



Personal Assistance Services Council of Los Angeles Health Care Benefits Initiative

June 2003

Active, Eligible and Enrolled Workers by Supervisorial District

Supervisorial District	Active		Eligible		Enrolled		
	Number:		Number:	% of Active:	Number:	% of Eligible:	% of Active
Gloria Molina (District 1)	20,059		5,839	29.1%	1,722	29.5%	8.6%
Yvonne B. Burke (District 2)	21,723		6,001	27.6%	1,402	23.4%	6.5%
Zev Yaroslavky (District 3)	20,403		6,664	32.7%	1,917	28.8%	9.4%
Don Knabe (District 4)	13,766		4,580	33.3%	1,251	27.3%	9.1%
Michael D. Antonovich (District 5)	23,576		6,341	26.9%	1,768	27.9%	7.5%
Total Inside County	99,527		29,425	29.6%	8,060	27.4%	8.1%
Total Active Provider	102,584		30,303	29.5%	8,304	27.4%	8.1%
Total Outside County	3,057		878	28.7%	244	27.8%	8.0%

NOTE: Count for supervisorial district are determined using zip code.

Active, Eligible and Enrolled Workers by Region

Region	Active		Eligible		Enrolled		
	Number:		Number:	% of Active:	Number:	% of Eligible:	% of Active
Antelope Valley	4,346		1,440	33.1%	388	26.9%	8.9%
NW San Fernando Valley	4,475		1,285	28.7%	326	25.4%	7.3%
NE San Fernando Valley	5,272		1,431	27.1%	374	26.1%	7.1%
SW San Fernando Valley	1,933		626	32.4%	165	26.4%	8.5%
SE San Fernando Valley	4,934		1,505	30.5%	442	29.4%	9.0%
W San Gabriel Valley	19,394		4,733	24.4%	1,412	29.8%	7.3%
E San Gabriel Valley	7,493		2,538	33.9%	741	29.2%	9.9%
Metro	9,897		3,035	30.7%	970	32.0%	9.8%
West	3,816		1,467	38.4%	353	24.1%	9.3%
South	20,076		5,534	27.6%	1,296	23.4%	6.5%
East	10,995		3,734	34.0%	1,063	28.5%	9.7%
South Bay	8,096		2,510	31.0%	652	26.0%	8.1%
Total Inside Regions	100,727		29,838	29.6%	8,182	27.4%	8.1%
Total Active Provider	102,584		30,303	29.5%	8,304	27.4%	8.1%
Total Outside Regions	1,857		465	25.0%	122	26.2%	6.6%

NOTE: Regional counts are determined using zip code.



Source: RTZAssociates

fds data set for LA County PASC

**Impact of Health Benefits on Retention of Homecare Workers:
Preliminary Analysis of the IHSS Health Benefits Program in Los Angeles County**

**Prepared for the Los Angeles County Personal Assistance Services Council (PASC)
by RTZ Associates
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Background

Across the nation, states and counties are striving to maximize consumer direction, a guiding tenet of in-home services for frail, elderly consumers and adults with disabilities. Policymakers are trying to replace institutional care with consumer-directed, in-home services whenever possible. The State of California has spearheaded this effort with legislation and funding incentives for counties that work to improve delivery of In-Home Supportive Services (IHSS). IHSS is a county-administered program funded primarily by Medicaid with federal and state dollars, that provides personal care services to low-income elderly and disabled Californians, enabling them to remain in their homes and communities. The vast majority of IHSS services are provided by independent providers, who are hired directly by consumers.

In the early 1990s, California legislation gave counties the option of creating Public Authorities – quasi-governmental, consumer-directed agencies designed to enhance the delivery of IHSS. Public Authorities facilitate worker/consumer matches by operating homecare worker registries, make possible collective bargaining by functioning as IHSS providers' employer of record, arrange training and support services for workers and consumers, and offer workers and consumers a voice in program and policy development. In 1993 the California State Medicaid plan was amended to allow Title 19 Medicaid funding for personal care services delivered through IHSS. This change to the Medicaid plan enabled Public Authorities to use federal Medicaid funds to cover costs related to IHSS employee taxes, support services, wages, and benefits.

In 1997, Los Angeles County created a Public Authority called the Personal Assistance Services Council (PASC), and the agency has made significant headway in its efforts to enhance and improve the county's IHSS program. The agency's exclusive purpose is to enhance the delivery of personal assistance services to consumers and improve working conditions for independent IHSS workers. It functions as the employer of record for more than 102,000 homecare workers in Los Angeles County, who are hired directly by service recipients. Los Angeles County is home to more than 125,000 IHSS consumers.

Traditionally, independent providers have been plagued by low wages, no benefits, and little or no training or support. Not surprisingly, **turnover** in the field is high, creating chronic provider shortages, low skill levels, and compromised quality of care. Consumers, as a consequence, often have difficulty finding qualified, available providers. In an effort to address some of these issues, the Los Angeles County PASC, beginning in April 2002, embarked on an innovative effort to improve homecare worker

retention: it became the largest county in California to offer **healthcare benefits to qualified** IHSS independent providers. To become eligible for the benefit, providers must work 112 hours per month for two consecutive months.

PASC's benefits program was designed to provide healthcare for a large workforce that is typically uninsured. Based on evidence that this workforce values and desires healthcare, the PASC also hoped that the program would be an incentive for IHSS providers to remain in the workforce and for new and more highly qualified individuals to enter the workforce. In many cases, workers leave the homecare field when an assignment ends. An assignment can end because the consumer dies, no longer needs care, or decides that the provider is not a good match. Often, consumers receive services from family members, and the provider ceases to perform the work once the family member no longer requires assistance.

One of the initial goals of the PASC benefits program was to keep workers in the field *beyond* the initial assignment. The program was therefore structured to accommodate the inherent instability of an employment model in which the recipient determines the length of each assignment. Program rules were structured such that health plan enrollment continues for two months after an assignment ends, giving providers the opportunity to seek further IHSS work – and thereby maintain benefit eligibility.

This paper is a preliminary study of the impacts of health benefits on homecare worker retention and recruitment. Specifically, this initial analysis assesses whether new enrollees in the PASC benefits program do, in fact, remain in the workforce longer than non-enrollees and whether those receiving benefits are more likely to return to the workforce after an assignment ends.

Method

Study Design

The study design is based on a longitudinal analysis of existing state homecare worker employment authorization data. New workers entering the system who were eligible for, selected, and received healthcare benefits were compared to new workers who did not receive benefits. Employment rates for both groups were tracked monthly and differences in employment rates after 12 months were compared.

Source Data

Data for the study came from the California State Case Management Information and Payroll System (CMIPS). CMIPS is the information system used by the Department of Human Services to record IHSS recipient assessment and authorization data, as well as IHSS provider work authorizations. State employment data for Los Angeles County, for the period January 2002 through March 2003, was obtained and analyzed to identify workers entering the PASC workforce in each month. A 12-month history of work activity and health plan enrollment was compiled for each of four cohorts: providers entering the workforce in January, February, March, and April of 2002. Providers with

CMIPS work authorizations in a given month were considered active, and those that did not were deemed inactive. Turnover patterns for all cohorts were aggregated and analyzed.

Calculating Rate of Worker Retention

For purposes of this study, retention rate is defined as percentage of new workers that remain active members of the workforce in each month. For example, if 4,000 workers enter the workforce in January and 2,000 of those workers remain active in February, there was a 50% retention rate after one month. A retention rate was calculated for each cohort, for each of 11 months following entry into the workforce. Aggregated retention rates for health plan enrollees were then compared with those of non-enrollees. A χ^2 test was used to verify the statistical significance of that comparison.

Calculating Workforce Stability

Worker retention rates alone can be slightly misleading, because some independent providers of homecare may enter and exit the field frequently. For example, after six months, 80% of new workers may be active, but if 90% were active only in the first and sixth months, the retained workers would not constitute a very stable workforce. Therefore, a consistency percentage was calculated for workers in each cohort who remained active in month 12. Workers remaining active in all 12 months received a consistency rate of 100%, those remaining active in 11 of the 12 months were assigned a consistency rate of 91.7%, and so on. Health plan enrollees and non-enrollees were then compared, using the consistency rate as a rough indicator of workforce stability.

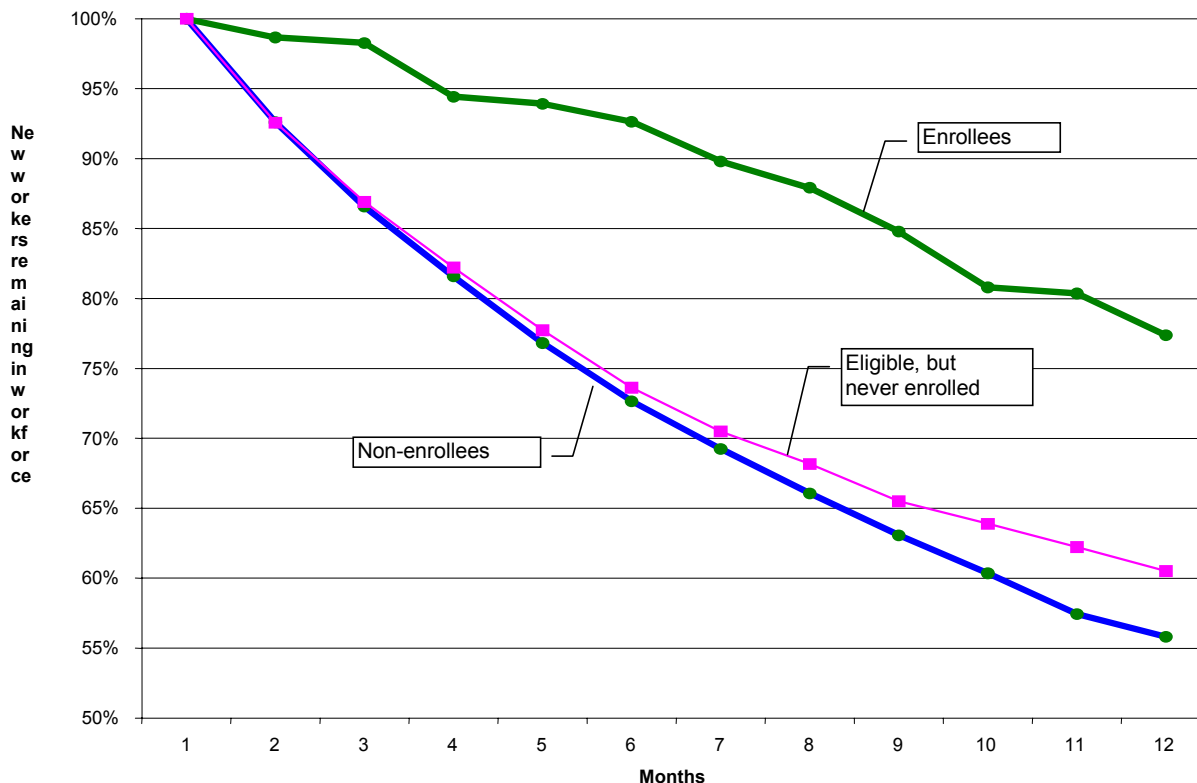
Results

The design of PASC's IHSS health benefits program in Los Angeles was predicated on the idea that benefits are valuable to IHSS workers and therefore are an incentive to enter and remain in the workforce. ***The current analysis therefore focuses on worker retention and stability.*** The analysis revealed two striking trends:

- 1) Workers who enroll in the PASC's health benefits program are far more likely to remain in the workforce in month 12 than workers who do not enroll.
- 2) Health plan enrollees who leave the workforce during the 12-month period are much more likely to return to the workforce within those 12 months than are non-enrollees.

Figure 1 (below) plots and compares, by month, the retention rates for workers with and without benefits for 12 months following their initial work authorization. Data from the four cohorts, new workers for each month from January through April 2002, were compared, found to be similar and combined for analysis. Figure 1 shows that 77.4% of workers receiving health benefits remained active in the 11th month after initial entry into the workforce, compared with only 55.8% of non-enrollees and just over 60% for non-enrollees working more than 112 hours.

**Figure 1: Comparative New Worker Retention over 1 year Period:
Health Plan Enrollees vs. Non-enrollees**



It should be noted that the higher retention rate for enrollees during the first three months of employment may be a function of the benefits eligibility requirements and enrollment process. Eligibility requires two consecutive months' work, of at least 112 authorized hours per month. During month 3, eligible workers are offered the benefit, and enrollment commences at the beginning of month 4. Therefore, workers who enroll at that point *must* have remained in the workforce. It is therefore important to focus on disparities in the retention rate from the third month forward.

A χ^2 test (Table 1, below) revealed that the 22.6% difference in 12-month retention (77.4% for enrollees versus 55.8% for non-enrollees) is statistically significant.

Table 1: χ^2 Test Determining Statistical Significance

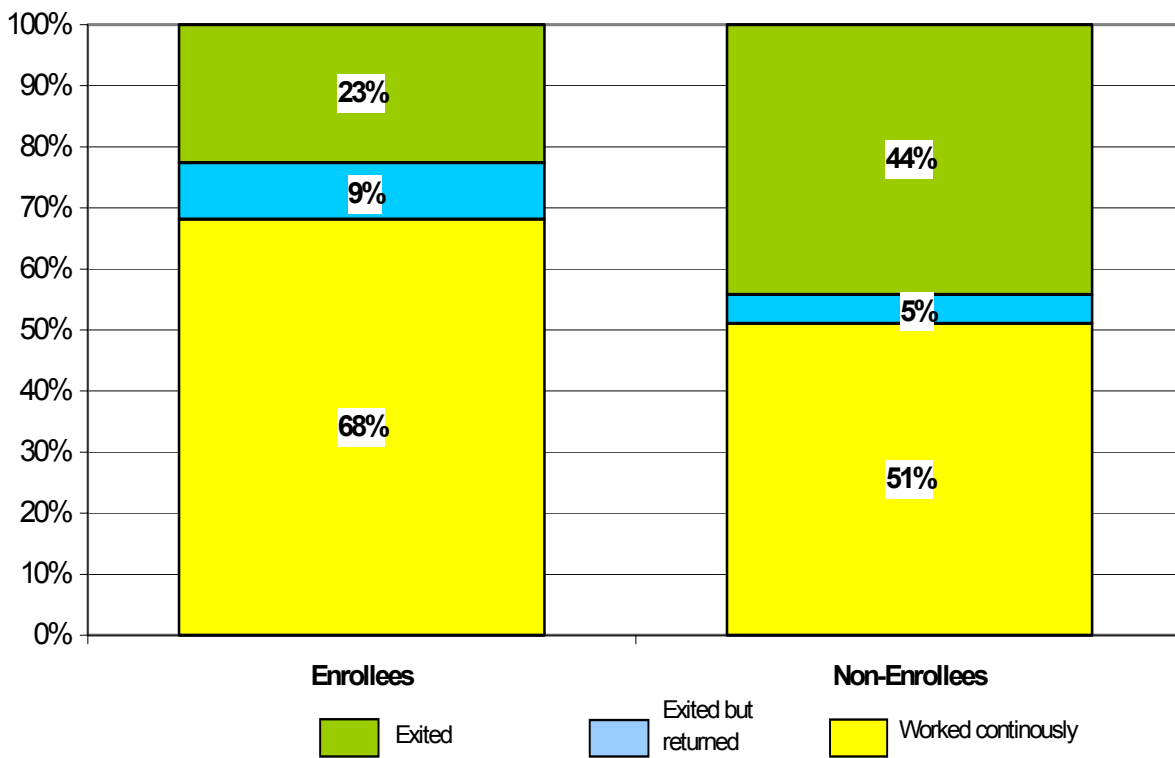
	Enrollees (n=370)	Non-Enrollees (n=8,373)	Total (n=8,743)
Working in Month 12	77.4%	55.8%	4,960
Not Working in Month 12	22.6%	44.2%	3,783

df = 1, $\chi^2 = 73.75, p \leq 0.001$

Cramer’s phi (p) is the relative magnitude of relationship between worker activity and health plan enrollment. Generally, a p value of 0.05 or more is considered to indicate a powerful match. For the current study $p \leq 0.001$, indicating that the retention difference is statistically significant. The fact that $p \leq 0.001$ means that there is a likelihood of only 1 in 1,000 that the difference in 12-month retention occurred by chance.

Health plan enrollees who left the workforce were also more likely than non-enrollees to return to the workforce during the 11 months following initial work authorization. The overall work patterns of enrollees and non-enrollees is shown in Figure 2, below.

Figure 2: Work Patterns of Health Plan Enrollees versus Non-Enrollees



In summary, a higher percentage of health plan enrollees (68% versus 51%) worked in all 12 months of the study. Moreover, a higher percentage (9% versus 5%) of enrollees who left the workforce returned within the 12-month period. In total, then, 77% of enrollees were active in month 12, compared with only 56% of non-enrollees.

Discussion

The findings above suggest that the PASC has progressed toward its goal of creating a more permanent, stable IHSS workforce to meet Los Angeles County’s growing

consumer demand for in-home services. For the workers studied, those with health benefits were significantly more likely than non-enrollees to remain active in the 12th month after entering the field, more likely to have worked all 12 months, and more likely to have returned to the field if they did leave at any point. ***These findings strongly suggest that the PASC benefits program is creating a more permanent, stable workforce – an elusive goal for many states and counties.***

Since this preliminary analysis suggests that health benefits do improve worker retention, the PASC will be examining methods for increasing worker awareness of its health benefits program to expand enrollment. Enrollment in the health plan requires an active response from providers, and non-enrolled workers may be unaware of the program. Currently, workers are sent health plan information packets only once: when they become eligible for the benefit. If workers disregard, do not receive, or are unable to read the one-time mailing, they remain unaware of their eligibility *and even of the existence of the benefits program*. Therefore, many Los Angeles IHSS providers may be unaware of this incentive to remain in the workforce.

In early 2003, PASC commissioned a study to examine the feasibility of lowering benefit eligibility requirements from 112 hours per month for two consecutive months to 80 hours per month for two consecutive months. The conclusion of that study indicated that it was affordable and desirable, from both economic and pragmatic viewpoints, to lower the benefit eligibility requirement and thereby increase the number of workers covered by health benefits. Based on the findings of the current study, this lower eligibility requirement is likely to further improve overall worker retention rates, especially if workers are fully aware of the benefit program.

Workforce Stability – Indicator of Professionalization

A good job is one that provides regular, stable, sustainable income. A major goal of the PASC health benefits program is to make IHSS work a viable, stable option. Workforce stability ultimately impacts IHSS recipients by ensuring a more experienced and consistent workforce at any given point in time.

A consumer-directed model, combined with low wages and the traditional lack of benefits, makes it difficult to achieve IHSS workforce stability. Under the consumer-directed model, IHSS recipients – whose needs often change significantly over time – hire and fire workers at will. For workers, this translates into limited job stability: an elderly person enters a nursing home, a client is rehabilitated and no longer needs services, a worker/client match is unsuccessful, a client dies, etc. These are just a few scenarios that lead to job loss. IHSS workforce stability, then, can only be achieved if the provider finds another consumer for whom to work.

The current study reveals that health plan enrollees, at least during their first year of tenure, are unlikely to exit and re-enter the workforce multiple times. As shown in Table 2, only 1.3% of enrolled workers who were active in month 12 had worked only 5 months during the year. This suggests that workers do not attempt to manipulate the

system, i.e., sustain benefits enrollment by working in carefully planned minimum intervals.

The fact that 9% of health benefits enrollees (versus only 5% of non-enrollees) left the workforce but returned within the 12-month period, suggests that instead of leaving the workforce after completing one consumer assignment, many enrollees sought and found another consumer for whom to work. ***Such behavior would be indicative of a professional and highly motivated workforce.***

Next Steps

While significant, these findings raise additional questions about the impact of health benefits on the Los Angeles IHSS workforce. More in-depth studies of PASC initiatives, including the health benefits program, are necessary to fully understand the nature of program impacts, establish causal relationships, and measure the impact of other factors on worker tenure and stability.

For instance, while the present analysis reveals a strong relationship between health benefits enrollment and longer worker tenure, it does not rule out other causal factors. A regression analysis studying the interrelationship of worker characteristics, benefits enrollment, and tenure can assess the relative impact of these different factors. A formal worker survey would more clearly reveal individual workers' motivations and the role of healthcare benefits in their decision-making process. Similarly, while the current analysis reveals that enrollees are more likely to return after a work hiatus, it would be useful to determine – either directly through a survey, or indirectly, by examining whether the hiatus ended with a new worker/client match – whether this is due to the incentive of continued health benefits.

It will also be important to study the role of potential moderator variables on the relationship between health benefits and worker tenure. Does the relationship between enrollment and tenure vary by age or ethnic group? Is it different for family and non-family providers? Subgroup analyses on a variety of worker groups, e. g., family and non-family or primary language spoken, can pinpoint factors influencing the enrollment/tenure relationship. For example, the relationship between benefits and tenure may be stronger for non-family providers who view homecare as a career; or the relationship may be less strong for workers in a particular language group. Such findings would shape PASC decisions about how to effectively market its benefits program.

Researchers and policymakers would also benefit from longer, cross-county analyses. Multi-year longitudinal analyses would reveal the longer-term effects of benefits on workforce retention and stability. Cross-county analysis – for example, comparing work patterns in communities with large wage and benefit increases with those in communities with only benefits – would yield important information about the relative impacts of worker incentives implemented by California Public Authorities.

This initial study demonstrates that homecare workers with health benefits remain in the workforce longer and, if they leave, are more likely to return. However, it does not explain underlying causes. Do healthcare benefits attract a more professional, career-oriented workforce, or does the benefit encourage members of an existing workforce to view personal care services as a long-term career? Additional analyses are necessary to evaluate whether factors other than employer incentives contribute to longer worker tenure. Comparing characteristics of workers hired before and after implementation of the health benefits program, and studying relationships between other worker characteristics and tenure, will contribute to a conceptual model for understanding how benefits affect tenure.

Finally it should be noted that the current study examines the impacts of one benefits program, with a single set of eligibility requirements – 112 hours of work in two consecutive months. However, independent homecare providers are a unique workforce: many providers enter the field as part-time workers and wish to remain part-time. Workers tend to be women with outside responsibilities, such as childcare, that make them uninterested in full-time work. More in-depth research would compare the impacts of a variety of program designs, including lower eligibility requirements. Given the idiosyncrasies of the homecare workforce, it is reasonable to expect that reduced eligibility requirements will produce not only an increase in number of insured workers, but also a greater magnitude of impact on worker recruitment and retention.

Additional analyses will enable policymakers and program managers to refine benefit programs, making them more attractive in the eyes of current and prospective providers. Ultimately, this work will help Public Authorities and other entities to attract a larger, more permanent workforce to meet the nation's growing demand for in-home services. It may even form the basis of a multi-state, national policy.

Health Care Benefits Program Impact of Reducing Eligibility Requirement

***Prepared for the Personal Assistance Services Council of Los Angeles
by RTZ Associates***

In April 2002, the Los Angeles Personal Assistance Services Council (PASC) began to offer IHSS workers a health insurance package. Workers authorized to work at least 112 hours per month for two consecutive months qualify for the County Community Health Plan benefit, and those who consent are enrolled in the program. A proposal has been made to lower the authorization requirement from 112 to 80 hours per month. The purpose of this analysis is to review the initial health enrollment data and investigate the effects of a reduced 80-hour requirement on enrollment and health benefit costs.

Background: Health Benefits and the 112-Hour Requirement

One of PASC's original goals in adopting the health benefits program was to provide an incentive for existing members of the large and heterogeneous IHSS workforce to remain in the field. At the same time, offering affordable health insurance would attract additional workers into the IHSS workforce. For the county, an added benefit of IHSS worker health benefits was to come in the form of a reduced burden on indigent care services. The efficacy of the IHSS program depends in large part on the quality and reliability of the IHSS workforce. PASC's health benefits program was implemented to address these issues.

The program is supported by a combination of federal, state and local funds. The Los Angeles County Board of Supervisors, in authorizing the health benefit program, used the state-approved reimbursement rate of \$0.60 per authorized work hour as a guideline to allocate funds to pay for the program. Based on projected costs, a 112-hour authorization requirement was adopted to insure that the cost of providing health insurance to every eligible worker would never exceed the \$0.60/hour ceiling. It should be noted that this \$0.60 per hour ceiling has been increased by more recent legislation.

Method of Analysis

Table 1 draws upon CMIPS data from April 2002 through November 2002 to provide a historical context for evaluating a reduced authorization scenario. The number of eligible workers is divided by the total number of active workers to yield the rate of eligibility under the current 112-hour-per-month requirement. "Enrollment rate" refers to the percentage of eligible workers who chose to enroll in the benefits program.

To simulate the effects of a reduced authorization requirement, the number of eligible workers for November 2002 was recalculated using an eligibility requirement of 80 authorized hours per month for the months of August and September 2002. Then the

number of would-be health care enrollees was determined for each of ten potential rates of enrollment. Using CMIPS data to determine the total number of authorized work hours for the entire active workforce, the total cost per premium and cost per premium per authorized hour was calculated for each of the ten rates of enrollment. The results of this analysis are shown in Table 2.

Findings 1: Historical Context

Month/Year	Active Providers	Providers Eligible for HealthyWorkers (112 hrs)	% of Eligible Active providers	Eligible Providers Enrolled in HealthyWorkers	Penetration rate: % of Eligible Providers enrolled	% of Active Providers Enrolled
April-02	92,761	26,090	28.13%	4,084	15.65%	4.40%
May-02	93,471	26,343	28.18%	5,362	20.35%	5.74%
June-02	94,063	26,630	28.31%	6,040	22.68%	6.42%
July-02	94,833	27,016	28.49%	6,710	24.84%	7.08%
August-02	95,378	27,364	28.69%	7,057	25.79%	7.40%
September-02	96,050	27,644	28.78%	7,375	26.68%	7.68%
October-02	96,880	27,867	28.76%	7,560	27.13%	7.80%
November-02	97,612	28,305	29.00%	7,680	27.13%	7.87%

Table 1 summarizes the first eight months of IHSS workers’ health benefits eligibility and enrollment information. Since the plan’s inception in April 2002, worker enrollment has grown steadily. As workers have gained familiarity with the program, increasing numbers have chosen to enroll. The size of the workforce has increased, as has the percentage of the workforce receiving the health care benefit.

Specifically, from April through November 2002:

- The number of active providers increased 5%, from 92,716 to 97,612.
- The percentage of eligible providers, those working at least 112 hours in two consecutive months, has increased 3%, from 28.13% to 29%.
- The enrollment rate has increased 74% since inception, from 15.65% to 27.13%.
- As of November 2002, 7,680 workers, or 7.9% of the workforce, are currently enrolled in the benefits program, making PASC the state’s largest provider of IHSS health benefits.

Findings 2: 80-Hour Eligibility Requirement

Table 2: Projected Enrollment and Cost at 80 hours*

Scenarios: Eligibility Rate n %	Number of Providers Enrolled at n % eligibility	Increase over Number of Providers currently Enrolled	% of Active Providers Enrolled	Total Cost of Premiums**	Cost per authorized hour
60%	29,859	22,179	30.59%	\$ 6,188,875	\$ 0.65
55%	27,371	19,691	28.04%	\$ 5,673,135	\$ 0.60
50%	24,883	17,203	25.49%	\$ 5,157,396	\$ 0.54
45%	22,394	14,714	22.94%	\$ 4,641,656	\$ 0.49
40%	19,906	12,226	20.39%	\$ 4,125,917	\$ 0.43
35%	17,418	9,738	17.84%	\$ 3,610,177	\$ 0.38
30%	14,930	7,250	15.29%	\$ 3,094,437	\$ 0.33
27.13%	13,501	5,821	13.83%	\$ 2,798,403	\$ 0.29
25%	12,441	4,761	12.75%	\$ 2,578,698	\$ 0.27
20%	9,953	2,273	10.20%	\$ 2,062,958	\$ 0.22

* Projections based on an 80-hour work authorization requirement and provider data for November 2002.

**NOTE ON CONSTANTS USED IN CALCULATIONS: Based on an 80-hour work authorization requirement, 49,765 workers would be eligible accounting for 50.98% of all active workers. The current price per premium is \$207.27. For the month of October, the total number of authorized work hours totaled 9,499,895.

If the 80-hour eligibility requirement were applied to the current month, November 2002:

- 51% of the IHSS workforce, or 49,766 workers would be eligible for the health benefit, compared with 28,300 or 29% under the current 112 hour authorization requirement.

Further, if the 80-hour eligibility requirement were applied to the current month of November 2002, at the current enrollment rate of 27.13%:

- A total of 13,501 workers, or 13.83% of the active workforce, would receive the health benefit.
- Benefit enrollment would increase by 5,821 workers 81%.
- The cost per authorized hour for the health benefit would be \$0.29.
- The cost of premiums per hour would not exceed the budgeted \$0.60 per authorized hour, unless the enrollment rate grew to more than 55%.

Recommendations

These findings suggest that, in the context of November 2002, maintaining the current system but lowering the eligibility requirement from 112 to 80 hours per month would increase the number of workers covered from 7,680 to 13,501, an increase of nearly 43% at the current enrollment rate of 27.13%. Costs for health benefits would amount to approximately \$0.29 per authorized hour, still well under the originally budgeted \$0.60 per hour.

The enrollment rate in Los Angeles County is expected to grow, as it has in other counties with similar health care programs, such as Sacramento and San Francisco. For example, the HealthyWorkers program of San Francisco County, now in its fifth year, boasts an enrollment rate of 52%. It is unlikely that Los Angeles' enrollment rate will approach such levels in the foreseeable future. However, even at an enrollment rate of 52%, the cost per authorized hour would not exceed the original state-allocated level of \$0.60. Recent changes to state legislation has increased the level of funding available for health care to a combined total of \$11.10 per hour in wages and benefits. That means that even after the upcoming wage increase from \$6.75 to \$7.50 per hour, significantly more funds are available for health care. There is little chance of running over state matching limits by lowering the requirement to 80 hours per month.

Lowering the eligibility requirement is both reasonable and affordable. Over 40% of the cost of premiums is now covered by Federal Medicaid dollars, another 40% is covered by the state, and the remaining local share can be paid for with Realignment dollars. Under this existing financing arrangement, health care benefits can be increased and extended to a larger portion of the workforce at little or no additional cost to Los Angeles County. As such, lowering the requirement is an excellent opportunity for Los Angeles County to greatly increase the number of workers receiving health benefits and the benefit will likely attract new workers into the field. By making home care a more attractive employment opportunity, the County can increase the work force, reduce its cost for indigent care and make it easier for disabled and aged consumers find the assistance they need.

PostScript

In January 2003, Governor Davis proposed an expanded realignment initiative that would switch state costs for IHSS services to realignment funds. If implemented, this change would alter the source of funds but not alter the rules or levels of allowable reimbursement. Essentially, all costs for IHSS services including PASC operations and benefits would still be covered by federal dollars and state-wide funding pools. Due to changing interpretations of potential cost savings Interest in expanded realignment has been fading and today, March 2003, it seems unlikely.

In the first year of benefits operation the County advanced the local share of health care costs. That local share is now eligible for Realignment reimbursement under the Caseload Growth sub-account. Due to the state budget deficits and lower sales tax revenues, the Growth Fund Payments under realignment will, however, likely be delayed. If growth fund payments are not made in the year due, the obligation and claim will carry-forward to future years. State H&W Code recognizes IHSS services as a State mandated entitlement and makes it a priority and ongoing obligation of Realignment Growth Funds. Even if Growth fund payments under realignment are delayed, Baseline payments for Health care, which are based on current year expenses, will become available with the next fiscal year. Baseline realignment payments will cover an estimated two-thirds of the local share of current health care costs for next year and a growing share of the local cost in future years.