Senate Bill 90:

1991 Realignment Report

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SENATE BILL 90: 1991 REALIGNMENT REPORT

INTRODUCTION

In 2014, the state implemented the Coordinated Care Initiative (CCI), a demonstration project to coordinate care for individuals eligible for Medicare and Medi-Cal. These dual-eligible beneficiaries were passively enrolled into managed care plans for their Medicare and Medi-Cal benefits in seven counties. Long-term care services under the In-Home Supportive Services (IHSS) program were included in the demonstration. The IHSS program, a Medi-Cal benefit, provides eligible aged, blind, and disabled persons the services they need to remain safely in their own homes and avoid costly institutionalization.

The IHSS program is funded in part through the Social Services Subaccount within 1991 Realignment. As part of the 1991 Realignment structure, counties had a fixed 35-percent share and the state a 65-percent share of the non-federal costs (the federal government pays about 50 percent of the program costs). Prior to 1991 Realignment, counties had an original share-of-cost in IHSS that was about 3 percent. As a result of the CCI, the traditional state-county sharing ratios for IHSS costs were replaced by a county maintenance-of-effort (MOE) requirement for all counties. At that time, a base MOE was established for each county that was calculated using their 35-percent share of IHSS costs. The MOE was adjusted by an inflation factor of zero for two years and then increased by 3.5 percent annually. A county's base was only adjusted by its 35 percent

share for any increase in collective bargaining costs due to locally-negotiated wage and/or benefit increases.

The statute included a "trigger" that allowed the Director of Finance to discontinue CCI if the state was not realizing savings from its implementation. As part of the January 2017 Governor's Budget, the Director notified the Legislature that CCI was no longer cost-effective and the CCI program would end in 2017-18 based on the trigger provisions. This meant the MOE provisions associated with IHSS would be discontinued and the program would return to the prior state-county sharing ratios of 65 and 35 percent, respectively.

This change led to an immediate General Fund savings and a shift in costs to the counties of an estimated $592 million in 2017-18 and over $626.2 million in 2018-19, growing annually thereafter. This cost to the counties would ostensibly be an obligation under 1991 Realignment. However, 1991 Realignment revenues were insufficient to fund this immediate cost, and counties would have had to use their county general purpose funds to supplement Realignment funding for IHSS. There was a negotiated Budget agreement in June 2017 that involved additional General Fund support for IHSS, plus a redirection of 1991 Realignment growth funds from other subaccounts to the Social Services Subaccount, to help pay for counties' IHSS costs in the near term and mitigate the effects of this shift in costs to counties. After providing this relief, projections at the time showed a significant impact on counties to provide funding for IHSS beyond available Realignment funds beginning in 2020-21. Therefore, part of the Budget agreement included a requirement for a "look back" report to review the funding structure of 1991 Realignment, how revenues and costs are growing, and the ability of available revenues to meet program costs of the realigned programs.

Specifically, Chapter 25, Statutes of 2017 (Senate Bill 90), added Section 17600.70 to the Welfare and Institutions Code:

"(a) As part of the development of the 2019-20 budget, the Department of Finance, in consultation with the California State Association of Counties and other affected parties, shall reexamine the funding structure within 1991 Realignment. Pursuant to subdivision (b), the Department of Finance shall report findings and recommendations regarding the In-Home Supportive Services Maintenance of Effort created in Section 12306.16 and other impacts on other 1991 Realignment programs, including, but not limited to, the following:

(1) The extent to which revenues available for 1991 Realignment are sufficient to meet program costs that were realigned.

(2) Whether the In-Home-Supportive Services program and administrative costs are growing by a rate that is higher, lower, or approximately the same as the maintenance of effort, including the inflation factor.

(3) The fiscal and programmatic impacts of the In-Home Supportive Services Maintenance of Effort on the funding available for the Health Subaccount, the Mental Health Subaccount, the County Medical Services Program Subaccount, and other social services programs included in 1991 Realignment.

(4) The status of collective bargaining for the In-Home Supportive Services program in each county.

(b) Findings and recommendations shall be reported to the Legislature no later than January 10, 2019."

This Report is divided into the following sections:

I. 1991 Realignment Background
II. In-Home-Supportive Services Background
III. Specific Report Questions
IV. Findings and Recommendations

This report is respectfully submitted to the Legislature in fulfillment of the requirement outlined in SB 90.

I. 1991 REALIGNMENT BACKGROUND

In California, counties are generally responsible for providing health and social services programs on behalf of the state. Most of these programs have traditionally been funded with a combination of federal, state, and county monies divided into shares-of-cost. In 1991, the state enacted a major change in this state-local government relationship, commonly referred to as Realignment.

Realignment is defined as a transfer of program responsibility and funding from one level of government to another. While there had been some prior similar transfers, 1991 Realignment was the first that proposed a major increase in new revenue dedicated to counties for the transferred programs, most of which were in the health and human services area. The primary goals were to help mitigate a significant state budget shortfall, give counties greater funding stability, and create an incentive for counties to operate programs with greater efficiency and effectiveness.

The January 1991-92 Governor's Budget identified an approximate $7 billion budget shortfall and proposed to realign $942 million in revenues for community mental health and certain health and public health programs. These programs had previously been funded through General Fund grants to counties. Due to prior budget shortfalls, these programs had been reduced in previous budgets and, if not for Realignment, would have been subject to additional major reductions. The funding sources for Realignment were a proposed increase in the alcohol beverage tax and a change in the Vehicle License Fee (VLF) depreciation schedule. The Budget also proposed new authority for counties to add a half-cent sales tax for local public safety purposes.

As the Budget shortfall increased to over $14 billion, in spring 1991 the Realignment proposal also increased in value. The funding sources for the revised proposal became the VLF depreciation schedule change and a half-cent sales tax increase that had been proposed for local public safety. Because this generated $2.2 billion in revenue, the state needed to identify more programs and associated costs to be realigned. In addition to more program transfers, specified shares-of-cost in programs were changed to arrive at a $2.2 billion funding transfer. See Figure 1 for the programs included in 1991 Realignment and Figure 2 for associated changes to the county share-of-cost for programs.

Figure 1

Components of State and Local Realignment

(Dollars in Millions)

Transferred Programs	Cost Shifted to Counties
Mental Health	
Community-Based Mental Health Programs	$452
State Hospital Services for County Patients	210
Institutions for Mental Diseases	88
Public Health	
AB 8 County Health Services	503
Local Health Services	3
Indigent Health	
Medically Indigent Services Program	348
County Medical Services Program	57
Local Block Grants	
County Stabilization Subventions	15
County Juvenile Justice Subventions	37
County Cost Sharing Ratios Changes	
California Children's Services	30
Foster Care	362
Child Welfare Services	42
In-Home Supportive Services	235
County Services Block Grant	13
Adoption Assistance	12
Employment Services	26
CalWORKs Aid (formerly AFDC)	-155
County Administration	-96
Net Additional County Expenditures	**$2,182**

Figure 2

County Shares:

Pre- and Post-Realignment

Realigned Program	Pre-Realignment	Post-Realignment
CalWORKs Aid	11%	5%
CalWORKs Eligibility	50%	30%
CalWORKs Employment Services	0%	30%
Foster Care	5%	60%
Child Welfare Services	24%	30%
Adoption Assistance	0%	25%
County Services Block Grant	16%	30%
In-Home Supportive Services	3%	35%
California Children's Services	25%	50%

The component programs of Realignment were primarily discretionary with the exception of Foster Care and Aid to Families with Dependent Children (AFDC, now CalWORKs), which were both federal entitlement programs. While most county shares of cost were increased, the county sharing ratios for AFDC and county administration were reduced. The total for the Social Services Subaccount is determined by netting the increased costs and savings of the sharing ratio changes.

1991 Realignment was a critical component of the 1991-92 budget solutions. However, when realigned, there were no major program changes or increased flexibility provided to counties except in the community mental health program. The mental health program transfer allowed counties to determine how best to provide treatment between funding programs in the community or purchasing beds for civil Lanterman-Petris-Short (LPS) state hospital commitments. The subsequent decrease in the use of LPS beds indicated counties significantly increased community treatment options. Counties seemed more comfortable in creating additional community options because the funding, while not "recession proof," was more stable and not subject to reductions due to a General Fund shortfall. Since community mental health programs were not entitlements, the statute also specified counties were to provide mental health services to the extent resources were available.

STRUCTURE OF 1991 REALIGNMENT

The initial structure created for 1991 Realignment was fairly straightforward. There were three primary accounts—Health, Mental Health and Social Services. Each account was funded at a level consistent with the General Fund appropriations they were replacing. Similarly, allocations of the new revenue for each county were a replacement for what that county would otherwise have received if General Fund had been allocated. Those amounts became the bases for each account and for each county within each account.

It was also determined there would be a rolling base, whereby each account and each county's prior year base plus growth would equal the next year's base funding. For example, if a county's base equaled $1 million in one year and growth added $100,000, the next year's base would be $1.1 million. If there are insufficient revenues to fully fund the base for each county, there is no requirement to restore the base. However, the state is required to keep track of the social services growth each year and fund the growth in subsequent years because of potential mandate issues. The base has been short several times, including the very first year when the actual

revenue estimate ($2.2 billion) came in at $1.9 billion. Consequently the base was reset. This occurred at least two additional times since these programs were realigned.

The more important aspect of Realignment was the possibility of growth from the dedicated revenue sources. Growth accounts were established for both VLF and sales tax to separately track revenue increases. The sales tax growth was first dedicated to the Caseload Subaccount (which funds social services programs) to pay for any potential mandate costs associated with the changes in sharing ratios. Growth payments for the Caseload Subaccount are calculated based on annual changes in caseload, comparing costs in one year to the costs from the previous year.

Any remaining sales tax growth funds are then allocated to the County Medical Services Program (CMSP), which provides medical care to low-income medically indigent adults in smaller counties and receives about 4 percent of the remaining sales tax growth funds. If the caseload account receives more than $20 million then CMSP receives about 8 percent of the sales tax growth. Any remaining sales tax growth and all of the remaining VLF growth is then allocated to the General Growth Subaccount. Funds in the General Growth Subaccount are allocated among the realigned programs according to a statutory formula.

The formula for the allocation of growth was developed as part of the overall Realignment agreement with counties. With the exception that the social services caseload increases be funded first, the state left the allocation of growth funds to the California State Association of Counties and the counties. With this flexibility, counties took the opportunity to provide funding not only for social services growth but also for health and mental health equity to those counties meeting the definition of being "under equity." Equity was defined as a county's percentage share of the statewide Realignment base allocation in comparison to both the jurisdiction's percentage share of the statewide population and poverty population. Counties whose payments were a lower percentage than the combined population/poverty percentage were determined to be under equity, which could be measured in dollars based on expenditures for each county. When the equity caps were reached, the accounts set up for this purpose became dormant and are no longer part of the structure.

Due to the recession and the funding of mental health and health equity, there was no general growth funding available for the Mental Health or Health accounts until 1994-95; all available growth went to fund social services caseload increases.

See below for a description of how the growth allocations changed under SB 90.

MAJOR CHANGES TO THE REALIGNMENT STRUCTURE SINCE 1991

Over the years, there have been some significant changes to both the programs that were realigned and the structure of 1991 Realignment. These changes, described below, have altered the character of some of the realigned programs, changed what is funded within 1991 Realignment, and squeezed funds available for the realigned programs.

Implementation of Personal Care Services Program. In the 1992-93 Budget, the Personal Care Services Program (PCSP) was implemented in IHSS. PCSP is a federal Medicaid benefit which allowed services provided by non-relatives to become eligible for federal reimbursement. In 2004-05, the federal government approved a waiver allowing services provided by relative caretakers and protective supervision to also be eligible for federal reimbursement. This completely changed the character of IHSS from a largely discretionary social services program with flexibility to change statutory requirements to reduce costs, to mostly a federal entitlement program with significantly less ability to affect costs. Also, when PCSP was first implemented in 1993, both the state and counties realized savings from the increase in federal funding for this program. Net county savings from PCSP were used to reduce the value of the increased county share-of-cost funded from Realignment. This reduced the amount of realignment revenue allocated to the IHSS program. Counties were to utilize the federal funds received to improve IHSS as well as offset their costs.

Implementation of Medi-Cal Mental Health Managed Care. In 1994-95, the state implemented Medi-Cal Mental Health Managed Care as part of the overall transition from a fee-for-service to a managed care payment model. Mental Health Managed Care became a "carve out" from overall managed care plans with counties requesting to be the service provider for specialty mental health services. As such, the plans were not provided a managed care payment for specialty mental health services, which are services for persons with higher level needs, including inpatient care. All Medi-Cal recipients needing this higher level of care are required to receive these services from the county.

Counties use their 1991 Realignment funds as a match for federal funds under this program. Moving to a federal entitlement program had two impacts. First, it created an entitlement program whereas the funding structure for mental health was provided "to the extent funds are available." As an entitlement program, this would strain the resources in the Mental Health Subaccount. Second, it focused services on the

Medi-Cal population with less funding available from 1991 Realignment to spend on the non-Medi-Cal-eligible population, typically childless adults and undocumented persons.

Transfer of Mental Health Funding from 1991 Realignment to 2011 Public Safety Realignment. The 2011 Budget Act included a second major realignment: 2011 Public Safety Realignment. This Realignment reflected a $5.6 billion transfer of dedicated funding and programs to the counties. As part of that proposal, $1.1 billion in funding for mental health services was switched from 1991 Realignment to 2011 Realignment. This not only allowed most of the Realignment funding for mental health to be constitutionally protected, but was also a strong signal that mental health services were critical support services for the population of low-level offenders transferred to county jurisdiction. The $1.1 billion that was freed up in 1991 Realignment was used to offset state General Fund costs in the CalWORKs program by creating the CalWORKs MOE Subaccount, capped at $1.12 billion. No changes were made to any county requirements for CalWORKs because of this switch.

Implementation of the Affordable Care Act (ACA). In 2013, the state implemented health care reform under the ACA resulting in a significant expansion in the number of individuals eligible for Medi-Cal. Specifically, the optional expansion allowed childless adults with incomes of up to 138 percent of the federal poverty level to receive health benefits through Medi-Cal. Under health care reform, county costs and responsibilities for indigent health were expected to decrease significantly as recipients moved to Medi-Cal, which increased state General Fund costs. Savings for each county from a new statutory formula were redirected from the Health Subaccount to a new subaccount, the Family Support Subaccount. These funds are used to offset state General Fund costs for CalWORKs with no changes made to county requirements for the program.

Implementation of the Coordinated Care Initiative (CCI). Also in 2013, the state implemented the CCI. As part of the transition to managed care for certain counties, the share of IHSS program costs for all counties shifted from a fixed share-of-cost to a Maintenance-of-Effort (MOE) structure. The MOE required that a county's base costs increased annually by an inflation factor of 3.5 percent after no inflation factor for the first two years. This inflation factor resulted in county costs within Realignment growing more slowly as the state took on all non-federal IHSS costs above the MOE. As a result, there were "savings" within the structure of 1991 Realignment which were transferred to a new Child Poverty and Family Supplemental Support Subaccount to fund CalWORKs cost-of-living increases and the elimination of the CalWORKs maximum family grant restriction. This took funding out of the original Realignment structure for a new program component, and therefore these funds were not available for growth

allocations to the Health and Mental Health accounts. When the CCI trigger was pulled and the IHSS program returned to a share-of-cost structure, this new subaccount exacerbated the demand on the 1991 Realignment revenue available for the original program structure.

Additionally, as part of the changes implemented in 2013 to 1991 Realignment, a set percentage equal to its historic growth level (18.4545 percent) was dedicated to the Health Subaccount. The Mental Health Subaccount continued to receive growth according to the current statutory formula. Also, the Child Poverty and Family Supplemental Support Subaccount would begin receiving a share of general growth funds to fund CalWORKs grant increases.

End of the Coordinated Care Initiative. The 2017 Budget Act and Chapter 25, Statutes of 2017, reflected the fiscal impact to the state and counties associated with ending CCI. The end of CCI automatically returned IHSS from a county MOE funding structure to the prior 65-35 percent state-county sharing ratio. Compared to the MOE structure under CCI, the counties' share of cost for IHSS increased by $583.9 million in 2017-18, with the state costs decreasing by that amount. To mitigate the fiscal impact to counties, the 2017 Budget Act established a revised MOE structure including an infusion of state General Fund and the redirection of growth funds from other 1991 Realignment accounts to help offset the increased county share of cost.

Specifically, the following adjustments were made within the 1991 Realignment structure:

- General Fund Assistance – $400 million in 2017-18, $330 million in 2018-19, $200 million in 2019-20 and $150 million per year thereafter.
- Use of Growth Funds – Redirection of all VLF growth for three years from the Health, CMSP, and Mental Health Subaccounts to provide additional resources to IHSS. In years four and five, 50 percent of the VLF growth would be redirected. Additionally, 2016-17 growth funds totaling $93.8 million ($73.7 million in VLF and $20.1 million in sales tax) was redirected from the Health, CMSP, and Mental Health Subaccounts. $76.9 million of this amount became part of the on-going Social Services Subaccount base.
- Maintenance-of-Effort Structure – Instituted a revised MOE structure with the base amount calculated using historic sharing ratios (65-percent state and 35-percent county) for 2017-18. Similar to the structure under CCI, the state General Fund

would pay the difference between the MOE and the non-federal share of IHSS costs in future years.

- Inflation Factor – An annual inflation factor was phased in and applied to the base. In 2017-18, the inflation factor was zero and in 2018-19, it was 5 percent. In future years the inflation factor is dependent on 1991 Realignment revenue growth. If Realignment revenue growth is above 2 percent, the inflation factor would be 5 percent in 2018-19 and 7 percent annually thereafter (the expected IHSS annual cost growth). If revenue growth is greater than zero but less that 2 percent, the inflation factor applied would be one-half of the 7-percent inflation rate. If revenue growth is negative, then no inflation factor would be applied.
- More Current Cost Data – The methodology for calculating IHSS caseload growth in the Caseload Subaccount was changed to use the current estimate of caseload and cost information. This accelerates growth funding available to cover costs in the Caseload Subaccount.

These mitigations affected the resources available for health and mental health programs within 1991 Realignment but were a critical component of the budget solution so that counties would not have to immediately use county general purpose funds for IHSS costs. Even with these measures, it was estimated that by 2020-21, counties would have to cover almost $190 million for increased IHSS costs.

II. In-Home-Supportive Services Program Background

IHSS is a federal Medicaid benefit. It provides various services to eligible aged (over 65 years of age), blind, or disabled persons who are unable to remain safely in their own homes without such assistance. IHSS providers assist recipients with a variety of tasks such as housework, bathing, feeding and dressing. Recipients are eligible to receive up to 283 hours of services per month.

County workers determine eligibility for the program taking into account the applicant's income and need for services. A county social worker visits the home of the IHSS applicant and performs an individualized assessment to determine the need for services using a tool called the hourly task guidelines. This tool is used to determine the number of hours for each type of service a recipient may require to stay safely at home. A Functional Index (FI) score is assigned in various categories, or activities of daily living, which indicates the level of assistance needed to perform tasks safely in the home. The FI scores range between 1, which is defined as independent, to a high of 6, which indicates a recipient requires paramedical services prescribed by a licensed health care professional. Recipients are generally reassessed for service needs every twelve months, or upon request if a recipient's condition changes.

The IHSS recipient is considered to be the employer and is responsible for hiring, supervising, and firing his or her provider. About 75 percent of IHSS recipients have a relative provider. IHSS wages and benefits are collectively bargained at the local level (see additional information about collective bargaining in the section below on Specific Report Questions).

The composition of the IHSS caseload has changed over time. While many think of it as a program for an aged population, it has increasingly become a program for disabled recipients. This is particularly true as the state has closed Developmental Centers and clients have moved into the community, where IHSS is one of the programs they can access. With the increased diagnosis of autism, the IHSS caseload has also seen an increase in minor cases, which has fueled an increase in protective supervision cases.

Figure 3 displays the total authorized cases and different categories of cases along with the authorized hours for those cases and the average FI score.

Figure 3

IHSS Recipient Demographic Data

July 2004 through June 2018

(Source: Department of Social Services)

Fiscal Year	Total Authorized Cases	Average Authorized Hours	Average Functional Index Score
FY 2004/05	339,768	85.5	2.7
FY 2005/06	357,479	86.0	2.7
FY 2006/07	376,135	87.5	2.8
FY 2007/08	401,157	87.5	2.8
FY 2008/09	429,839	88.0	2.8
FY 2009/10	441,939	87.9	2.8
FY 2010/11	441,037	86.6	2.9
FY 2011/12	437,852	86.2	2.8
FY 2012/13	443,403	87.4	2.8
FY 2013/14	466,479	85.7	2.8
FY 2014/15	494,584	89.7	2.8
FY 2015/16	519,625	97.8	2.8
FY 2016/17	546,444	100.0	2.8
FY 2017/18	569,912	102.4	2.8

Fiscal Year	Total Aged Cases	Average Authorized Hours	Average Functional Index Score
FY 2004/05	157,558	80.3	2.7
FY 2005/06	164,592	80.9	2.7
FY 2006/07	172,038	81.0	2.8
FY 2007/08	181,803	82.3	2.8
FY 2008/09	192,081	82.8	2.8
FY 2009/10	194,246	82.4	2.9
FY 2010/11	190,755	79.5	2.9
FY 2011/12	188,202	78.7	2.9
FY 2012/13	187,977	78.9	2.9
FY 2013/14	193,328	78.7	2.8
FY 2014/15	198,626	82.8	2.8
FY 2015/16	203,578	89.9	2.8
FY 2016/17	209,798	91.9	2.8
FY 2017/18	215,074	93.8	2.8

Fiscal Year	Total Blind Cases	Average Authorized Hours	Average Functional Index Score
FY 2004/05	9,597	98.2	2.8
FY 2005/06	9,740	98.8	2.9
FY 2006/07	9,811	99.6	3.0
FY 2007/08	10,068	101.1	3.0
FY 2008/09	10,259	101.8	3.0
FY 2009/10	10,220	101.3	3.0
FY 2010/11	9,893	98.2	3.0
FY 2011/12	9,694	98.6	3.0
FY 2012/13	9,807	100.4	3.0
FY 2013/14	9,828	98.4	3.0
FY 2014/15	9,849	102.4	2.9
FY 2015/16	9,803	111.4	3.0
FY 2016/17	9,758	114.1	3.0
FY 2017/18	9,679	115.9	2.9

Fiscal Year	Total Disabled Aged 0-64 Cases	Average Authorized Hours	Average Functional Index Score
FY 2004/05	131,226	91.9	2.7
FY 2005/06	137,824	92.2	2.7
FY 2006/07	149,278	93.3	2.8
FY 2007/08	160,869	94.5	2.8
FY 2008/09	174,031	94.9	2.8
FY 2009/10	179,481	95.0	2.8
FY 2010/11	179,816	92.8	2.8
FY 2011/12	178,033	94.5	2.8
FY 2012/13	179,935	96.2	2.8
FY 2013/14	191,614	94.0	2.8
FY 2014/15	207,166	89.7	2.8
FY 2015/16	221,370	106.7	2.8
FY 2016/17	235,381	109.4	2.7
FY 2017/18	246,993	112.3	2.7

Fiscal Year	Total Disabled Cases Aged 65+	Average Authorized Hours	Average Functional Index Score
FY 2004/05	36,520	80.7	2.7
FY 2005/06	39,607	81.5	2.7
FY 2006/07	43,549	81.8	2.7
FY 2007/08	48,237	82.8	2.7
FY 2008/09	53,783	83.7	2.7
FY 2009/10	57,005	83.4	2.8
FY 2010/11	59,779	80.6	2.8
FY 2011/12	61,924	80.6	2.8
FY 2012/13	65,670	81.3	2.8
FY 2013/14	71,708	79.9	2.8
FY 2014/15	78,942	83.8	2.8
FY 2015/16	84,893	91.4	2.8
FY 2016/17	91,507	93.2	2.8
FY 2017/18	98,226	95.2	2.8

Fiscal Year	Total Cases Aged 85+	Average Authorized Hours	Average Functional Index Score
FY 2004/05	41,023	97.1	2.9
FY 2005/06	44,390	97.2	2.9
FY 2006/07	47,241	97.0	2.9
FY 2007/08	51,657	97.6	3.0
FY 2008/09	56,594	97.8	3.0
FY 2009/10	60,449	97.3	3.1
FY 2010/11	62,963	94.3	3.1
FY 2011/12	65,006	93.2	3.0
FY 2012/13	67,615	89.3	3.0
FY 2013/14	72,136	92.4	3.0
FY 2014/15	76,758	96.3	3.0
FY 2015/16	80,666	105.1	3.0
FY 2016/17	84,173	107.7	3.0
FY 2017/18	87,375	109.7	3.0

Fiscal Year	Total Minor Cases	Average Authorized Hours	Average Functional Index Score
FY 2004/05	13,901	105.6	2.7
FY 2005/06	14,857	106.5	2.7
FY 2006/07	17,088	110.0	2.7
FY 2007/08	17,200	111.5	2.7
FY 2008/09	18,971	121.5	2.7
FY 2009/10	20,171	117.5	2.3
FY 2010/11	20,781	103.4	2.4
FY 2011/12	21,013	116.4	2.3
FY 2012/13	21,558	119.7	2.3
FY 2013/14	23,569	116.8	2.3
FY 2014/15	26,699	127.2	2.2
FY 2015/16	30,246	141.3	2.2
FY 2016/17	34,369	146.0	2.2
FY 2017/18	38,489	149.6	2.2

Fiscal Year	Total Protective Supervision Cases	Average Authorized Hours	Average Functional Index Score
FY 2004/05	14,613	249.0	3.2
FY 2005/06	15,270	250.7	3.2
FY 2006/07	16,029	250.7	3.2
FY 2007/08	17,574	251.7	3.1
FY 2008/09	19,404	251.1	3.1
FY 2009/10	20,688	250.2	3.1
FY 2010/11	22,053	240.3	3.1
FY 2011/12	23,243	239.1	3.0
FY 2012/13	22,638	239.1	3.0
FY 2013/14	26,669	228.3	3.0
FY 2014/15	30,027	237.6	2.9
FY 2015/16	34,097	256.9	2.9
FY 2016/17	39,410	257.6	2.9
FY 2017/18	44,382	258.0	2.9

From 2004-05 to 2017-18, the number of authorized cases has increased by 67.7 percent, from 339,768 to 569,912. The number of aged cases in the same timeframe only increased by 36.5 percent. The number of disabled cases, aged 0 to 64, has increased by 88.2 percent and has grown in proportion to the total number of cases, from 38.6 percent to 43.3 percent. At the same time, the number of disabled cases, aged 65 and over, has increased by 169 percent. Once a person is in the IHSS system as a disabled case, the case continues to be identified as disabled rather than moving to the aged category.

There has also been a significant increase in the number of cases over 85 years of age, from 41,023 to 87,375, or 113 percent. Their overall share of the total caseload, however, has only increased from 12.1 percent to 15.3 percent. There has been a dramatic increase in the total number of minor cases from 13,901 to 38,489, or 176.9 percent. Their average authorized hours have also increased by 41.7 percent, though the average FI score has decreased. Normally, these measures would grow more consistently. Even more dramatic is the number of protective supervision cases, from 14,613 to 44,382, or a 203.7 percent increase. A large number of these cases are probably minors (under 18 years of age).

The IHSS caseload, one program cost driver, will continue to increase as the population ages. Costs are also driven by an increase in the hours per case, primarily due to an increasing disabled and protective supervision caseload.

Major Changes to IHSS Since 1991-92

While caseload, its composition, and the hours per case are major factors contributing to increasing program costs, there have also been many changes to the IHSS program since it was realigned in 1991. Some of these changes are detailed in the 1991 Realignment Background section above.

Figure 4 identifies other major changes specific to IHSS. This figure does not include the 2017-18 mitigations that were implemented at the end of CCI, as those are also discussed in the 1991 Realignment Background section. However, it does include the collective bargaining portion of the 2017-18 Budget agreement.

Figure 4
In-Home Supportive Services Changes
1991-92 through 2017-18

Fiscal Year	Summary of Major Changes
1991-92	**Enacted 1991 Realignment—**1991 Realignment transferred funding for certain health and mental health programs to counties and adjusted shares-of-cost in some social services programs thereby increasing county costs by $2.2 billion. Dedicated state funding was provided through a ½ cent state special fund sales tax and an increase in Vehicle License Fee revenue. IHSS was included as one of the realigned programs within the Social Services Subaccount and the county share-of-cost for services was increased from 3 percent to 35 percent accounting for $235 million of the $2.2 billion. The original estimated Realignment base of $2.2 billion had to be adjusted to $1.9 billion in 1992-93 based on actual Realignment revenue received.
1992-93	**Created Public Authorities—**The Public Authorities (PAs) were created by Chapter 722, Statutes of 1992 (SB 485). A PA is a local agency legally separate from the county that has certain responsibilities for the IHSS program, such as managing enrollment of providers, maintaining a registry of providers, and providing training.
1993-94	**Implemented the Personal Care Services Program—**The Personal Care Services Program (PCSP) was implemented through a state plan amendment making IHSS services a Medi-Cal benefit for a portion of the existing IHSS caseload and thus eligible for Medi-Cal reimbursements. Services provided by relatives were excluded and those cases remained in the Residual Program. The county share-of-cost remained at 35 percent for both the Residual Program and the nonfederal costs of the PCSP.
1999-00	**Established an Employer of Record**—The Employer-of-Record (EOR) requirement was created in the 1999 Budget Act. Each county was required to establish an EOR by January 2003 to serve as the employer of IHSS providers for the purposes of collective bargaining for wages and benefits. Counties had several options to establish an EOR, including: (1) acting as the employer of record; (2) contracting with an entity to provide IHSS services; (3) creating a PA or establishing a nonprofit consortium; or (4) developing a mixture of the above. Fifty-six counties have established PAs or nonprofit consortia.
2000-01	**Established an IHSS Trigger**—An IHSS "Trigger" mechanism was established requiring that the level up to which the state participated in individual provider wages and benefits be increased at increments of $1.00, up to $12.10 per hour, in each year the May Revision projection of General Fund revenues was at least 5 percent higher than revenues in the year in which the last increase was provided.
2004-05	**Received a Quality Assurance Waiver**—Pursuant to Chapter 229, Statutes of 2004 (SB 1104), the state received a waiver from the federal government to draw down additional federal financial participation by moving the majority of recipients left in the Residual Program (primarily relative caregivers) to the PCSP. Additionally, the federal government began to allow Protective Supervision cases in the PCSP. The state established a quality assurance program at both the state and county level to reduce IHSS costs by improving the quality of service need assessments and authorizations.
2009-10	**Attempted to Adopt Wage/Benefit Participation Decrease and Implemented Other Savings**—The 2009 Budget Act reduced state financial participation in costs of IHSS provider wages and benefits to $10.10 per hour, down from a maximum of $12.10 per hour. A legal challenge to the reduction (*Dominguez* class action lawsuit) prevented the reduction from being implemented. The revised 2009 Budget Act: (1) included reforms to strengthen efforts to reduce and prevent fraud in the IHSS program; (2) limited the provision of certain IHSS services to the neediest consumers; (3) eliminated the state's payment of the difference between the Medi-Cal share-of-cost and the IHSS share-of-cost for IHSS recipients; and (4) reduced the funding provided to Public Authorities for administration.
2010-11	**Adopted a Temporary Reduction to Recipient Hours**—The 2010 Budget Act included a 3.6-percent across-the-board reduction to recipients' assessed hours, effective through 2011-12.

2011-12	**Enacted IHSS Budget Solutions**—The 2011 Budget Act included $122.5 million in General Fund savings to reflect various statutory changes enacted by Chapter 8, Statutes of 2011 (SB 72), including: (1) eliminating the mandate for counties to establish IHSS advisory committees; (2) eliminating IHSS services for recipients unable to provide medical certification that personal care services were needed to avoid out-of-home care; and (3) implementing the federal Community First Choice Option for IHSS, which allowed the state to leverage a 6-percent increase in federal matching funds for providing home and community-based attendant services to eligible individuals.
2013-14	**Established the Coordinated Care Initiative**—Chapters 33 and 45, Statutes of 2012, authorized the Coordinated Care Initiative (CCI). Under CCI, persons eligible for both Medicare and Medi-Cal (dual eligibles) received medical, behavioral health, long-term services and supports, and home and community-based services (HCBS) through a single health plan. The CCI also enrolled all dual eligibles in managed care plans for their Medi-Cal benefits, including IHSS benefits. Beginning in April 2014, dual eligibles enrolled in CCI in seven counties participating in the demonstration. It was expected that CCI would generate General Fund savings from a reduction of inpatient and long-term care institutional services through increased utilization of HCBS. Concurrent with enactment of CCI, the responsibility for collective bargaining for wages and benefits with provider representatives shifted from counties to the state for those counties participating in the CCI demonstration. The California IHSS Authority was established for these seven CCI counties. As part of the transition to CCI, IHSS county program costs for all counties shifted from a fixed share (35 percent of the non-federal share for services and 30 percent for county administration) to a maintenance of effort (MOE) requirement. The MOE meant that base costs increased annually by an inflation factor of 3.5 percent after a zero inflation factor for the first two years. The county share-of-cost for any locally negotiated wage and health benefit increases was added to a county's MOE and became subject to the annual inflation factor. **Settled Litigation**—In March 2013, the Administration reached agreement with plaintiffs in the *Oster* and *Dominguez* class-action lawsuits. Chapter 4, Statutes of 2013 (SB 67), repealed IHSS provider wage and service reductions enacted in prior years and instituted an 8-percent across the board reduction effective July 1, 2013, decreasing to 7 percent after 12 months.
2014-15	**Revised Federal Overtime Regulations**—In September 2013, the United States Department of Labor announced new regulations, effective January 1, 2015, that effectively required overtime pay for IHSS providers and made applicable to IHSS providers other existing regulations that required compensation for providers traveling between multiple recipients and for wait time. The 2014 Budget Act included $394.8 million ($172.2 million General Fund) and $819.7 million ($354.4 million General Fund) annually thereafter to comply with the new federal regulations. However, this funding was not used in 2015 due to a federal court ruling to vacate the regulations.
2015-16	**Restored Reduction in Service Hours**—The 2015 Budget Act implemented a one-time General Fund restoration of the 7-percent across-the-board reduction to authorized IHSS hours. Estimated costs to fund the restoration in 2015-16 were $514.5 million ($240.8 million General Fund).

2016-17	**Extended the Restoration of the Reduction in Service Hours**—The 2016 Budget Act also restored the 7-percent across-the-board reduction to service hours through fiscal year 2018-19. The restoration cost $590.5 million ($265.8 million General Fund) in 2016-17. The restoration remains in effect until June 30, 2019, when the managed care organization tax is scheduled to expire. **Complied with Fair Labor Standards Act and Overtime Exemptions**—In February 2016, in response to revised federal Fair Labor Standards Act rules, the state implemented the requirements of Chapter 29, Statutes of 2014 (SB 855), related to overtime, travel time, and medical accompaniment compensation for IHSS providers. **Enacted Exemptions from Overtime Restrictions**—The 2016 Budget Act reflected the fiscal impact of exempting providers who met specified criteria from IHSS overtime restrictions contained in SB 855. Exemptions are available for live-in family care providers who, as of January 31, 2016, reside in the home of two or more disabled minor or adult children or grandchildren for whom they provide services. A second type of exemption is available on a case-by-case basis for providers who provide services for two or more recipients with extraordinary circumstances. Under either exemption, the maximum number of hours a provider may work cannot exceed 360 hours per month. **Increased the State Minimum Wage and Adopted Sick Leave Pay IHSS Providers**—The 2017 Budget Act included costs of $72.9 million ($34.2 million General Fund) for counties that pay IHSS providers at the state minimum wage level to reflect an increase from $10 to $10.50 per hour, effective January 1, 2017. The state minimum wage will continue to increase gradually over the next several years until it reaches $15 per hour on January 1, 2022, unless an increase is paused due to state economic conditions. The 2017 Budget Act also required implementation of sick leave pay for IHSS providers: up to 8 hours annually beginning July 1, 2018; up to 16 hours annually beginning January 1, 2020; and up to 24 hours annually beginning January 1, 2022.
2017-18	**Ended the Coordinated Care Initiative**—As noted in the 1991 Realignment Background Section, the 2017 Budget Act reflected the fiscal impact associated with the discontinuation of CCI along with county mitigations to help offset increased county costs **Changed IHSS Collective Bargaining Provisions**—Under CCI, if a county negotiated a wage and benefit increase, its MOE increased by its 35 percent share. State participation has been capped at $12.10 per hour for wages and benefits since 2007-08. The IHSS budget solution maintained the 35-percent county share (and MOE adjustment) of negotiated increases and increases the state participation cap as the state minimum wage increases so the cap is always $1.10 above the minimum hourly wage set in Chapter 4, Statutes of 2016 (SB 3), for large employers. The cap would rise with inflation once the state minimum wage reaches $15 per hour. For counties at or above the current state cap of $12.10 per hour, the state will participate at its 65-percent share of costs up to a cumulative 10-percent increase in wages and benefits over three years. A county may use this option a maximum of two times and only before the state minimum wage reaches $15 per hour. Counties may also negotiate a wage supplement which is a specified amount that is in addition to the county provider wage. When a wage supplement is first negotiated and applied, there is an adjustment to the county IHSS MOE. The state participation in the non-federal costs of the wage supplement depends on where the county's wage is in relation to the state participation cap. For subsequent applications of the wage supplement, there is no adjustment to the county IHSS MOE. A wage supplement will be subsequently applied when the state minimum wage equals or exceeds the county provider wage absent the wage supplement amount. The annual inflation factor will apply to all local wage and benefit MOE adjustments. Additionally, until January 1, 2020, the Budget established a mediation and fact-finding process with specified timelines through the Public Employment Relations Board, if a county and the collective bargaining representative for IHSS providers fail to reach agreement by January 1, 2018.

More information regarding these changes and the resulting impact on IHSS and 1991 Realignment can be found in the answer to Question 2 in the Specific Report Questions section below.

III. Specific Report Questions

As indicated in the Introduction, SB 90 requires specific questions to be answered. This section provides the required information.

Question 1. *The extent to which revenues available for 1991 Realignment are sufficient to meet program costs that were realigned.*

As noted in the 1991 Realignment Background section above, there was never an agreement that 1991 Realignment revenues would always match the realigned expenditures. Since the first priority for any sales tax growth money is to fund increased caseload costs, in times of slow revenue growth, those costs could easily exceed available revenue. As such, the state was required to track the unfunded costs and pay for it out of growth funds available in future years. It also meant counties probably had to use county general purpose funds, or Realignment reserves, to pay for program costs and be reimbursed when growth funds were again available. In those years, the Health and Mental Health Subaccounts did not receive growth. That was understood to be a consequence of the priority of funding potential reimbursable mandate costs. It was also generally expected that over time, and through economic cycles, the available funding would cover the costs of the realigned programs.

However, as outlined in both the 1991 Realignment and IHSS Background sections above, there have been many changes to both the structure of 1991 Realignment and the programs within the Realignment structure. These changes, rather than the original structure of Realignment, have led to the inability of the 1991 Realignment revenues to keep up with the growing costs within the Social Services Subaccount. This was not obvious when the CCI was in effect because the county share was capped by the MOE and the state funded any increased IHSS costs above the MOE.

1991 Realignment Revenue Growth

Since 2005-06, there have been three years when revenues declined due to the Great Recession. Figure 5 shows total funding available for 1991 Realignment since 2005-06.

Figure 5

1991 Realignment Revenues

(Dollars in Thousands)

Fiscal Year	Total Realignment Revenue	Percent Change
2005-06	$4,399,670	
2006-07	4,419,299	0.4
2007-08	4,345,333	-1.7
2008-09	3,850,497	-11.4
2009-10	3,664,683	-4.8
2010-11	3,778,569	3.1
2011-12	3,931,111	4.0
2012-13	4,363,864	11.0
2013-14	4,635,887	6.2
2014-15	4,874,728	5.2
2015-16	5,111,180	4.9
2016-17	5,356,829	4.8
2017-18	5,583,696	4.2
2018-19[1]	5,868,556	5.1
2019-20[1]	6,126,307	4.4

[1]Estimated

Total revenue growth has been uneven since 2005-06 but since 2014-15 has hovered between 4 and 5 percent. At the same time, IHSS program costs have grown on average by over 11 percent annually.

For three years, 2007-08, 2008-09, and 2009-10, there was no growth available for any of the Subaccounts. As the state was coming out of the Great Recession and revenue growth increased, growth funds became available for the Social Services and Health Subaccounts but not Mental Health. Mental Health did not receive a portion of these growth funds because when growth is insufficient for all subaccounts, the Health Subaccount has a statutory advantage.

Also, as indicated previously, the structure of 1991 Realignment and programs funded within the structure have changed significantly over time. Changes to IHSS such as collective bargaining, minimum wage increases, and the implementation of federal overtime rules have required more growth funds be allocated to the Social Services Subaccount.

The implementation of CCI in 2013-14 was another significant change. Since the state funded the non-federal share of IHSS costs above the MOE, under CCI, additional growth funding was available for and allocated to both the Mental Health and Health Subaccounts.

The creation of the Child Poverty and Family Supplemental Support Subaccount in 2015-16 again altered the distribution of funding available for growth allocations to the original subaccounts. In 2018-19, the amount of 1991 Realignment funding going to the Child Poverty and Family Supplemental Support Subaccount is estimated at $387.9 million, growing to $487.4 million in 2019-20.

Figure 6 shows the distribution of available growth funds since 2005-06. Figure 7 identifies the total amount of 1991 Realignment funds (including growth) going to the Child Poverty and Family Supplemental Support Subaccount.

Figure 6
Distribution of 1991 Realignment Revenue Growth
(Dollars in Thousands)

Fiscal Year	Mental Health	Health	Social Services	Child Poverty and Family Supplemental Support
2005-06	$27,209	$71,869	$201,218	-
2006-07	13,815	23,432	19,808	-
2007-08	-	-	-	-
2008-09	-	-	-	-
2009-10	-	-	-	-
2010-11	-	-	113,886	-
2011-12	-	-	248,779	-
2012-13	-	112,167	123,114	-
2013-14	31,689	58,950	17,670	116,235
2014-15	59,926	42,705	51,544	72,931
2015-16	46,116	42,243	57,388	56,080
2016-17	262	207	178,474	61,675
2017-18	197	157	209,371	48,230
2018-19[1]	119	95	255,380	29,266

[1]Estimated

Figure 7
Total 1991 Realignment Funds Available for the Child Poverty and Supplemental Family Support Subaccount
(Dollars in Thousands)

Fiscal Year	Total Funds
2015-16	$280,913
2016-17	347,619
2017-18	358,594
2018-19[1]	387,860
2019-20[1]	487,354

[1]Estimated

It is clear that the revenue sources for 1991 Realignment are not sufficient to cover this level of increased costs. Further, the redirection of funds to the new Subaccount within the structure of Realignment exacerbates any shortfall caused by increased IHSS costs.

Question 2. *Whether the IHSS program and administrative costs are growing by a rate that is higher, lower, or approximately the same as the maintenance of effort, including the inflation factor.*

Figure 8 shows the historical IHSS expenditures since 1990-91, the year prior to 1991 Realignment.

Figure 8

In-Home Supportive Services

Historical Expenditures

(Dollars in Thousands)

Year	General Fund	Federal/ County Funds	Total	GF Percent Change	Total Funds Percent Change
1990-91	$ 310,389	$ 325,536	$ 635,925		
1991-92	170,349	353,382	523,731	-45.1%	-17.6%
1992-93	159,140	405,527	564,667	-6.6%	7.8%
1993-94	232,267	423,793	656,060	46.0%	16.2%
1994-95	226,832	462,122	688,954	-2.3%	5.0%
1995-96	254,133	458,206	712,339	12.0%	3.4%
1996-97	311,678	497,828	809,506	22.6%	13.6%
1997-98	370,445	802,371	1,172,816	18.9%	44.9%
1998-99	527,129	847,697	1,374,826	42.3%	17.2%
1999-00	596,474	985,263	1,581,737	13.2%	15.0%
2000-01	689,325	1,154,188	1,843,513	15.6%	16.5%
2001-02	854,879	1,403,742	2,258,621	24.0%	22.5%
2002-03	1,085,857	1,691,068	2,776,925	27.0%	22.9%
2003-04	1,090,926	2,091,162	3,182,088	0.5%	14.6%
2004-05	1,197,983	2,333,433	3,531,416	9.8%	11.0%
2005-06	1,355,407	2,582,277	3,937,684	13.1%	11.5%
2006-07	1,474,037	2,851,289	4,325,326	8.8%	9.8%
2007-08	1,650,274	3,230,437	4,880,711	12.0%	12.8%
2008-09	1,544,271	3,830,702	5,374,973	-6.4%	10.1%
2009-10	1,475,282	4,142,302	5,617,584	-4.5%	4.5%
2010-11	1,540,957	4,025,211	5,566,168	4.5%	-0.9%
2011-12	1,725,930	3,764,090	5,490,020	12.0%	-1.4%
2012-13	1,705,884	4,123,701	5,829,585	-1.2%	6.2%
2013-14	1,926,312	4,364,110	6,290,422	12.9%	7.9%
2014-15	2,214,815	4,976,960	7,191,775	15.0%	14.3%
2015-16	2,737,320	5,556,151	8,293,471	23.6%	15.3%
2016-17	3,201,398	6,169,150	9,370,548	17.0%	13.0%
2017-18	3,197,291	7,035,366	10,232,657	-0.1%	9.2%
2018-19 [1/]	3,716,876	7,718,384	11,435,260	16.3%	11.8%

[1/] Estimated

In 1991-92, IHSS funding was reduced in accordance with statutory guidelines to help balance the budget for that year. Similarly, the 2010 Budget Act adopted a temporary reduction to authorized service hours of 3.6 percent as part of overall budget solutions. The enacted 2011-12 budget also included $122.5 million in General Fund savings from the IHSS program. Other than those reductions, as can be seen by the growth rates, IHSS has been one of the fastest growing programs in the state budget with mostly double-digit growth rates.

When CCI was implemented in 2013-14, counties had an MOE with two years of zero inflationary growth and then an annual MOE increase of 3.5 percent. Clearly during that time, IHSS grew well beyond the 3.5 percent-MOE increase, effectively reducing the county share of costs for the program.

Beginning in 2017-18, with the new budget agreement and depending on revenue growth, the county MOE is expected to increase by 7 percent annually. This is still significantly below the average annual growth rate of over 11 percent for IHSS. If revenues decrease, the MOE would increase by a lesser amount, as required in the statutory framework. Absent a change to dampen IHSS growth, the MOE growth would be well short of the growth in IHSS costs, shifting even more costs to the state General Fund.

However, it is important to identify why the IHSS program grows significantly and goes beyond "normal" caseload increases. The two biggest cost drivers outside of caseload and hours per case are the increase in the state minimum wage and the implementation of federal overtime rules.

In 2019-20, the state minimum wage increases to $12 per hour as of January 1, 2019 and $13 per hour as of January 1, 2020. The non-federal share of IHSS costs due to minimum wage increases is estimated at $497.1 million. If all increases to the state minimum wage occur without a pause due to economic or budget conditions, the non-federal IHSS costs will be $1.6 billion in 2022-23.

For 2019-20, it is estimated that the non-federal share of IHSS costs associated with federal overtime rules will be $299.3 million. By 2022-23, this cost will increase to $411.3 million. These changes to IHSS have added over $2 billion in costs that were not considered in Realignment, and 1991 Realignment revenue growth is insufficient to cover those costs.

Question 3. *The fiscal and programmatic impacts of the IHSS MOE on the funding available for the Health Subaccount, the Mental Health Subaccount, the County Medical Services Program Subaccount, and other social services programs included in 1991 Realignment.*

As shown in Figure 6, in the years that CCI was in effect and the annual county MOE growth was 3.5 percent, both the Mental Health and Health Subaccounts received growth funding. Because the formula for the allocation of growth favors the Health

Subaccount, this increase in growth funding was particularly important for Mental Health.

With the elimination of CCI and the subsequent 2017-18 budget agreement, the Health, CMSP and Mental Health Subaccounts would, after the period of redirection, only receive VLF growth. All available sales tax growth would now go to fund the increased caseload costs for the social services programs. At the time the Department of Finance modeled this change, the other programs within social services received their estimated caseload increases before funding IHSS.

The allocation of growth chart (Figure 6 above) identifies the fiscal impact to health and mental health. As can be seen in that chart, there have been very few times since 2005-06 when both mental health and health received growth funding. This is due to a combination of factors, including available revenue, increase in the costs of IHSS funded by the Social Services Subaccount, and redirection of 1991 Realignment revenues to the Child Poverty and Family Supplemental Support Subaccount.

With counties receiving their base funding in mental health and health, program reductions would be avoided, but there also would be no opportunity for increased service levels or expansion of existing programs.

It is also important to note that there is an interaction between growth going to the Health Subaccount and the redirection of funds under AB 85 after the implementation of the ACA. The state benefits from that increase, as it results in additional funds transferred to the Family Support Subaccount to offset General Fund costs in CalWORKs.

Question 4. *The status of collective bargaining for the IHSS Program in each county.*

Figure 9 shows the latest information (as of November 2018) regarding the status of collective bargaining by county.

Figure 9

IHSS Collective Bargaining Status

County	Wages	Benefits	Benefits Offered	Last Negotiated Wage Increase	Expiration of Existing Collective Bargaining Agreement	Bargaining Status [1/]
Alameda	$12.50	$1.19	Medical/Dental/Vision	11/1/2014	9/30/2016	Reached a tentative agreement
Alpine	$11.00	-	None	None	No MOU	Currently negotiating
Amador	$11.00	$0.60	Medical/Dental/Vision	8/1/2007	6/30/2008	No negotiations reported
Butte	$11.00	$0.60	Medical	3/1/2013	10/1/2014	Currently negotiating
Calaveras	$11.00	$0.44	Medical/Dental/Vision	7/1/2009	8/31/2011	No negotiations reported
Colusa	$11.00	-	None	10/1/2013	7/31/2016	No negotiations reported
Contra Costa	$12.25	$1.31	Medical/Dental	1/1/2017	6/30/2018	No negotiations reported
Del Norte	$11.00	-	None	4/1/2016	9/30/2017	Currently negotiating
El Dorado	$11.00	$0.20	Medical	7/1/2016	6/30/2017	Currently negotiating
Fresno	$11.00	$0.85	Medical/Dental	10/1/2008	9/30/2015	Currently negotiating
Glenn	$11.00	-	None	10/1/2013	7/2/2014	No negotiations reported
Humboldt	$11.00	-	None	8/1/2013	6/30/2016	Currently negotiating
Imperial	$11.00	$0.37	Medical	7/1/2016	6/30/2017	Currently negotiating
Inyo	$11.00	-	None	7/1/2016	10/21/2017	No negotiations reported
Kern	$11.00	-	None	2/1/2014	6/30/2017	Currently negotiating
Kings	$11.00	-	None	8/1/2015	6/30/2016	Currently negotiating
Lake	$11.00	-	None	6/1/2014	9/30/2016	Currently negotiating
Lassen	$11.00	-	None	None	No MOU	Currently at an impasse; fact finding found in favor of the union
Los Angeles	$11.18	$0.92	Medical	2/1/2017	6/30/2021	MOU has not expired
Madera	$11.00	-	None	4/1/2014	12/31/2014	Currently negotiating
Marin	$14.20	$0.82	Medical/Dental	2/1/2018 [2/]	12/31/2016	No negotiations reported
Mariposa	$11.14	-	None	7/1/2016	6/30/2017	No negotiations reported
Mendocino	$11.00	-	None	1/1/2016	6/30/2016	No negotiations reported
Merced	$11.00	-	None	3/1/2015	12/31/2015	Currently negotiating
Modoc	$11.00	-	None	1/1/2016	6/30/2016	No negotiations reported
Mono	$11.00	-	None	5/1/2003	6/30/2003	Currently negotiating
Monterey	$12.50	$0.44	Medical	7/1/2017	6/30/2018	Currently negotiating
Napa	$12.10	-	None	11/1/2014	12/31/2015	No negotiations reported
Nevada	$11.00	$0.60	Medical/Dental/Vision	10/1/2014	12/31/2015	Currently negotiating
Orange	$11.00	$0.60	Medical/Dental/Vision	2/1/2016	6/30/2016	Currently negotiating
Placer	$11.00	$0.08	Dental/Vision	9/1/2015	6/30/2016	Currently negotiating
Plumas	$11.00	$0.60	Medical/Dental/Vision	10/1/2014	12/31/2015	Currently negotiating
Riverside	$11.50	$0.60	Medical	4/1/2011	6/30/2015	Currently negotiating
Sacramento	$12.00	$0.80	Medical/Dental	9/1/2018	12/31/2022	MOU has not expired
San Benito	$11.00	$0.20	Dental/Vision	10/1/2014	6/30/2014	Currently negotiating
San Bernardino	$11.00	$0.38	Medical/Dental	8/1/2008	12/31/2014	Currently negotiating
San Diego	$11.50	$0.60	Medical	11/1/2013	12/31/2022	MOU has not expired
San Francisco	$15.00	$2.59	Medical/Dental	7/1/2018 [2/]	6/20/2019	MOU has not expired
San Joaquin	$11.00	$0.74	Medical/Dental/Vision	7/1/2014	3/31/2016	Currently negotiating
San Luis Obispo	$13.00	$0.20	Dental/Vision	12/1/2018	6/30/2019	MOU has not expired
San Mateo	$13.90	$0.63	Medical/Dental/Vision	7/1/2018	12/31/2020	MOU has not expired
Santa Barbara	$12.10	-	None	7/1/2018	6/30/2019	MOU has not expired
Santa Clara	$13.00	$3.27	Medical/Dental/Vision	2/1/2016	2/1/2017	Currently negotiating
Santa Cruz	$12.46	$0.85	Medical/Dental/Vision	3/1/2018	12/31/2020	MOU has not expired
Shasta	$11.60	-	None	10/1/2018	12/31/2021	MOU has not expired
Sierra	$11.00	$0.60	Medical/Dental/Vision	10/1/2014	12/31/2015	Currently negotiating
Siskiyou	$11.00	-	None	None	No MOU	No negotiations reported
Solano	$12.00	$0.60	Medical/Dental/Vision	5/1/2018	6/30/2020	MOU has not expired
Sonoma	$13.00	$0.60	Medical/Dental	3/1/2017	9/30/2018	No negotiations reported
Stanislaus	$11.00	$0.10	Dental/Vision	1/1/2018	6/30/2019	MOU has not expired
Sutter	$11.00	-	None	4/1/2015	12/31/2015	Currently negotiating
Tehama	$11.00	-	None	3/1/2011	4/30/2012	Currently negotiating
Trinity	$11.50	-	None	5/1/2017	12/31/2021	MOU has not expired
Tulare	$11.00	-	None	7/1/2015	3/31/2017	No negotiations reported
Tuolumne	$11.50	-	None	7/1/2018	6/30/2020	MOU has not expired
Ventura	$12.78	-	None	7/1/2018	6/11/2021	MOU has not expired
Yolo	$11.02	$0.60	Medical/Vision	2/1/2014	12/31/2014	No negotiations reported
Yuba	$11.00	$0.60	Medical/Dental/Vision	7/1/2009	6/30/2014	Currently negotiating

[1/] Status of collective bargaining negotiations as of November 30, 2018.
[2/] Wage increase due to ordinance.
(Source: Department of Social Services, Service Employees, Service Employees International Union Local 2015, United Domestic Workers/AFSCME Local 3930)

As indicated in Figure 9, twenty-seven counties are engaged in collective bargaining. Fourteen counties have expired MOUs but no negotiations are reported. Fourteen other counties have MOUs that have not yet expired. Only one county reports being at impasse.

IV. Findings and Recommendations

It is evident that the amount of revenue available under 1991 Realignment cannot support the costs of the current programs within 1991 Realignment. This is not because of the construct of the original design but because of changes that have been incorporated into the realigned programs, primarily in IHSS, but also the implementation of the ACA and the redirection of funds to the Child Poverty and Family Supplemental Support Subaccount.

The 2019-20 Governor's Budget proposes a number of changes to 1991 Realignment so counties do not have to use significant county general purpose funds to cover IHSS costs, and the Mental Health and Health Subaccounts can receive growth based on the historical formula for the allocation of growth.

Specifically the Budget proposes the following:

- Reset the county IHSS base costs in 2017-18 using historical state-county cost-sharing ratios.
- Apply a 5-percent growth factor in 2018-19 and 7-percent growth factor in 2019-20, consistent with current law.
- Rebase the IHSS MOE in 2019-20 with a 4-percent inflation factor beginning in 2020-21, and as a result, eliminate the General Fund mitigation funding beginning in 2019-20.
- The rebased IHSS MOE will only be applied to county IHSS services costs. A General Fund allocation will be provided to counties for IHSS administrative costs.
- Stop the redirection of VLF growth funds going only to the Social Services Subaccount beginning in 2019-20.
- Return to the original methodology for calculating the IHSS caseload (comparison to prior years) versus using the accelerated approach to allocating funds using current estimate of caseload and cost estimates.

- Eliminate growth allocations to the CMSP Board beginning in 2019-20 until the Board's operating reserves fall below three months. The Board currently has a reserve of over $360 million.

These proposals require a significant infusion of state General Fund to cover IHSS costs. The estimated additional amounts above those included in the 2017 Budget agreement are $241.7 million in 2019-20, $369.4 million in 2020-21, $454.4 million in 2021-22 and $547.3 million in 2022-23. By 2022-23, the total General Fund needed under the revised MOE structure is $697.3 million, including the $150 million of General Fund mitigation that was assumed under current law.

The Budget also proposes to restore the 7-percent across-the-board reduction to authorized IHSS hours, estimated to cost $342.3 million General Fund in 2019-20.

With these changes, current estimates indicate that there would be a minor Realignment revenue shortfall of about $9.5 million in 2021-22 and almost $25 million in 2022-23. Given all the factors in the estimate, these shortfalls are highly speculative.

This proposal does not eliminate the risk to counties from potential revenue declines, whether recessionary or not, that were part of the original structure of 1991 Realignment. However, the significant infusion of state General Fund means significantly less risk to the counties associated with using county general purpose funds to cover program costs.

In addition, the Budget proposes to eliminate the general growth schedule. Under current law, Finance is required to develop the general growth schedule, which is no longer relevant since enactment of AB 85. General growth for the Health Subaccount is currently set at 18.4545 percent; the Mental Health Subaccount requires a calculation based on a statutory calculation (which equates to approximately 37.4 percent in 2017-18), and the Child Poverty and Family Supplemental Support Subaccount receives the balance. The schedule requires a calculation of each county's share of general growth for each of the subaccounts. This generally results in each county's subaccount base being increased proportionately by the amount of growth funds available. Because of the required AB 85 redirection from the Health Subaccount to the Child Poverty and Family Supplemental Support Subaccount, and because growth for the Mental Health Subaccount is distributed proportionately, there is no need to continue the development of an annual general growth schedule.

The proposed solution is to set the general growth percentage for the Mental Health Subaccount at 37.4333 percent and for the Child Poverty and Supplemental Family

Support Subaccount at 44.1122 percent. There would be no change to the percentage for the Health Subaccount. Growth funds going into the Mental Health and Health Subaccounts would be distributed to counties in proportion to their respective bases.

Additionally, the Budget proposes that once the state minimum wage reaches $15 per hour, state participation in future county-negotiated IHSS wage and/or health benefit increases will be 35 percent of the non-federal share of those cost increases, with the implementing county responsible for 65 percent. Currently, the cost-sharing ratio is 65-percent state/35-percent county for wage/health benefit increases negotiated by counties. The rationale for this change reflects the significant commitment of General Fund resources to fund increased IHSS costs resulting from state minimum wage increases. This change also reflects alignment with the current statutory framework that makes counties responsible for IHSS collective bargaining activities.