January 16, 2014

Hon. Kamala D. Harris
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed initiative (A.G. File No. 13-0052) that would require In-Home Supportive Services (IHSS) providers to be paid a "minimum wage supplement" in addition to their regular wage and to undergo 75 hours of paid basic training.

BACKGROUND

The IHSS Program Provides Personal Care and Chore Services to Eligible Recipients. The IHSS program provides personal care and chore services to certain individuals to help them remain safely in their own homes and communities. Recipients, who must be low-income and aged, blind, or disabled, are eligible to receive up to 283 hours per month of assistance with tasks such as bathing, dressing, housework, and meal preparation. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider—oftentimes a family member or relative. Social workers employed by county welfare departments conduct an in-home IHSS assessment of an individual's needs in order to determine the amount and type of service hours to be provided. In 2013-14, it is estimated that about 450,000 individuals will receive IHSS and approximately 390,000 individuals will work as IHSS providers. The total cost to the state for the IHSS program is estimated to be approximately $1.9 billion (along with roughly $960 million in county funds) in 2013-14.

Individuals Must Follow Four Steps to Work as IHSS Providers. Currently, prospective IHSS providers must complete four steps in order to be enrolled as a provider and receive payment from the IHSS program. First, the prospective provider must complete an application in which the individual reports whether he/she has been convicted of any crimes that would bar the individual from working as an IHSS provider. Second, the prospective provider must be fingerprinted and undergo a criminal background check by the California Department of Justice. Third, the prospective provider must attend a brief IHSS Program Provider Orientation given by the county that covers rules and requirements to be followed. Fourth, the prospective provider

must sign the IHSS Program Provider Enrollment Agreement, certifying that he/she understands and agrees to the rules and requirements for working as an IHSS provider.

Although providers are required to complete the provider orientation, this mandatory provider training is currently unpaid. (Due to new federal labor regulations effective January 1, 2015, we note that the state will be required to pay providers for their participation in the required orientation.) While the provider orientation is currently the only mandatory training requirement, providers can also participate in voluntary, unpaid training opportunities in certain counties.

Wages of IHSS Providers Vary by County. The wages of IHSS providers are determined at the county level through collective bargaining between the local union representing IHSS providers and the Public Authority, the employer of record for the purposes of wage negotiations. As a result, the wages of IHSS providers vary by county, currently ranging from the state-mandated hourly minimum wage of $8 to as high as $12.20. (We note that recent legislation provides for the future transfer of collective bargaining responsibilities from the county level to the state level in eight counties.)

IHSS Is a Medicaid Benefit. Medicaid is a joint federal-state program that provides health coverage to low-income populations. The federal government pays for a share of the cost of each state's Medicaid program. In California, the Medicaid program is known as Medi-Cal. In general, the percentage of Medi-Cal costs paid by the federal government is set at 50 percent. (This percentage will increase for the Medi-Cal expansion population under federal health care reform.) For nearly all IHSS recipients, the IHSS program is delivered as a Medi-Cal benefit that receives federal financial participation. For IHSS recipients who generally meet the state's nursing facility clinical eligibility standards, the federal government provides in general an enhanced reimbursement rate of 56 percent referred to as Community First Choice Option (CFCO). (Because of the large share of IHSS recipients eligible for CFCO—about 40 percent of the caseload—the average federal reimbursement rate in general for the IHSS program is 54 percent.) The remaining nonfederal costs of the IHSS program are paid for by the state and counties, with the state assuming the majority of the nonfederal costs.

PROPOSAL

This measure affects home care workers who provide personal care and chore services to recipients of IHSS (hereinafter referred to as IHSS providers). Under the measure, all IHSS providers would receive a minimum wage supplement in addition to their regular wage, tied to and growing with increases in the state-mandated hourly minimum wage taking effect after January 1, 2014. Beginning January 1, 2016, most IHSS providers would be required to undergo 75 hours of paid basic training within specified time periods. Although the measure requires the state to be ultimately responsible for the costs of this measure, it also stipulates that the state Department of Health Care Services (DHCS) must seek federal financial participation, to the extent possible, in the costs associated with the wage supplement and provider training.

Requires IHSS Providers to Be Paid a Minimum Wage Supplement

All IHSS Providers Would Receive a Wage Supplement Equivalent to Increases in the Minimum Wage. This measure requires the state to pay all IHSS providers a supplement equal to the amount of any increase in the state-mandated hourly minimum wage above the level in effect on January 1, 2014 ($8 per hour). In accordance with Chapter 351, Statutes of 2013 (AB 10, Alejo), the minimum wage is scheduled to increase from $8 per hour to $9 per hour effective July 1, 2014—and to $10 per hour effective January 1, 2016. Upon enactment, the wage supplement provided for in the measure would supplement the wages of all IHSS providers by $1 per hour because of the scheduled $1 increase in the hourly minimum wage from $8 to $9 on July 1, 2014. Beginning January 1, 2016, all IHSS providers would receive a supplement of $2 per hour (or, an additional $1 per hour) due to the additional scheduled increase in the hourly minimum wage from $9 to $10 on January 1, 2016. If the state enacted further hourly minimum wage increases, the total supplement would continue to grow—equaling the difference between the new hourly minimum wage and the $8 hourly minimum wage in effect on January 1, 2014. However, if the state-mandated hourly minimum wage were to decrease, the measure stipulates that there would be no corresponding decrease in the amount of the total wage supplement.

Wage Supplement Does Not Count Toward Obligation to Pay Minimum Wage. The measure stipulates that the wage supplement does not count toward the obligation to pay IHSS providers the state-mandated hourly minimum wage. This is interpreted to mean, for example, that as of January 1, 2016, a wage of $9 per hour plus a $1 supplement—while $10 in total—would not meet the requirement to pay the state-mandated hourly minimum wage of $10. The IHSS provider would need to receive at least a $10 hourly wage without counting his/her supplement in order to fulfill an hourly minimum wage requirement of $10.

Requires IHSS Providers to Undergo 75 Hours of Paid Basic Training

Most IHSS Providers Would Be Required to Undergo Training. The measure would require all IHSS providers—except providers who are trained as registered nurses, licensed vocational nurses, certified nurse assistants, or home health aides—to undergo 75 hours of paid basic training beginning January 1, 2016. The training would be provided by qualified individuals or organizations and would cover "core competencies," including, but not limited to, the following: managing common chronic diseases; personal care; nutrition, diet, and physical activities; universal precautions and workplace safety; consumer and provider roles and rights; understanding the health care system; and communication and teamwork skills. The measure specifies the timeframe for the completion of the required training.

- ***New IHSS Providers Have Six Months to Complete Training.*** Individuals who become IHSS providers after January 1, 2016 will have until June 30, 2016 or six months from their date of hire (whichever is later) to complete the training.
- ***Existing IHSS Providers Have Five Years to Complete Training.*** Individuals who worked as IHSS providers in the 2014 or 2015 calendar years would have until December 31, 2020 or six months from their date of hire (whichever is later) to complete the training.

IHSS Providers Would Be Paid Regular Wage Plus Supplement for All Training Hours. The IHSS providers who undergo the basic training would be paid their regular wage plus the supplement for all training hours. The measure stipulates that IHSS providers cannot be charged for any part of the training and that the training hours cannot be deducted from the IHSS recipient's authorized service hours determined by a county social worker.

Failure to Complete Training Prevents Individuals From Working as IHSS Providers. The measure stipulates that individuals who do not complete the basic training within the specified time periods may not work as IHSS providers.

Creates State Agency Implementation and Oversight Responsibilities

The Department of Social Services (DSS) to Develop Training Curriculum. The measure requires DSS, which administers IHSS at the state level, to work in consultation with DHCS and stakeholders to develop the IHSS provider training curriculum. In developing the curriculum, DSS is responsible for identifying the appropriate modes of training, which are required by the measure to include an in-person component and incorporate best practices for adult education.

The DSS Must Create a Completion Form. The measure requires DSS to create a form for IHSS providers to certify that they have completed the required training.

FISCAL EFFECTS

Below, we discuss the elements of the measure that result in either costs or savings to state government.

State Costs for Wage Supplement

Wage Supplement as of January 1, 2016 Costs Roughly Half a Billion Dollars Annually. We estimate that the $2 hourly minimum wage supplement associated with the scheduled increase of the hourly minimum wage to $10 as of January 1, 2016 would cost the state roughly half a billion dollars annually. (In arriving at this fiscal estimate, we assumed an annual 2 percent growth in the IHSS caseload beginning 2013-14 through 2015-16.)

Cost of Wage Supplement Less in Initial Years. Because the hourly minimum wage will first increase under current law to $9 and remain at that level for a year and a half before further increasing under current law to $10, the initial cost of the wage supplement will be lower in the initial years of the measure's implementation. We estimate that the cost to the state of a $1 supplement associated with a $9 minimum wage (the supplement that would be in effect until January 1, 2016) would be in the low hundreds of millions of dollars annually.

Cost of Wage Supplement Would Grow With Any Future Minimum Wage Increases. If the state-mandated hourly minimum wage were to further increase above $10 in the future due to future law changes, the resulting annual cost to the state of the total wage supplement would exceed the roughly half a billion dollars associated with the $2 wage supplement. The exact annual additional state cost of future increases to the wage supplement would depend upon the amount of the minimum wage increase and the total number of service hours performed by IHSS providers in the year in question.

Assume Federal Government Will Pay its Traditional Share of Cost for the Wage Supplement. We note that our estimate of the cost to the state of the wage supplement assumes that the state would continue to receive an effective federal reimbursement rate in general of 54 percent applied to the higher cost of paying IHSS providers.

State Costs Related to Training Requirement

The state would incur two main sets of annual costs from the requirement that IHSS providers receive basic training: (1) the cost of paying IHSS providers their regular wage plus the supplement for all training hours and (2) the cost of administering the training and ensuring compliance with the training requirement. Together, these costs would likely exceed $100 million dollars annually through 2020, and be somewhat lower thereafter.

Costs in the Tens of Millions of Dollars Annually for Paying IHSS Providers to Complete Training. We estimate state costs in the tens of millions of dollars annually in the initial five-year period from January 1, 2016 (when training begins for new and existing IHSS providers) to December 31, 2020 (the deadline for existing IHSS providers to complete training). After December 31, 2020, the state would incur ongoing costs that would be somewhat lower as a result of only paying new IHSS providers to complete training. Historically, the annual turnover rate within the IHSS workforce has been about one-third. However, for the purposes of our estimate, we assume that the turnover rate could decrease somewhat as the wage supplement may encourage some individuals to remain in the provider workforce for a longer period of time than they otherwise would have.

One-Time State Costs in the Low Millions of Dollars to Develop Training Curriculum. We estimate that DSS will incur one-time costs in the low millions of dollars for developing the IHSS provider training curriculum. The costs to develop the training could be higher initially if the curriculum involved a software or online component.

Administering Training Costs in the Tens of Millions of Dollars Annually. We estimate that the cost to the state of administering the training to IHSS providers would be in the tens of millions of dollars annually. The cost reflects several expenditures: (1) labor costs for qualified individuals or organizations to administer the training; (2) materials costs, such as classrooms and training documents; and (3) overhead costs, such as communication to IHSS providers about the training requirement. We note that the cost to administer the training would be more in the initial five-year period (in the high tens of millions of dollars), when existing IHSS providers are completing the training requirement. After the initial five-year period, we estimate that the cost to administer the training would be somewhat lower since the training would only be administered to new IHSS providers.

Ongoing State Cost in the Low Millions of Dollars Annually to Ensure Compliance. In order to ensure that all IHSS providers have complied with the basic training requirement within the specified time frames, we estimate that DSS will incur costs in the low millions of dollars annually. This cost could be higher initially if DSS ensures compliance through the use of software or online tools.

Training Requirements Could Raise Issues Related to Federal Rules

The measure's training requirement raises a couple key fiscal issues related to federal rules, which we discuss more fully below.

Federal Financial Participation for Training Costs Is Uncertain. Our fiscal estimate for the cost to the state of paying providers to undergo training and administering the training assumes that the state will receive in general federal reimbursement of 54 percent for these new costs. We make this assumption based on the precedent set in Washington State, where the cost of training home care workers received federal financial participation. (In Washington State, federal financial participation for training costs required federal approval of an amendment to the state's Medicaid contract with the federal government.) If the costs associated with training prove not to be eligible for federal financial participation, then the cost to the state would be roughly double what we estimate.

New Federal Overtime Regulations Could Add Uncertain Costs to Training Requirement. The federal Department of Labor has recently issued new regulations to take effect January 1, 2015 that require IHSS providers (and other direct care workers) to receive overtime pay. In California, this requirement means that IHSS providers would receive one-and-a-half times their regular rate of pay for working more than 40 hours in a week. The federal regulations also specify that mandatory provider training is to be counted as hours worked for the purposes of calculating overtime. However, because the measure does not specify how the training would be structured within a provider's regular work schedule, it is uncertain how many total training hours in a given year could be counted as overtime and therefore subject to the higher rate of pay. Although the cost of paying overtime for training hours will ultimately depend on how the training is structured, we estimate that this cost is not likely to exceed the low tens of millions of dollars annually.

State Costs Potentially Partially Offset by Savings

We estimate two sets of potential savings associated with the measure that, collectively, could serve to partially offset the state costs discussed above.

Tens of Millions of Dollars in Potential Annual Savings Resulting From Reduced Provider Reliance on Public Assistance. We estimate that a portion of IHSS providers currently receive some form of public assistance, such as Medi-Cal. A subset of these IHSS providers might no longer be eligible for public assistance programs as a result of the higher income the measure provides. This potential decreased reliance on public assistance could lead to state savings, not likely to exceed tens of millions of dollars annually.

Potential Savings Resulting From Training of IHSS Providers. We find there is a potential for state savings, potentially in the millions of dollars annually, resulting from the measure's requirement for basic training of IHSS providers. The exact amount of these savings is uncertain and largely dependent on the efficacy of the training. The savings could result from two factors.

- ***Health Care Utilization by Recipients Possibly Reduced.*** The aspects of the provider training which address the management of common chronic diseases, personal care, nutrition, diet, and physical activities may enhance the quality of care provided to

recipients by IHSS providers. To the extent that the care provided by the trained IHSS providers reduces more costly health care utilization for a certain segment of recipients, the training could potentially yield Medi-Cal savings in the millions of dollars annually.

- ***Workers' Compensation Costs Possibly Reduced.*** The aspect of the provider training that addresses universal precautions and workplace safety may reduce the number of workers' compensation claims. This possible reduction in the number of workers' compensation claims could potentially yield savings in the low millions of dollars annually.

Other Impacts

We note that state and local governments would collect more in personal income, sales, and other taxes due to the higher income of IHSS providers due to this measure. These higher revenues could total in the low tens of millions of dollars per year. The higher IHSS expenditures, however, would prevent the state from spending that money on alternative public programs or initiatives, thereby reducing the tax revenue and economic activity that otherwise would be generated from those alternate uses. These two economic effects generally would offset each other.

Fiscal Summary

Based on our analysis, we estimate that the measure would have the following significant fiscal impacts:

- State costs upwards of $600 million annually associated with the measure's requirements to pay a wage supplement and provide paid training to In-Home Supportive Services (IHSS) providers, with costs growing with any future increases in the state-mandated hourly minimum wage.
- Potential state savings—not likely to exceed the low tens of millions of dollars annually—from reduced public assistance utilization by IHSS providers and a potential reduction in higher-cost publicly funded health care.

Sincerely,

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Mac Taylor
Legislative Analyst

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Michael Cohen
Director of Finance