designated ADRCs to 58. The proposal is intended to address the difficulty older Californians and people with disabilities faces accessing the services and supports they need. Getting timely, accurate information is critical to avoiding costly institutional care, preventing health and safety emergencies, or seeking aid during disasters. The California Association of Area Agencies on Aging proposes a three-year phased in approach where in year 1 designated and emerging ADRC's in the system would be funded, year 2 additional ADRCs would be established, and in year three the network would be extended to cover all counties.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 1: Overview

The In-Home Supportive Services (IHSS) program provides personal care services to approximately 610,457 qualified low-income individuals who are blind (1.5 percent), over 65 (36.8 percent), or who have disabilities (61.7 percent). 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.

As of November 2019, 15.2 percent of IHSS consumers are 85 years of age or older, 40.3 percent are ages 65-84, 36.9 percent are ages 18-64, and 7.5 percent are 17 years of age or younger. There are approximately 522,500 IHSS providers. Close to 54 percent of providers are live-in.

Budget Summary. The budget proposes $14.9 billion ($5.2 billion General Fund) for services and administration in 2020-21. 2019-20 funding includes $13.2 billion ($4.5 billion General Fund) for the program. 2020-21 funding is about 13 percent above estimated 2019-20 expenditures.

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 annually reassess 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. The average number of service hours provided to IHSS recipients in 2020-21 is estimated to be 114 hours per month.

Program Funding. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. About 98 percent of the IHSS caseload receives federal funding. The IHSS program predominately is delivered as a benefit of the Medi-Cal program. According to the Legislative Analyst's Office (LAO), IHSS is subject to federal Medicaid rules, including the federal reimbursement rate of 50 percent of costs for most Medi-Cal recipients. The state receives an enhanced federal reimbursement rate—93 percent in calendar year 2019 and 90 percent in calendar year 2020 and beyond—for individuals that became eligible for IHSS as a result of the Patient Protection and Affordable Care Act (about three percent of IHSS recipients). The federal government provides a 56 percent match for about 45 percent of recipients based on their higher assessed level of need. This higher reimbursement rate is referred to as the Community First Choice Option.

When the state transferred various programs from the state to county control during 1991 Realignment, 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. Beginning in 2011, an IHSS county maintenance-of-effort (MOE) was put into place, meaning county costs would reflect a set amount of nonfederal IHSS costs. Historically, counties paid 35 percent of the nonfederal share of costs.

Major Drivers of Increasing Costs. Primary drivers of the increased costs are caseload growth, an increasing number of paid hours per case, and wage increases for IHSS providers.

- Caseload growth. According to the LAO, the average monthly caseload for IHSS increased 30 percent over the past ten years from 430,000 in 2009-10 to an estimated 560,000 in 2019-20. The average year-to-year caseload growth is about five percent, and is estimated to continue to grow at that rate in 2020-21.

- Increasing paid hours per case. Over the past ten years, the average number of monthly hours per case for IHSS has increased by 29 percent, from about 87 paid hours in 2009-10 to an estimated 112-paid hours in 2019-20. Just between 2013-14 and 2018-19 average paid hours per case increased by 22 percent. Note that this increase is in part due to policy changes within the program. For example, in 2015-16, the state implemented requirements that providers be compensated for previously unpaid tasks, such as waiting during their recipient's medical appointments.

- State and Local Wage Increases. The LAO estimates that about 40 percent of the increase in wage costs ($220 million General Fund) are due to recent state minimum wage increases from $12 per hour to $13 per hour, and the scheduled increase to $14 per hour on January 1, 2021. The LAO estimates that the remainder of the increase in wage costs ($305 million General Fund) is due to local wage increases above the state minimum wage, largely because of collective bargaining agreements.

Recent and Proposed Policy Changes. In addition to the policies listed above, several other proposed and recently enacted policies impact the IHSS program – both fiscally and programmatically, including:

- **IHSS Maintenance of Effort (MOE).** The enactment of the 2019 Budget Act legislated several changes to the state IHSS MOE. The 2019 budget established the statewide MOE at $1.6 billion. The new MOE created a more sustainable fiscal structure for counties to manage costs by increasing the General Fund commitment for those costs. Specific changes to the MOE are discussed in detail in the next item.

- **Restoration of the seven percent reduction in service hours.** A legal settlement in *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an eight percent reduction to authorized IHSS hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours was changed to seven percent. The 2015 Budget Act approved one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours. Starting in 2016, the seven percent restoration was funded for the duration of the Managed Care Organization (MCO) tax. The MCO tax expired on July 1, 2019. The 2019 budget restored the seven percent reduction, but with a potential suspension date of December 31, 2021. The proposed 2020 budget proposes $894.5 million ($402.4 million General Fund) to continue to fund the restoration with a later suspension date of July 1, 2023.

- **Undocumented 65 and Older Full-Scope Expansion.** Currently, California provides full scope Medi-Cal coverage to the undocumented population up through 25 years of age. The proposed 2020 budget expands full-scope Medi-Cal to undocumented residents of California who are 65

years of age or older, regardless of immigration status, effective January 1, 2021. Estimated costs associated with the proposed expansion equal $5.9 million General Fund in 2020-21, increasing to $120 million in 2021-22. An additional $1 million is included in the budget for automation updates within the Department of Health Care Services budget.

- **Paid sick leave.** SB 3 (Leno), Chapter 4, Statutes of 2016, provided eight hours of paid sick leave to IHSS providers who work over 100 hours beginning July 1, 2018. Beginning January 1, 2020, IHSS providers will accrue 16 hours, and when the state minimum wage reaches $15, providers will receive 24 hours of sick leave. The proposed budget includes $52 million ($24 million General Fund) in 2019-20 for this purpose and $116.4 million ($53.3 million General Fund) in 2020-21. The budget assumes that about 80 percent of providers will use the maximum amount of paid sick leave. However, the LAO notes that costs could come in lower than estimated if fewer providers utilize paid sick leave or if providers use a lower than estimated amount.

- **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, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2021 to comply for personal care services, and until January 2023 for home care services, or escalating penalties will be incurred.

  In October 2018, the department submitted a request for $8 million ($800,000 General Fund and $7.2 million federal funds) to the Department of Finance (DOF) in order to comply with the federal mandate to implement EVV. The department used the funds to modify its existing Case Management, Information, and Payrolling System (CMIPS). The department has leveraged its existing Electronic Services Portal and Telephonic Timesheet System to meet EVV requirements. The EVV was piloted in Los Angeles County from July-December 2019. EVV will be implemented statewide during 2020. The proposed 2020 budget includes county administration funds to implement the remaining cases. $2.6 million is included for implementation in 2020-21, and $3.2 million is included for ongoing maintenance. Additional EVV funding is discussed in a later item.

Staff Comment and Recommendation. Hold open.

Questions.

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

2. The Governor's budget estimates that average hours per case in 2019-20 will be maintained at the same level as they were in 2018-19. Additionally, the budget estimates only a slight increase in 2020-21. Based on recent growth trends, the average hours per case will likely be higher in 2019-20. How does the DOF plan to adjust if average hours do turn out to be higher than estimated?

Issue 2: Update on IHSS MOE

Background. The 2019 budget enacted many changes to the IHSS county MOE. The most significant of which was lowering the county MOE and increasing the state's General Fund commitment. Beginning in 2019-20, the county MOE was rebased to $1.56 million. The 2020-21 budget updates the MOE to $1.59 billion in 2019-20 and $1.67 billion in 2020-21. This reflects a slight decrease in 2019-20 due to lower projected hours based on recent actual data and an increase in 2020-21 due to anticipated adjustments to the MOE calculation. While total IHSS county MOE costs increase from 2019-20 to 2020-21, the IHSS county MOE is projected to offset a decreasing share of the nonfederal IHSS costs—26 percent and 24 percent, respectively.

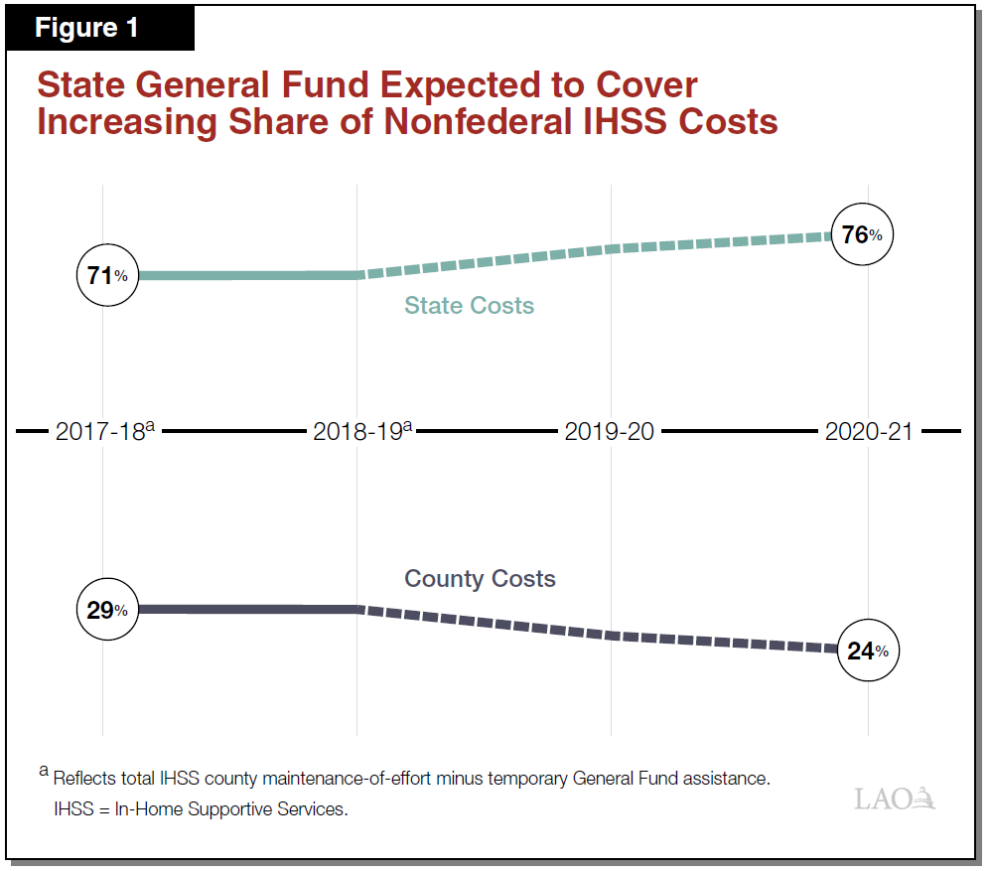
1991 Realignment. In 1991, the Legislature shifted significant fiscal and programmatic responsibility for many health and human services programs from the state to counties—referred to as 1991 realignment. The 1991 realignment package: (1) transferred several programs and responsibilities from the state to counties, (2) changed the way state and county costs are shared for certain social services programs, (3) transferred health and mental health service responsibilities and costs to the counties, and (4) increased the sales tax and VLF and dedicated these increased revenues to the new financial obligations of counties for realigned programs and responsibilities.

IHSS County Costs. Historically, counties paid 35 percent of the nonfederal—state and county—share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs. Beginning in 2012-13, however, the historical county share of cost model was replaced with an IHSS county maintenance-of-effort (MOE), meaning county costs would reflect a set amount of nonfederal IHSS costs as opposed to a certain percent of nonfederal IHSS costs. In 2017-18, the initial IHSS MOE was eliminated and replaced with a new county MOE financing structure—referred to as the 2017 IHSS MOE. Under this MOE, counties were responsible for paying based on 2017-18 actual expenditures, which is adjusted for locally negotiated, mediated, imposed, or adopted by ordinance increases to wages and/or benefits and an annual inflation factor. The county MOE was scheduled to increase by an inflation factor – five percent for 2018-19, and seven percent for the following fiscal years.

Senate Bill 90 – 1991 Realignment Report. The Budget Act of 2017 included a requirement for the DOF to submit a report to the Legislature that would review the funding structure of the 1991 realignment. The DOF released the report with the Governor's 2019-20 budget. The report acknowledged that the revenue sources for 1991 Realignment are not sufficient to cover increased program costs due to several changes in the structure of 1991 Realignment including collective bargaining, minimum wage increases, and federal overtime rules. IHSS has been one of the fastest growing programs within the state budget with mostly double-digit growth rates each year, with the exception of years where reductions were made in order to balance the budget. The 2017 MOE included an inflation factor of seven percent annually, which is below the average annual growth rate of eleven percent. The report proposed a number of recommendations that were reflected in the 2019 budget.

2019 MOE Changes. The 2019 changes to the MOE provided a supportable financial structure for counties. In addition to providing that sustainable arrangement, the annual inflation factor for counties will be lowered from seven percent to four percent, beginning in 2020-21. The county MOE will only increase by the inflation factor and the county share of locally negotiated wage and benefit

increases. Once the state minimum wage reaches $15 per hour, county negotiated increases for IHSS wages and benefits will shift to a non-federal sharing ratio of 35 percent state and 65 percent county of the non-federal share of the increases with no state participation cap. The MOE no longer consists of four separate components for services, county administration, public authority administration and now contains only one component for services. Administrative costs will now be funded through a General Fund allocation and counties will be responsible for administrative costs above the General Fund allocation. Overall, these changes shifted about $300 million of what otherwise would have been county costs to the state in 2019-20, increasing to about $550 million in 2022-23. With the changes to the MOE, state IHSS costs are expected to increase more over time. The figure below, provided by the LAO, shows how the state share of nonfederal costs will increase over time, while county costs will decrease.



Collective Bargaining. The 2019 budget also made changes to IHSS collective bargaining provisions. Budget language requires a specified mediation process, including a fact-finding panel and recommended settlement terms, to be held if a public authority or nonprofit consortium and the employee organization fails to reach agreement on a bargaining contract with IHSS workers on or after October 1, 2019. The mediation process also includes the county board of supervisors holding a public hearing after the fact-finding panel's public release of its findings and recommended settlement terms. Counties would be subject to withholding of a specified amount of realignment funds if, after completion of the mediation process, the fact-finding panel issues recommendations more favorable to the employee organization, the parties do not reach an agreement within 90 days after release, and the collective bargaining agreement has expired. These provisions will expire on January 1, 2021.

The subcommittee has requested the following panelist, in addition to DSS, DOF, and the LAO, to provide comment on the implementation of changes made to the IHSS MOE in the 2019 budget:

- Justin Garrett, Legislative Representative, California State Association of Counties

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an update on how the implementation of the 2019 changes to the IHSS MOE is going.

2. Please provide an update on the status of collective bargaining.

3. How is the state planning for the increase in state costs given the 2019 MOE changes, as well as the inevitable increase to the IHSS caseload due to changing state demographics?

For Justin Garrett, CSAC:

4. Please detail the counties' perspectives on the 2019 changes to the IHSS MOE.

5. Please provide an update on the status of collective bargaining from the county perspective.

Issue 3: Mandatory IHSS Social Worker Training TBL

Governor's Proposal. The Administration proposes language that would mandate new IHSS caseworkers, caseworker supervisors, quality assurance and program integrity staff, and program managers receive training within the first six months of employment to ensure compliance with IHSS statues, policies, and regulations on service assessment and authorization. The language would further require existing staff that did not have training before July 1, 2019, to complete a one-day refresher training on service assessment and the hourly task guide during 2020-21. The Governor's budget includes $3.7 million ($1.9 million General Fund) for the refresher training.

Background. Since 2005, the DSS, in partnership with the California State University of Sacramento's Office of Continuing Education, has offered year-round IHSS training to all 58 counties through the IHSS Training Academy. In December 2017, an All-County Information Notice provided clarification regarding the IHSS assessment process, transmitting new and/or updated assessment tools, and ensuring appropriate case documentation. However, IHSSTA training is not mandatory and a refresher was not required for current IHSS caseworkers, supervisors, quality assurance and program integrity staff, or program managers. Therefore, even with this guidance, annual state quality assurance reviews and technical assistance continue to find that counties are not correctly trained on provisions of supportive services.

Mandating all IHSS caseworkers and case supervisors, quality assurance and program integrity staff and program managers regardless of years of experience, to participate in the training would ensure uniformity and decrease errors when administrating the IHSS program. The academy will ramp up core competency training for new staff and facilitate 70 new one-day modules for experienced social workers and social worker supervisors, to refresh the use of functional ranks and hourly task guidelines to assess and authorize IHSS. The training will be provided to 3,306 new and existing social workers and managers.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

Issue 4: Proposals for Investment

1. Proposals related to collective bargaining

Budget Issue. UDW/AFSCME Local 3930 submits the following proposals related to collective bargaining issues.

- Increase penalty for counties to seven percent annually. The average wage for IHSS providers across UDW's 21 counties is just above minimum wage, $13.23 per hour, and less than ten percent of providers receive county-sponsored health benefits. In fiscal year 2019-20, the state enacted a one-time fiscal penalty (equal to one percent of a county's IHSS MOE) against counties that fail to reach collective bargaining agreements in a reasonable amount of time. According to UDW, this penalty has not been enough to incentivize counties to reach an agreement. UDW requests the Legislature increase the penalty for counties who refuse to bargain in good faith from one percent to seven percent of the county's IHSS MOE and from a one-time penalty to an annual penalty so long as the contract remains at an impasse.

- Require transparency in spending of taxpayer dollars. According to UDW, some counties contract with anti-union law firms to represent them in IHSS contract negotiations. This results in counties spending millions of taxpayer dollars for outside contractors when that money could be better used to fund wage and benefit increases for IHSS providers. UDW requests the Legislature ensure transparency in taxpayer funding for IHSS collective bargaining by mandating public disclosure of costs paid by counties for vendor contracts for IHSS negotiations. In addition, UDW requests that the state ensure these costs do not exceed 80 percent of the total cost of the wage and benefit increase proposed by the union.

- Reverse 2019 change to state/county cost sharing in IHSS wage and benefit increases. Currently, the non-federal share of cost for negotiated wage and benefit increases in IHSS is 65 percent paid by the state and 35 percent paid by county. In the 2019-20 budget, the state reversed this formula to become 65 percent county/35 percent state, beginning on January 1, 2022. Local collective bargaining in IHSS has always been very difficult. According to UDW, this will only get worse once the new formula goes into effect. UDW requests that the Legislature rescind the changes enacted in last year's budget and to retain the current share of cost formula of 35 percent county – 65 percent state.

Staff Comment and Recommendation. Hold open.

2. Reinstate accelerated caseload growth allocations in 1991 realignment

Budget Issue. In 2019-20, the state returned to the pre-2017 methodology for calculating IHSS caseload growth, which is a comparison to prior years, instead of using the accelerated approach to allocating funds, which uses current estimate of caseload and cost estimates. According to UDW, the accelerated approach was adopted in 2017-18 because of longstanding complaints by counties in collective bargaining that they could not afford to fund wage and benefit increases because of the lag in time before they would receive caseload growth allocations.

UDW requests the Legislature reinstate accelerated caseload growth in order to incentivize wage and benefit increases for IHSS providers.

Staff Comment and Recommendation. Hold open.

3. Allow Waiver Personal Care Service (WPCS) Providers the ability to receive paid sick leave

Budget Issue. SEIU California requests a General Fund appropriation of $223,000 annually for 965 WPCS---only providers to gain the ability to receive paid sick leave, mirroring the statute that gives sick leave to IHSS providers. On July 1, 2020, IHSS providers will receive 16 hours and on July 1, 2022, providers will gain 24 hours of paid sick leave. Unfortunately, WPCS---only providers, that do the exact same work as IHSS providers, do not have the ability to receive paid sick leave. SEIU requests state law be amended to entitle WPCS--- only providers the ability to receive paid sick leave.

Staff Comment and Recommendation. Hold open.

4. Permanent Restoration of the seven percent cut to IHSS hours

Budget Issue. SEIU Local 2015, representing 385,000 IHSS providers in 37 counties, continues to advocate for the permanent restoration of the seven percent across-the-board cut to IHSS service hours; a cut that was made in 2014 and has been restored through subsequent budget actions since 2015. In 2019, the General Fund ($342.3 million) restored the cut through December 31, 2021. The proposed 2020-21 budget proposes to extend the restoration an additional 18 months, through June 30, 2023. Estimated 2020-21 costs are $402.4 million General Fund. SEIU continues to urge rescinding WIC section 12301.01 through section 12301.05 to permanently restore the seven percent cut.

UDW is also in support of this request.

Staff Comment and Recommendation. Hold open.

0530 HEALTH AND HUMAN SERVICES AGENCY OFFICE OF SYSTEMS INTEGRATION (OSI)
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: BCP – Electronic Visit Verification (EVV) for In-Home Supportive Services (Phase I)

Governor's Proposal. The Administration requests a total of $20.7 million in 2020-21 and $19.4 million ongoing for local assistance and EVV implementation, outreach, and help desk, training, and system refinements. The tables below provide detailed cost breakdowns of 2020-21 and ongoing funding for Phase I of the EVV project.

CMIPS Budget Display

Activity	2020-21 Beginning Baseline	2020-21 Proposed Budget	2020-21 Budget Year Request
OSI Staff	$4,547,775	$4,547,775	-
Other	2,622,546	$2,622,546	-
CMIPS II Prime Contract	$40,736,996	$61,420,948	$20,683,952
State Support Contracts	$7,620,281	$7,620,281	-
Interfaces	$1,662,490	$1,662,490	-
Facilities	$413,000	$413,000	-
OSI Cost	**$57,603,088**	**$78,287,040**	**$20,683,952**
County Travel	$120,240	$120,240	-
Data Center Services	$19,800,000	$19,800,000	-
CDSS Cost	**$19,920,240**	**$19,920,240**	**-**
Total Local Assistance	**$77,523,328**	**$98,207,280**	**$20,683,952**
Local Assistance General Fund	$39,184,536	$45,296,521	$6,111,985
Local Assistance Other Funds	$38,338,792	$52,910,759	$14,571,967
State Operations Cost	**$1,400,049**	**$1,400,049**	**-**
Total CMIPS II Budget	**$78,923,377**	**$99,607,329**	**$20,683,952**

Activity	FY 2020-21	FY 2021-22	FY 2022-23	Total
EVV Implementation	$1,269,638	$0	$0	**$1,269,638**
EVV Cloud Infrastructure	$234,051	$160,674	$160,674	**$555,399**
EVV Telephone Transaction	$3,047,983	$3,230,862	$3,230,862	**$9,509,707**
EVV Application Maintenance	$3,253,592	$3,266,197	$3,266,197	**$9,785,986**
EVV Help Desk	$12,878,688	$13,073,474	$13,073,474	**$39,025,636**
Total Costs	**$20,683,952**	**$19,731,207**	**$19,731,207**	**$60,146,366**

Cloud infrastructure costs include vendor staff to support expansion of the web portal and additional cloud software licenses. The telephone transactions costs refer to costs associated with the anticipated increase in call volume. Application maintenance costs are for ongoing system development to fix defects found in testing and continually refine the system based on user feedback and program needs. Help desk costs relate to staff and infrastructure needed to support EVV.

Background. The federal 21st Century Cures Act was signed in December of 2016, and contains provisions related to EVV. These provisions 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, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2021 to comply for personal care services, and until January 2024 for home care services, or escalating penalties will be incurred. Penalties would progressively increase, estimated to start at $29.4 million in 2019-20 and going up to $180 million by 2023-24.

The Administration will implement this project in two phases. Phase I will implement EVV requirements for personal care services in the IHSS and Waiver Personal Care Services (WPCS) programs. This phase will be implemented by making changes to the already existing Case Management, Information, and Payrolling System (CMIPS) and the Telephonic Timesheet System. Phase II includes planning, identifying, developing, implementing and/or modifying a system to implement EVV for non-IHSS/WPCS providers and agencies that provide home health care services to eligible Medi-Cal beneficiaries. Phase II will consists of a new project comprising the efforts of multiple state departments. Note that a discussion of Phase II implementation will take place during the subcommittee's March 12, 2020 hearing.

EVV Implementation. The EVV application pilot on the IHSS web portal begin in the Lancaster district office in Los Angeles County in July 2019. Other LA district offices were added throughout the rest of 2019. As of November 2019, 85 percent of all LA providers were enrolled in the EVV system. The remaining counties will be added in waves throughout 2020 to achieve compliance by January 1, 2021. After the pilot, the state will be divided into five multi-county waves, with the last wave going live in September 2020. Each wave will be a two-month roll-out, with providers and recipients currently using electronic timesheets going live in the first month, and the remaining population going live in the second month. The second month would include any providers/recipients selecting the EVV telephonic option. The table below depicts the EVV implementation schedule.

EVV Implementation Timeline

Group	Timeline	Counties
Pilot	July 2019-December 2019	Los Angeles
1	January 2020-February 2020	Orange, Lake, Napa, Placer, Sacramento, San Luis Obispo, Solano
2	March 2020-April 2020	San Bernardino, Riverside, Fresno, Kern, Tulare, Kings
3	May 2020-June 2020	Alameda, Contra Costa, Marin, Mendocino, Monterey, San Francisco, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sonoma
4	July 2020-August 2020	Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Lassen, Mariposa, Merced, Modoc, Mono, Nevada, Plumas, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba
5	September 2020-October 2020	Butte, Imperial, Madera, San Diego, Ventura

Federal Financial Participation (FFP). During design, development, and implementation of EVV, the state receives 90 percent FFP. Once the project enters maintenance and operations, the state receives 75 percent FFP. The federal Centers for Medicare and Medicaid Services (CMS) requires a single certification process for the two EVV phases that are on separate implementation tracks and timelines. Because CMS requires a single certification process for both phases, EVV phase I will initially receive 50 percent FFP for the first three years of maintenance and operations, starting in January 2021. Once EVV phase II completes the certification process in 2024, CMS will retroactively reimburse the state for the additional 25 percent FFP for those first three years.

On December 20, 2019, the Department of Health Care Services (DHCS) received a letter from the CMS regarding the state's EVV system. The letter stated that the state's electronic timesheet system is not sufficient in and of itself to meet the EVV requirements. CMS does not believe that California's EVV system complies with the requirement that specified data elements be "electronically verified." The DHCS and the CMS continue to engage in discussions on this. However, note that the CMS did approve California's initial plan for its EVV system, and has not deviated from that plan since its approval. The Administration believes that its EVV system is still in compliance with the electronic verification requirement. Note that if the state is not fully compliant by January 1, 2021, FFP will be affected beginning in the first quarter of 2021. For the 2020-21 budget year, a 0.25 percentage point reduction in the FFP would be imposed if the state were not compliant. This would result in a loss of roughly $20 million in federal funds for the budget year.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Given the letter the state has received from the CMS on its adherence to the electronic verification component, would the resources requested in this proposal change if the state was considered to not be in compliance with the electronic verification requirement?

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP

Issue 1: Overview

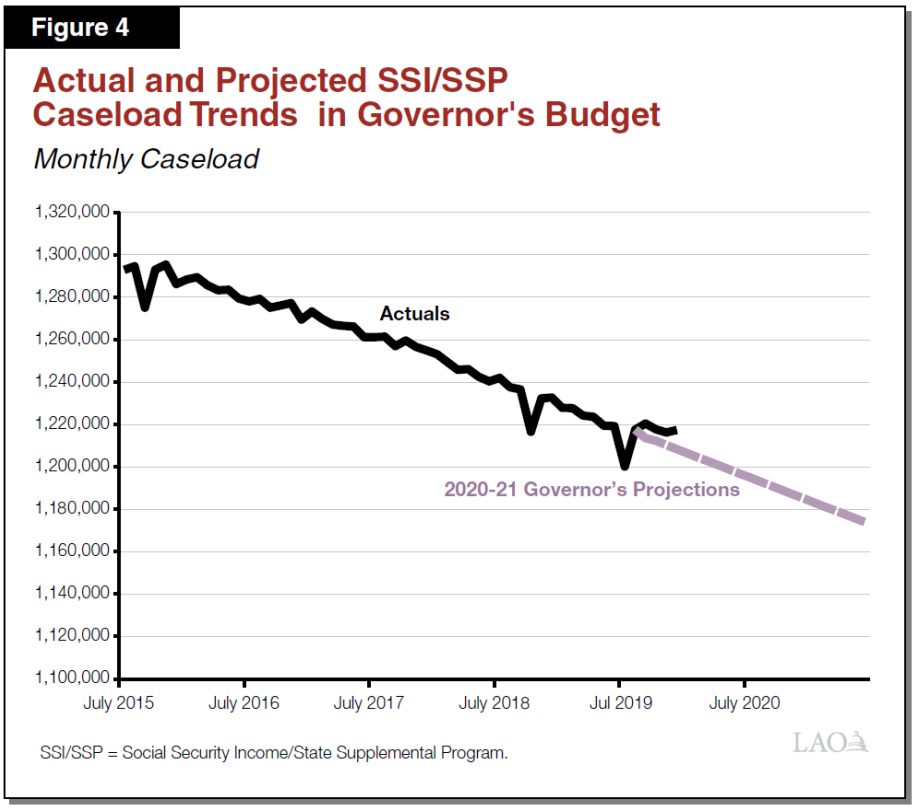
The Supplemental Security Income/State Supplemental Payment (SSI/SSP) programs provide cash assistance to around 1.2 million Californians, who are aged 65 or older (29 percent), are blind (one percent), or have disabilities (70 percent), and in each case meet federal income and resource limits. A qualified SSI recipient is automatically qualified for SSP. SSI grants are 100 percent federally funded. The state pays SSP, which augments the federal benefit.

Budget. The budget proposes $9.7 billion ($2.7 billion General Fund) in 2020-21 for SSI/SSP. The revised 2019-20 budget provides the same amount for the program. The flat funding level is largely due to estimated caseload decline being offset by increased federal expenditures. This increase in federally administered funds is due to the impacts of the 2020 and 2021 federal Cost-of-Living Adjustments (COLA) on the federal SSI version of the grant. The Governor's 2020-21 budget proposal does not include an increase to the SSP portion of the grant. The state pays administration costs to the Social Security Administration (SSA) to distribute SSP, around $183.3 million for the budget year. Costs for SSI/SSP include the Cash Assistance Program for Immigrants and the California Veterans Case Benefit Program.

Cash Assistance Program for Immigrants (CAPI). In 1998, the Cash Assistance Program for Immigrants (CAPI) was established as a state-only program to serve 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. 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 2020-21, the estimated monthly average caseload is 13,511 for extended CAPI.

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

Caseload. Since 2014-15, caseloads have shown a steady decline. The Governor's budget projects that the caseload will decrease by 1.8 in percent in 2019-20 and 2020-21. The graph on the next page, provided by the LAO, shows actual and projected caseload trends for SSI/SSP.



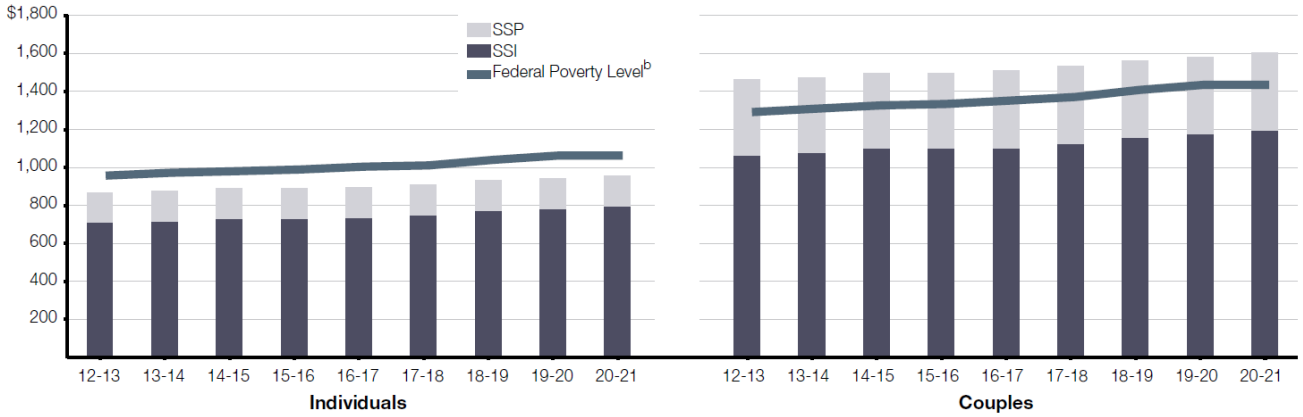
Grant Levels. The federal government, which funds the SSI portion of the grant, is statutorily required to provide an annual COLA each January. The state COLA for the SSP grant was suspended periodically throughout the 1990s and into the 2000s and was permanently repealed in 2011 through statute. The 2016 budget included a one-time SSP COLA of 2.76 percent.

The 2020-21 Governor's budget does not include an increase to the SSP grant, however the 2018 Budget Act included trailer bill language that codified COLAs to SSP grants beginning in 2022-23, subject to funding in the annual Budget Act. The LAO estimates the cost of providing the SSP COLA in 2022-23 (based on an estimated California Necessities Index of 2.8 percent) would cost about $70 million.

The Governor's budget estimates SSI/SSP monthly maximum grant levels will reach $957.72 for individuals and $1,602.14 for couples. The maximum grants for individuals and couples have gradually increased since 2011-12. Even with these increases, current maximum SSI/SSP grants for individuals are below the federal poverty level (FPL), and grants for couples are just above the FPL. As of January 2020, the federal poverty level for individuals is $1,063 per month and $1,436 per month for couples. The graph on the next page, provided by the LAO, shows SSI/SSP grant levels for both couples and individuals compared to the FPL.

Figure 3

Maximum SSI/SSP Grants for Individuals and Couples[a] Compared to Federal Poverty Level[b]



[a] The maximum monthly grants displayed refer to those for aged and disabled individuals and couples living in their own households, effective as of January 1 of respective budget year.

[b] Federal poverty guidelines as established by U.S. Department of Health and Human Services, effective as of January 1 of the respective budget year up to 2019-20.

LAO

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of caseload and funding levels for the SSI/SSP program.

2. What are the reasons for the declining caseload for SSI/SSP?

Issue 2: Housing and Homelessness Programs - Update on Housing and Disability Advocacy Program (HDAP)

Background. Applying to SSI is a complicated and challenging process, particularly for applicants that are homeless or have severe mental disabilities. HDAP offers assistance in applying for disability benefit programs and offers housing supports to individuals who are disabled and experiencing homelessness. The program is administered by individual counties. Counties provide a variety of services such as outreach, case management, advocacy, and housing support to all recipients. Counties must ensure that those with the highest needs are given priority, such as those experiencing chronic homelessness and those that most heavily rely on state- and county-funded services.

HDAP programs are operated at the county level. The DSS collects data from grantees on a monthly and quarterly basis and analyzes the data to provide targeted technical assistance. Grantees that receive HDAP funds are required to offer four components to all eligible participants. Those components include:

- Outreach. Active outreach is critical to ensuring the most vulnerable are engaged and served. Active outreach may include establishing and utilizing partnerships with local Homeless Outreach Teams within the community, or other engagement teams trained in seeking out and engaging with vulnerable individuals experiencing homelessness.

- Case Management. Activities associated with the role of the HDAP care coordination case management function may include general adult daily living skill development, case coordination and linkage to disability advocacy services, behavioral health services, medical care, and housing assistance, including housing navigation and housing specific case management.

- Disability Benefits Advocacy. Grantees provide benefits advocacy services for a variety of disability benefit programs, as appropriate. As part of a thorough disability benefit application, HDAP grantees seek out any and all entitlement benefits the client may be eligible to receive. Disability benefits advocacy services are provided through legal representation (at no cost to program participants) or through disability advocacy case managers with benefits assistance training.

- Housing Assistance. Housing assistance entails financial assistance for housing costs provided in coordination with both housing navigation and housing specific case management services. Housing specific case management provides support to HDAP clients specific to their housing needs.

Funding and Budget Actions. In 2016-17, the Senate "No Place Like Home" package of homelessness initiatives included a one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible people enrolled in the SSI/SSP program. $45 million General Fund was approved, and the HDAP was established. $513,000 was reserved for staffing the program and to make it operational as soon as possible. Implementation of HDAP was included in the 2017-18 budget, and funds are now available through June 30, 2020.

The 2019 budget provided $25 million General Fund ongoing for the program. SB 80 (Committee on Budget and Fiscal Review), Chapter 27, Statutes of 2019, required the DSS to submit an annual report on the implementation progress of HDAP. DSS submitted that report to the Legislature in February 2020. SB 80 also expanded eligible grantees to tribes, tribal consortiums, or tribal organizations. A dollar for dollar grantee match is required for the program.

Program Data. The tables below, found in the DSS annual HDAP report, show select program data.

Select Data Elements	Count
Enrollees	2568
Disability applications submitted	1536
Disability applications approved	341
Enrollees with a housing intervention (interim or permanent)	1302
Enrollees permanently housed	831

HDAP Target Population	Count	Percent
General Assistance (GA)/ General Relief (GR)	1647	50%
CalWORKs	38	1%
Diverted from Jail/ Prison	57	2%
Low Income Veteran	601	18%
Discharged from Institution	46	1%
Other Low/ No Income	938	28%
Total	3327	

Note: There is duplication in the above table. For example, a low-income veteran may also be on GA/GR.

Number of Submitted Applications by Type

Disability Benefit Type	Count	Percent
SSI	1487	75%
SSDI	487	24%
CAPI, Veteran's Benefits, or Other*	18	<1%
Total	1992	

Note: There is duplication in the above table. In some instances, a given HDAP enrollee is potentially eligible for more than one disability benefit program. *Note: These categories are combined to ensure that any personal identifying information in the data cannot be used to identify an individual.

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an update on HDAP implementation.

Issue 3: Proposals for Investment

1. Restoring SSI grants above the Federal Poverty Level (FPL)

Budget Issue. 1.2 million aged and disabled Californians rely entirely or partly on the federal/state SSI/SSP program for their income for housing, food, utilities, and transportation. In 2009, the state reduced the state contribution to the grant from $223 a month to $156. With the exception of a single cost-of-living adjustment, these recession era grants have never been restored. With housing costs and availability at crisis levels, SSI grants are simply inadequate to afford housing and there is a rising number of SSI recipients that are homeless.

Restoring the cuts to SSI will reduce the housing cost burdens of SSI recipients. This means they will be less vulnerable to rent increases or losing their housing if an unexpected bill causes them to fall behind in their rent. Additionally, increased grants allow recipients to eat more and better food which will lead to better health outcomes.

Californians 4 SSI requests SSI/SSP grants be increased to restore them to the FPL. Restoring these grants is estimated to cost $1.2 billion General Fund annually.

Staff Comment and Recommendation. As mentioned earlier in this agenda, the Governor's budget estimates SSI/SSP monthly maximum grant levels will reach $957.72 for individuals and $1,602.14 for couples in 2020. As of January 2020, the federal poverty level for individuals is $1,063 per month and $1,436 per month for couples. Even with these proposed 2020-21 budget increases, maximum SSI/SSP grants for individuals would still be below the federal poverty level (FPL), and grants for couples would be right above the FPL. **Hold open**.

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

CCL OVERVIEW

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of 74,693 licensed facilities that include childcare centers; family child care homes; adult day care facilities; foster family homes; children, adult, and senior residential facilities; and certified family homes and home care organizations. CCL is responsible for protecting the health and safety of individuals served by those facilities. Licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. The CCL division has a total authorized position count of 1,486.8 positions.

To fulfill these objectives CCL focuses on three priorities:

- Prevention – provide licensees with technical support, online resources, and training to assure that facilities have the necessary tools to meet the standards for the health and safety of everyone they serve.

- Enforcement – provide CCL staff who conduct inspections with the necessary tools and training to ensure that inspections are thorough and consistent and take administrative actions when licensing standards are not met.

- Compliance – creating clear and consistent expectations for licensees in meeting licensing regulations and striving to address issues in real time to ensure the health and safety of the individuals that are served.

Total CCL Licensed Facilities in 2020-21

State Licensed Day Care Facilities	State Licensed 24-Hour Care Facilities	County Licensed 24-Hour Care Facilities	Certified Family Home Facilities[1]	Home Care Organization Facilities	Total
44,298	27,701	977	10	1,707	74,693

Funding. 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

[1] A certified family home is a foster home that is certified by a Foster Family Agency. DSS does not license certified family homes. However, DSS is responsible for investigating any complaint of certified family homes.

the TAF, and are required to be used by the department for technical assistance, training, and education of licensees.

Recent budget actions for program improvement. 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 included funding of $3.7 million General Fund for 36.5 positions.

In 2017-18, an additional $3.3 million from the Technical Assistance Fund (TAF) was approved to help complete timely complaint allegations, address the growing backlog of RCFE and Adult Residential Facilities (ARF), continue implementation efforts related to the RCFE Reform Act of 2014, and 5.5 permanent LPAs and one-half Attorney III. In 2019-20, the budget made many of the temporary positions approved in previous years permanent. In total, the 2019 budget approved permanent position authority for 207 positions to increase the frequency of inspections for licensed child care facilities.

Issue 1: Update on New Inspection Tools

Background. All facilities licensed by CCL 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 2015 budget 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 went into effect incrementally through 2018-19. The 2019 Budget Act approved permanent position authority for 207 positions to increase the frequency of inspections for licensed childcare facilities, and trailer bill language stated the intent of the Legislature that inspections in those facilities occur annually.

2020 Mandated Inspection Frequency by Facility Type

Facility Type	Inspection Mandate
Adult and Senior Care	1 year
Children's Residential	2 years
Child Care	3 years/1 year[a]

[a] By November 2020, mandated inspection frequency for child care facilities will increase from once every three years to an annual basis.

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 CCL began using several KITs as complements to their comprehensive inspection processes. KITs are intended to (1) standardize the inspection protocol between facilities and between inspectors, (2) enhance the efficiency of the inspection process, and (3) appropriately identify whether a more comprehensive inspection is warranted. Some facilities, such as facilities on probation, those pending administrative action, or those under a noncompliance plan, were ineligible for a key indicator inspection and would receive an unannounced comprehensive health and safety compliance inspection.

In 2017, the Legislature approved Supplementary Reporting Language that required the department to meet with legislative staff and stakeholders to discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. In September 2017, the department released a report detailing its planned approach for a new tool.

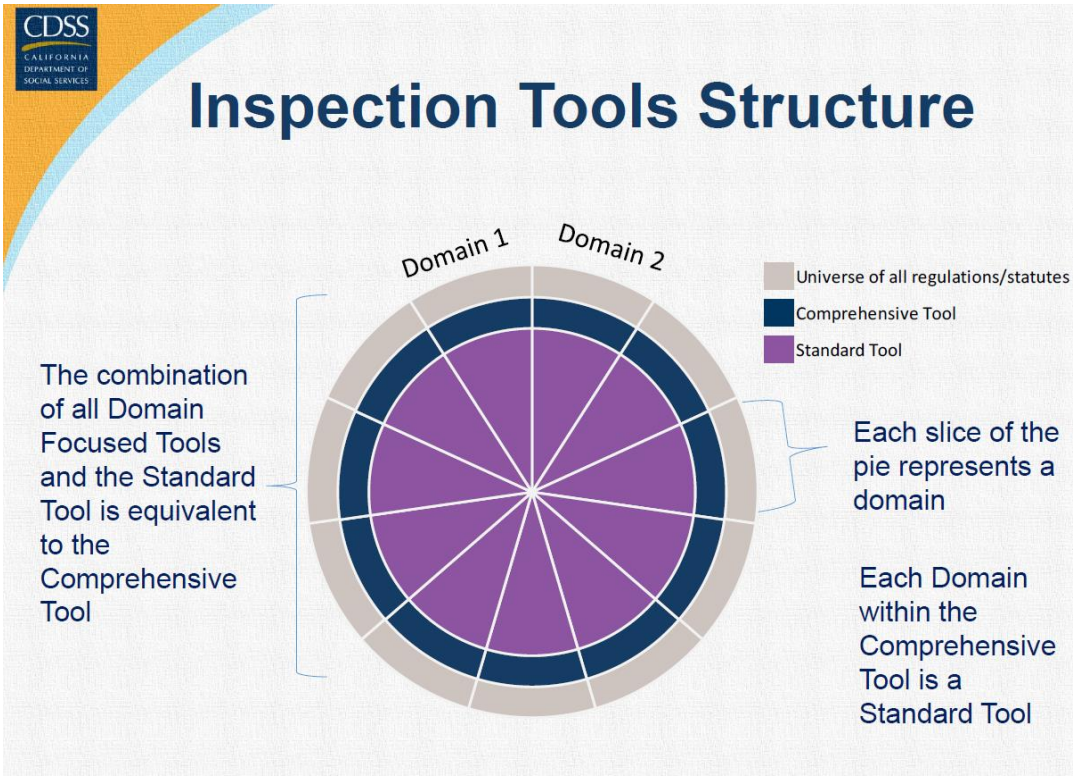
New Inspection Tools. In light of the absence of a standardized inspection tool, CCL is developing a variety of standardized inspection tools to improve the effectiveness and quality of the inspection process. These tools will also be developed differently for the various licensing categories,

[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.

understanding that different facility types will have different statutory requirements and indicators of compliance to meet. These tools will replace the KITs, designed for each CCL program type.

There are two types of inspection tools; a standard tool, which replaces the KIT, and domain focused tools. The standard tool includes regulations most critical to the health and safety of the individuals in that particular type of care facility. The domain-focused tools are organized into broad categories, or "domains," such as "physical plant and environmental safety" and "personnel records and training." The domain-focused tools facilitate deeper evaluation of the full array of statutes and regulations within the given domain. There are eleven domains included in the inspection tools for RCFEs. They are: operational requirements; physical plant/environmental safety; staffing; personnel records/staff training; resident rights/information; resident records/incident reports; food service; planned activities; incidental medical and dental; residents with special needs; and disaster preparedness.

Most facilities would be inspected using the standard tool. However, if the licensing program analyst (LPA) notes violations involving certain health and safety risks, the more extensive domain-focused tool is triggered for the domain category where violations were found. If an inspection triggers two or more domain-focused tools, comprehensive inspection is triggered. This requires the completion of all 11 domain-focused tools. The comprehensive tool is also used to inspect facilities that are in substantial noncompliance, on probation and other situations that CCL determines would warrant a higher level of inspection.



The Community Care Licensing Division (CCLD) began with the development and deployment of tools for the Adult and Senior Care (ASC) Program and subsequently completed tools for the Children's Residential and Child Care programs. The Senior Care pilot was carried out from July to September 2018 and statewide implementation of the tool for use in Residential Care Facilities for

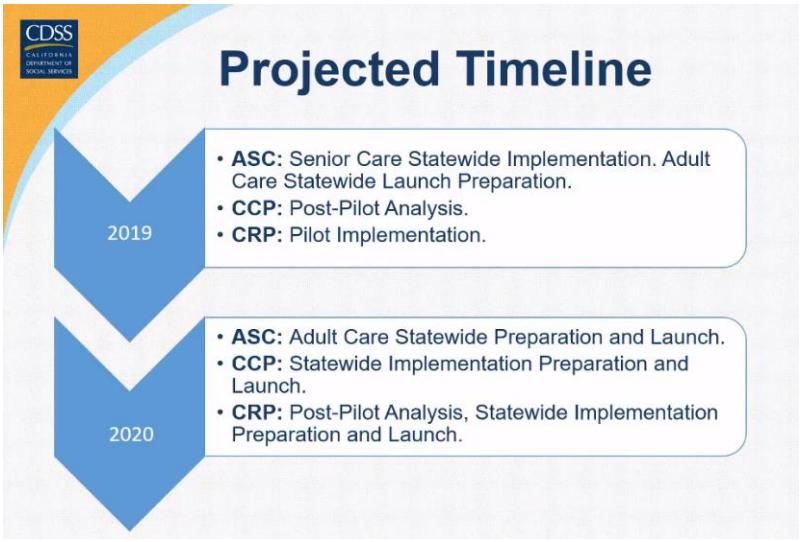
the Elderly (RCFEs) began in September 2019. The inspection tools replaced the KIT for all RCFEs as of November 2019. CCL will continue inspection data analysis and to gather feedback from licensing analysts and licensees to make continuous improvements to the tool. In fall 2019, CCL estimated that a soft launch of the adult care tools would occur in 2020.

The Adult Care program included new tools for the following facilities:

- Adult Day Programs
- Adult Residential facilities
- Adult Residential facilities for persons with special health needs
- Community crisis homes
- Enhanced Behavioral Support Homes
- Residential Care Facilities for the Chronically Ill
- Social Rehabilitation programs

The Child Care program tools, used for family child care homes, preschools, infants and school age children, was piloted during the spring and summer of 2019. At the last update provided by CCL in fall 2019 the next steps for CCL were to conduct post-pilot focus groups and to analyze data from to pilot to revise tools and other materials. The Children's Residential program tools would be used for Foster Family Agencies, group homes, short-term residential therapeutic programs, small family homes, and transitional housing placement programs. At the time of the last update, the pilot for these tools was underway, with a completion date of November 29, 2019.

A projected timeline of the implementation of the inspection tools is below.



*ASC – Adult Senior Care Program, CCP – Child Care Program, CRP – Children's Residential Program

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an update on implementation of the new inspection tools developed for CCL.

Issue 2: Informational - Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs)

Background. Over 200,000 Californians live in ARFs or RCFEs. These are adults who cannot live independently due to physical limitations or behavioral health needs and depend on licensed residential care facilities for housing and assistance with activities of daily living (ADLs). These facilities, commonly referred to as board and care or assisted living facilities, are licensed by the DSS Community Care Licensing Division (CCLD) as Adult Residential Facilities (ARFs) or Residential Care Facilities for the Elderly (RCFEs). ARFs serve adults ages 18 to 59 and RCFEs serve those 60 and older. All facilities serve individuals with differing needs. Those individuals include people with disabilities, cognitive impairments, and mental and behavioral health needs.

The facilities are typically privately operated and serve individuals with varying needs. Clients may be older adults who cannot safely live on their own, persons with disabilities, cognitive impairments, or behavioral health needs. Often, these facilities are viewed as an alternative to Skilled Nursing Homes or hospitalization, providing lower cost housing and care while also allowing individuals to remain in the community. ARFs and RCFEs do not provide medical services, but rather provide 24-hour, assistance with ADLs, such as meals, help with toileting or bathing, transportation to appointments in the community, and medication management.

Total Capacity and Number of RCFEs and ARFs in 2018-19

	Number of Facilities	Total Capacity
Residential Care Facilities for the Elderly	7,361	188,717
Adult Residential Facilities	5,206	37,240

Payments to ARFs and RCFEs. How individuals pay for these facilities varies as did how much the facilities charge. Some residents pay out of their own pocket. Other times facilities are reimbursed through public assistance programs such as SSI/SSP. The state provides a supplement to SSI/SSP grants known as the Non-medical Out of Home Care (NMOHC) rate. This rate is intended to support SSI/SS recipients who require additional care. As of January 2020, the SSI rate with the NMOHC supplement is $1,069.37 per month for an individual. This amount is meant to cover a resident's room and board and overall care and supervision. Facilities are not permitted to charge individuals receiving SSI above the state-mandated rate.

The Social Security Administration (SSA) reports the number of SSI/SSP recipients who are receiving the NMOHC rate. According to the SSA, the NMOHC rate is distributed for about 45,500 individuals statewide. However, data limitations make it difficult to accurately estimate how many SSI/SSP recipients receiving this rate reside in these facilities.

Supply of Facilities. CCL reports that from 2014-15 to FY 2018-19 the number of licensed ARFs has increased by 132 facilities, while the capacity of these facilities has decreased by 1,572. The number of licensed RCFEs has decreased by 187, but the capacity has increased by 9,159. This suggests newly opening RCFEs have larger capacity than those that closed, while newly opened ARFs have less capacity than those that closed.

CCL Regulation and Enforcement. CCL has a number of tools it can use to enforce applicable statutes and regulations: they have inspection authority; citation authority; authority to require a corrective action plan; authority to issue financial penalties; and, in extreme cases, they can revoke a license. LPAs working out of regional offices conduct inspections and complaint investigations. In addition to its enforcement and compliance activities, CCL has created a Technical Support Program (TSP), which is designed support to licensees and providers who are struggling to meet and maintain the requirements of operating a licensed facility. TSP is free, voluntary, and offers intense onsite assistance to licensees. In addition to hands on direct support for struggling facilities, TSP develops and publishes Resource Guides, which are intended to serve as tools to help licensees understand the requirements of compliance and provide best practice suggestions.

Staff Comment and Recommendation. Informational item. No action necessary.

With the Governor's Homelessness and Housing package including funding to stabilize ARFs and RCFEs, it is important that the Legislature has an understanding of what services these homes provide, who they serve, and the role of CCL in their regulation. As conversations around these types of facilities have increased, in part due to the Governor's proposed budget, questions remain surrounding the scope of the supply and demand of these facilities. Various stakeholders have expressed concerns surrounding reports that board and care facilities are closing at an increased rate. This is, in part, blamed on the low reimbursement rates for facilities that accept SSI/SSP recipients and facilities' generally high operating costs. However, despite these growing concerns, questions remain regarding the severity of closures, reasons for closures, and what happens to residents when facilities close.

Questions.

1. How would the department go about figuring out how many SSI/SSP recipients reside in these facilities?

2. How many of these facilities have closed in recent years? What effect have those closures had on capacity?

3. Describe the process that occurs when a facility is closing and the role of CCL, if any, in that process.

Issue 3: BCP – Caregiver Background Checks

Governor's Proposal. The Administration requests $898,000 ($730,000 General Fund) and seven positions to address criminal background check workload within the CCL Caregiver Background Check Bureau.

Background. The CCL division processes criminal background check requests for licensed community care facilities, their employees, volunteers and non-client adults residing in facilities, as well as for individuals desiring to be registered on license-exempt registries focused on providing care to the elderly and children. Applicants who have criminal histories are required to go through a process to receive a Criminal Record Exemption prior to working or coming into contact with clients. DSS processes approximately 70,000 criminal histories per year, resulting in approximately 40,000 exemption cases per year. In 2016, the California State Auditor found DSS took too long to process exemptions, which resulted in recommendations for the improvement to processing cases expeditiously. At the time, the DSS was taking more than six months to process requests.

Creation of Pilot Unit. In 2018, the DSS performed an in-depth analysis of their business process workflows and determined that the implementation of a specialized pilot unit focused on processing cases by a specific criterion would significantly streamline the exemption case process. This unit allowed other analysts more time to process cases in a timely manner. Because of the unit, less complex cases were identified faster, a quality assurance process was implemented, and cases were distributed equitably to staff with specialized training. The average number of days to process a simplified exemption decreased from 200 days to 7 days, the average number of days to process a transfer decreased from 30 days to 11 days, and the average number of days to process a standard exemption (more complex case) has decreased from 205 days to 120 days.

Staff Comment and Recommendation. Hold open.

Questions.

1. Provide an overview of the proposal.

Issue 4: BCP – Quality Oversight Staffing Resources

Governor's Proposal. The Administration requests $500,000 ($342,000 General Fund) and three positions to support the out-of-state community care facilities certification unit in the CCL's Children's Residential Program.

Background. The DSS is the primary agency responsible for ensuring that all out-of-state community care facilities accepting foster children from California are certified. The certification indicates that the facility meets the same standards as facilities that operate within the state. The Family Code Section 7911.1 establishes the requirements for certification and oversight of out-of-state community care facilities for placement of children. This includes conducting annual inspections, complaint investigations and reviewing serious incident reports. Furthermore, the DSS is responsible for conducting initial and on-going certification inspections, psychotropic medication oversight inspections, and assisting with a facility's efforts to meet California's requirements for a Short Term Residential Therapeutic Program (STRTP). The DSS oversees 26 out-of-state certified group homes/STRTPs in 11 states. Currently, approximately 285 California foster youth are placed in out-of-state facilities.

Inspection and Investigation Workload. According to the DSS, initial, annual, and case management inspections and complaint investigations require a physical inspection of all facility buildings and exterior grounds, review of client, employee, and facility files, and interviews with youth, staff, and home-state licensing personnel. Annual inspections require a minimum of two full days to complete all on-site inspection requirements; combined with travel and associated post-inspection documentation an annual inspection requires a minimum of five days for an analyst to complete. Family Code Section 7911.1(a) requires out-of-state facilities to submit incident reports for all youth in placement regardless of state of origin. The DSS receives approximately 330 reports per month and has a backlog of 1,500 incident reports awaiting review.

To be consistent with in-state licensing practices, staff will conduct initial and post-placement case management inspections of all certified out-of-state facilities that apply to be certified as a STRTP. Annual recertification visits are mandated to maintain the placement of a California client in an out-of-state facility and have been prioritized over other work to ensure the facilities continue to meet California requirements. With the requested resources, staff will make initial or post-placement visits for the facilities who have changed facility types from a group home to an STRTP. Last fiscal year, there was a gap of 18 of these visits that were not made resulting in certification of six programs as STRTPs that were later found to fail to meet STRTP requirements pertaining to staff to child ratios, staff qualifications, and service delivery.

In the last year, the program investigated 35 complaints. DSS staff initiate complaint investigations within ten days, however, due to inadequate staffing, complaint investigations have been conducted remotely with some investigation and delivery of findings occurring in conjunction with annual facility inspections. Of the 35 complaints investigated in 2018, 20 were conducted exclusively via telephone interviews and gathering documentation from out-of-state licensing and social services agencies.

According to the DSS, the requested resources will allow consistent completion of annual inspections, initiation of complaint investigations on-site within ten days, and the conduction of on-site case management inspections when needed.

Staff Comment and Recommendation.

Questions.

1. Provide an overview of the proposal.

2. How many of these out-of-state facilities have an ongoing certification versus a certification for the duration of placement of one child?

3. What is the current ratio of facilities per inspector?

4. Trailer bill language included in the 2019 Budget Act required all out-of-state facilities be certified as STRTPs by 2020. Will the department be able to meet this goal with the additional requested resources? Did the DSS foresee the need for these additional resources last year when this trailer bill language was being discussed?

Issue 5: BCP – Continued Oversight of Psychotropic Medications in Foster Care

Governor's Proposal. The Administration requests $909,000 ($622,000 General Fund) and eight positions ongoing to support the workload associated with monitoring the safe and appropriate usage of psychotropic mediations in short-term residential therapeutic programs (STRTPs) and group homes.

Specifically, the following positions are requested:

- One Licensing Program Manager (LPM)
- Five Licensing Program Analysts (LPA)
- One Associate Program Governmental Analyst (AGPA)
- One Office Assistant

Background. Senate Bill 484 (Beall), Chapter 540, Statutes of 2015, required DSS to establish a methodology to identify STRTPs and group homes that have levels of psychotropic drug utilization warranting additional review. The legislation also required the DSS to consult with the Department of Health Care Services (DHCS) and stakeholders every three years to revise the methodology.

Need for Additional Positions. A non-psychotropic medication inspection at a group home averages 5.5 hours (pre and post visit, related desk work and travel). By contrast, the workload associated with the psychotropic medication annual inspections takes a minimum of 20 hours to complete. Psychotropic medication inspections require more time, attention to detail, and greater depth of knowledge regarding the requirements for prescribing and assisting with self-administration of psychotropic medications for children in foster care. The extensive review of the children's trauma history, case files, employee files, as well as conducting in-depth interviews of staff and children makes the inspections time-consuming.

The DSS requests a LPA in each of its five regional offices along with the other requested positions to develop regulations, policy, procedures and a statewide summary report and to meet the ongoing workload to conduct more focused, time intensive review of STRTPs and group homes statewide. The DSS requests one permanent LPM I to provide supervisory support and guidance, four permanent LPAs who will provide oversight of psychotropic medications, and one LPA to cover inspections for each licensing region to conduct these focused, time-intensive inspections statewide.

With the additional positions, the DSS also plans to expand the scope of the inspections to explore additional topics, including quality of staff training and the licensee's level of initiative in informing children of their medication rights regarding their treatment.

Staff Comment and Recommendation.

Questions.

1. Provide an overview of the proposal.

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

Issue 1: Overview

Background. Each of California's 58 counties has an Adult Protective Services (APS) agency to aid 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 a 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.[3] DSS retains program oversight and regulatory and policymaking 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. APS expenditures since 2011 are in the table below.

Fiscal Year	Expenditures
2011-12	$119.7 million
2012-13	$120.7 million
2013-14	$126.3 million
2014-15	$137.6 million
2015-16	$147.6 million
2016-17	$159.7 million
2017-18	$169.9 million
2018-19	$191.4 million

APS Reports. APS reports have risen since 2011. Between 2014 and 2019, APS received 916,237 reports. During that same time, 800,709 cases were opened and 700,584 cases were resolved. Over the last year, the number of abuse reports received increased by 7.6 percent. Confirmed cases of financial abuse increased 10.3 percent in the last year.

[3] AB 118, (Committee on Budget), Chapter 40, Statutes of 2011, and AB 16 1X (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.

Training. The 2014 Budget Act included $150,000 in funding for one staff position within the department to assist with APS coordination and training. In 2015, trailer bill language was adopted that codified the responsibilities of this staff person. In addition, $176,000 ($88,000 General Fund) was allocated to DSS for APS training. The 2016 Budget Act included one-time funding of $3 million General Fund for APS training for social workers. The 2019 Budget Act included $11.5 million ($5.8 million General Fund) to be used over three years for training of APS social workers and public guardians.

Federal Grants. APS received a federal Administration for Community Living (ACL) grant of $198,665 to study and develop an improved comprehensive data collection system in line with the National Adult Maltreatment Reporting System (NAMRS). As a result of this funded the state is now collecting more comprehensive data including statewide staffing figures, services provided as a result of APS investigations, and interagency coordination and services referred. The grant also allows the collection of demographic information on clients and alleged perpetrators.

APS received another federal ACT grant of $373,259 per year from federal fiscal year (FFY) 2018-19 through FFY 2020-21 to increase the capacity of APS managers to drive program improvements. These improvements would be made by providing training to APS managers by national experts, and a pilot of the first ever APS Master of Social Work stipend program with a two year employment payback requirement.

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an overview of the APS program.

Issue 2: Housing and Homelessness Programs - Update on Home Safe Program

Background. The Home Safe Program was established by AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018. The program serves APS clients that are homeless or at risk of homelessness due to elder or dependent adult abuse, neglect, or financial exploitation. Local APS agencies provide homelessness prevention and short-term housing interventions to support safety and housing stability.

The goal of the Home Safe Program is to support the safety and housing stability of individuals involved in APS by providing housing-related assistance. Grantees operating Home Safe programs will implement a range of strategies to support housing stability for APS clients, including short-term financial assistance, legal services, eviction prevention, heavy cleaning, and landlord mediation, among other services.

The Housing and Homelessness Bureau of DSS will be offering ongoing technical assistance to counties participating in Home Safe as well as the greater APS community to ensure lessons learned and best practices are shared throughout the state. This will include regular and ongoing telephone and email correspondence as well as in-person site visits and meetings throughout the pilot. DSS is initiating data collection efforts and is collaborating with Dr. Margot Kushel at the University of California-San Francisco to provide an external evaluation of the program.

Funding. The Budget Act of 2018 provided $15 million General Fund (one-time) to fund the program over a three-year period, ending on June 30, 2021. The program is funded with a dollar-for-dollar match requirement, and a portion of funds are reserved for program evaluation purposes.

In December 2018, CDSS allocated funds on a competitive basis to 24 counties. A list of counties and the funds allocated is below.

County	Allocation	County	Allocation
Alameda	955,400	Riverside	1,969,541
Contra Costa	740,079	Sacramento	263,640
Fresno	588,571	San Bernardino	600,000
Humboldt	335,848	San Diego	500,000
Kern	170,000	San Francisco	773,981
Kings	113,440	Santa Clara	720,822
Los Angeles	2,648,128	Santa Cruz	743,440
Mariposa	170,000	Shasta	216,516
Mendocino	216,417	Sonoma	680,000
Merced	747,080	Tehama	170,000
Nevada	50,620	Ventura	170,000
Placer	468,885	Yuba	287,592

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an update on the Home Safe program.

2. What specific outcomes of the program will be measured to determine its success?

3. Has the program been showing any initial successes? If so, please describe them.

Issue 3: Proposals for Investment

1. Expand and Enhance Adult Protective Services

Budget Issue. The role of APS is growing as communities increasingly rely upon APS to address the complex needs of older adults, including those who are at risk of or experiencing homelessness or those with cognitive impairments. According to the California Welfare Directors Association (CWDA), the program will need additional state investment to support those individuals who require longer-term and more intensive assistance in order to remain safe in their homes and communities.

The CWDA is requesting a total of $100 million General Fund to:

- Provide long-term case management, including for those who are homeless and have cognitive impairments and allow APS to serve highly vulnerable adults aged 60-65 ($65 million General Fund).

- Build upon the APS Home Safe Program ($25 million General Fund). According to the CWDA, APS Home Safe should be expanded to interested counties and modified to assist victims of abuse and neglect who have become homeless or who need longer-term housing support as a bridge to other housing programs.

- Encourage Collaborative, Multi-Disciplinary Best-Practices across the state ($10 million General Fund). FAST and Forensic Centers are considered best practices in APS. They allow for a collaborative and targeted, rapid-response approach to the most complex cases. Currently, only a few counties have either model, but those that do see great success in interceding and stopping financial abuse and stabilizing victims who require a cross-systems response.

Staff Comment and Recommendation. Hold open.