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CSAC In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) Brief
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This document provides a quick overview summary, a basic timeline, and a more detailed background summary of the CCI and underlying fiscal structure of IHSS funding at the county level.

Introduction. On January 10, 2017, the Director of the Department of Finance issued notice that the state will end the Coordinated Care Initiative (CCI) and dismantle the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) deal enacted in 2012 and 2013, as well as shift millions of dollars of new program costs to counties. Under current statute, the county IHSS MOE would expire on June 30 of this year.

Costs

According to estimates developed by the County Welfare Directors Association, the demise of the county MOE will result in $625 million in increased county costs above the current MOE for the IHSS program in 2017-18 if statutory sharing ratios for the nonfederal share of the program are used: 65 percent state and 35 percent county.

The estimate above is based on normal program growth costs and includes the suite of new costs recently enacted by the state – the minimum wage increase up to $15 per hour by 2022 and the extension of three paid sick leave days to IHSS workers (SB 3, 2016) – as well as new federal overtime regulations.

The IHSS MOE deal had limited county IHSS costs to a base year calculation of 2011-12 costs plus an annual 3.5 percent inflator. The IHSS program grows roughly 6 to 7 percent a year, mostly due to demographics and an aging population.

Counties use dedicated 1991 Realignment revenues to pay for IHSS program costs. Further, IHSS is a caseload-driven program within 1991 Realignment, meaning increases in caseload are given priority for any growth funding. Increases in IHSS costs could affect the future share of growth funding received by the Health and Mental Health Subaccounts. Further, realignment revenues in the years in which the MOE was in effect were sufficient to cover the county share of costs for the program. Realignment revenues are currently less stable due to slowdowns in parts of the economy, and are not sufficient to cover the additional program costs enacted or imposed since 2012.

The state must participate in IHSS wages only up to $12.10 per hour. Currently, eight counties have wages above $12.10, 14 have wages between $10.50 (which is the current state minimum wage effective January 1, 2017) and $12.10, and 36 counties set wages at the $10.50 level.

Collective Bargaining

The CCI deal also included a provision to transfer IHSS collective bargaining from counties participating in the CCI to the state, and intent language to eventually expand CCI to all 58 counties and also transfer their collective bargaining responsibilities to the IHSS Statewide Public Authority. To date, only the seven current CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara) have transferred IHSS collective bargaining to the state.

All 58 counties participate in the MOE regardless of CCI status and had achieved significant stability in IHSS budgeting as a result.

Process

SB 94, one of the subsequent pieces of budget trailer bill legislation in 2013, contained a "poison pill" that allows Department of Finance Director Michael Cohen to declare that CCI will not generate State General Fund savings. Upon such declaration, SB 94 (2013) dictates that the CCI becomes inoperative on January 1 of the following year. SB 94 specifies that the MOE becomes inoperative on July 1 of that same calendar year as the CCI declaration. SB 94 also contains uncodified language indicating that collective bargaining returns to counties upon the demise of the CCI, but does not offer a timeline for that process.

The County Counsels' Association's Cost Shift Committee is carefully reviewing the relevant provisions to determine what statutory and constitutional protections are available, if any. It is important to note, however, that the mandate protections provided in Proposition 1A do not provide immediate remedies. If Proposition 1A applies, it requires counties to work through the Commission on State Mandates process, and then potentially through the courts on appeal. Such remedies, even if applicable to the CCI and MOE, would not prevent the MOE from becoming inoperable on July 1, 2017.

Timeline

Jan 10, 2017 - Deadline for Director of Finance to announce that CCI is not generating expected net State General Fund savings.

July 1, 2017 - County IHSS MOE (WIC §12306.15), including 3.5 percent inflator and state responsibility for collective bargaining, becomes inoperative.
Jan 1, 2018 - CCI becomes inoperative.

(Additional details on next pages)

IHSS Program Background

IHSS was realigned to counties as part of 1991 Realignment. It is a caseload-driven program, meaning 1991 Realignment revenues above the base amount for the year are first dedicated to increases in caseload for the program before becoming available to other subaccounts within 1991 Realignment (health and mental health).

IHSS is a federal entitlement Medicaid program and receives 50 percent federal funding. The remaining 50 percent of costs is shared by California and counties, with the state paying 65 percent of the nonfederal share and the counties paying 35 percent. Counties must administer the program in accordance with federal law and cannot cut or alter the program in response to cost pressures.

The IHSS program serves 463,000 consumers receiving an average of 101.9 hours per month from 436,000 providers statewide.

IHSS is based on the social services model as opposed to a medical model, and was developed to reduce the number of people who needed expensive institutional care. IHSS recipients are allowed to choose their IHSS care providers. Family members may qualify as IHSS providers. The services provided through IHSS include:

- Housecleaning
- Meal Preparation
- Laundry
- Grocery Shopping
- Personal Care Services (such as bowel and bladder care, bathing, grooming and paramedical services)
- Accompaniment to medical appointments – including travel time and waiting room time (new)
- Protective Supervision for the Mentally Impaired

To qualify for IHSS, a recipient has to be 65 years or older, disabled, reside in California, be eligible for Medicaid services (income of less than $1200 a month), reside at home (not an acute care hospital, long-term care facility, or licensed community care facility), and have a doctor's approval of the Health Care Certification form.

County social workers determine the number of IHSS hours for each consumer based on the consumer's needs. The social worker conducts a home visit, consults with medical professionals, family, caregiver and others. Once assessed for hours, the consumer hires the provider of their choice and notifies the county IHSS Public Authority.
The Public Authority conducts employment onboarding, administration, and initial timecard setup, as well as maintains a registry of approved providers and backup providers.

CCI Background

In July 2012, the Coordinated Care Initiative was enacted as part of the 2012-13 State Budget Act through SB 1036 (Chapter 45, Statutes of 2012) and AB 1471 (Chapter 439, Statutes of 2012), the companion clean-up measure. A subsequent budget trailer bill, SB 94 in 2013, was also enacted with the "poison pill" language.

The CCI program is a health care demonstration project in seven large counties intended to funnel more Medicare and Medicaid beneficiaries into managed care plans to achieve state Medi-Cal savings. It was aimed at improving care coordination for people on both Medi-Cal and Medicare, commonly referred to as dual eligibles. Dual eligible beneficiaries that choose to participate would receive coordinated medical, behavioral health, long-term institutional, home- and community-based services through a single organized delivery system. Dual eligible beneficiaries would be assigned into new and existing Medi-Cal managed care health plans for benefits in the counties participating in the demonstration. The long-term services and supports, including IHSS, would now be covered under the managed care health plans in participating counties. As such, the 2012-13 budget included IHSS changes impacting collective bargaining and the county share of cost.

The 2012-13 budget specified that collective bargaining for IHSS was to transfer to the state once the director of the Department of Health Care Services (DHCS) certified that enrollment into CCI had finished, but no sooner than March 1, 2013. Initially, the CCI was to be piloted in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara, with the intent – but no firm timeline – to further expand the CCI to all 58 counties.

Although collective bargaining would only shift for those eight counties and only upon completion of enrollment into the CCI, the 2012-13 budget made changes to the share of cost for all counties. Prior to these changes, counties funded roughly 35 percent of the non-federal share and the state funded 65 percent. The 2012-13 budget instead required a county Maintenance of Effort (MOE) level of funding for IHSS. As negotiated by the counties, the MOE was calculated based on IHSS expenditures in 2011-12 and would only be adjusted for the following reasons:

- A county negotiates an increase in IHSS provider wages and/or benefits after July 1,2012 and before the state takes over bargaining;
- An inflation factor of 3.5 percent to be applied annually beginning in July 1, 2014, unless there is a decline in Realignment revenues.

State IHSS Cost Increases

Since the MOE was enacted in 2012, the state has made several major policy changes related to IHSS workers that increase the costs of the program, including:

Minimum Wage

Minimum wage for all workers in CA, including IHSS providers, will rise to $15 per hour by 2020.

Current (as of Jan. 1, 2017)	$10.50
Jan. 1, 2018	$11.00
Jan. 1, 2019	$12.00
Jan. 1, 2020	$13.00
Jan. 1, 2021	$14.00
Jan. 1, 2022	$15.00

Paid Sick Leave

IHSS workers were granted three days paid sick leave in 2016 under SB 3. This policy is 100 percent state funded (no federal matching or cost sharing), with estimated costs of $90 million starting in 2018-19 when the first day is accrued, and increasing to $227 million in 2022-23, when the full three days are implemented.

FLSA Overtime

2013 Federal Fair Labor Standards Act (FLSA) regulations require overtime pay for in-home health workers. The state has budgeted $437 million for this cost in 2016-17. IHSS workers who work over 40 hours receive warnings, and the state has imposed a 66-hour cap per provider (not per consumer). A provider who repeatedly violates the cap is suspended from the program.

Restoration of the 2009 7 Percent Hours Cut

The state dedicated a portion of the new Managed Care Organization (MCO) tax to fund a restoration of hours for IHSS recipients that was made during the Great Recession. These costs are estimated a $265 million for 2016-17.

Conclusion

The IHSS MOE is a significant issue for all counties and remains a top CSAC priority. We will continue to analyze the impacts of the eradication of the MOE and the possible impacts on other 1991 Realignment-funded programs. We will also continue to maintain a dialogue with the Brown Administration as indicted in their budget summary, and work with other county, labor, and consumer stakeholders to ensure an equitable and sustainable solution for the IHSS Program.