



# United Domestic Workers of America

*Affiliated with NUHHCE, AFSCME, AFL-CIO*

## Analysis of the 2005-06 IHSS Budget Proposals

Revised March 2005

### Executive Summary

- At a minimum, the Administration's proposed roll-back of the state support for IHSS wages to California's minimum wage and elimination of health insurance would:
  - **Leave an estimated 16,485 clients without services,**
  - **Force at least 4,121 recipients (over 1%) into nursing homes. UDW believes a more accurate estimate is 5-10%.**
  - **Add an additional 19,233 families (including 15,848 children) to the poverty rolls, and**
  - **Increase state general fund costs by about \$100 million.<sup>1</sup>**
- These figures are based on methodology developed by a grant from the federal Center for Medicare and Medicaid Services (CMS) specifically for the purpose of determining home care wage rates necessary to ensure access to workers. They are calculated using the latest available data provided by the Paraprofessional Healthcare Institute.
- This analysis indicates the Administration's proposal will not achieve its desired effect of creating state savings. (The Administration made this proposal to save \$194.8 million in General Funds in the coming budget year). However, the additional cost of 4,121 nursing home residents, combined with the loss of Federal Medicaid Funds, added welfare costs, indigent health care and related expenditures, **will actually result in additional state costs.**
- Additionally, enactment of this proposal would invite immediate litigation to invalidate the proposed reduction in the state match. Forcing a projected 4,121 individuals into nursing homes and leaving an additional 16,485 clients without workers violates not only the *Olmstead* decision but also federal law requiring wage rates to be high enough to provide adequate workers. To assure access to home care workers, federal law requires **wage rate studies** be conducted to identify what wages are needed to attract sufficient workers. However, neither the state of California nor individual counties have conducted such studies, which would be the backbone of the state's case supporting the reduction in the state match. For this reason, the challenge is likely to succeed, as it did in the 2003 lawsuit challenging other Medi-Cal rate reductions.
- Counties negotiate IHSS worker wages under **strict state guidelines**. Most counties have not bargained up to the state limit of \$9.50 per hour and \$.60 for health care. **The state, not the counties**, financially benefits from diverting the elderly and disabled from nursing home care through the IHSS program.



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## Analysis of the 2005-06 IHSS Budget Proposals

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The United Domestic Workers of America is greatly concerned regarding the Administration's 2005-06 budget proposal to roll back state support for worker wages and health insurance to the minimum wage. Following is a detailed description of the results of the proposed reduction in the state match for IHSS worker wages.

### I. Reducing State Support for Wages and Benefits Will Increase State Costs

The provision of wage rates that are high enough to attract sufficient workers is already required in federal SSI/SSP law and state statutes. Ensuring sufficient wage rates is an important new priority of the Bush administration, which the New Freedom Initiative is designed to ensure. The federal Health and Human Services Agency has sponsored studies by the Paraprofessional Healthcare Institute designed to evaluate the wage levels needed to ensure an adequate workforce in each state. Our projections stem from this research and are specifically based on California data.<sup>2</sup>

The following analysis employs standard econometric Return on Investment (ROI) projections developed by the Paraprofessional Healthcare Institute and the latest available California data to assess the total impact of the Administration's proposals.

Both the federal study and our extension of its conclusions are necessarily predicated on assumptions. We have attempted to apply mid-range economic cost figures to these. Note, however, although no one can predict with precision the exact impact of the Administration's proposal, **research uniformly indicates each of the enumerated consequences will occur.**

**A. Insufficient workers will be available to care for eligible clients, increasing costs due to institutionalization.** Because IHSS enables many aged, blind and disabled SSI/SSP recipients to avoid living in nursing homes, any fiscal changes that increase the nursing home population increase the state cost of caring for this population. Many clients already have difficulty finding and retaining homecare workers, a situation that will worsen with the administration's proposals to reduce worker wages.

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\* This revision incorporates cost projections made by the Paraprofessional HealthCare Institute Wage Calculator in lieu of some cost estimates made in our earlier paper. In addition, we use updated information on the number of workers and corrected minor errors in our earlier version.

IHSS costs per client average \$9,924 annually, according to the Legislative Analyst's office, while Medi-Cal nursing home care approximately costs 4.5 to 5 times this amount.<sup>3</sup> Disabled nursing home patients cost more, about \$60,000 annually. (These costs are much less than those for private nursing homes, which average \$70,080 per year, or for home health aides, which average \$18 per hour.<sup>4</sup>) While the personal rights of individuals to remain in the community are, of course, paramount, taxpayer costs for additional institutional care strengthens arguments to maintain wages at levels that afford access to all who desire to remain in the community.

Already, data indicates there are insufficient workers in some areas of the state. The existing shortage of available workers was highlighted in the Department of Social Services October 2001 report.<sup>5</sup> Moreover, our own research documents many Northern California counties that pay minimum wage have an insufficient supply of workers.<sup>6</sup> Other studies show increased IHSS wages improve worker supply.<sup>7</sup>

This has important fiscal and legal implications. Declining worker retention will force many current IHSS recipients to seek care in nursing homes. The Return On Investment (ROI) calculator discussed above indicates at least 4,121 individuals would be forced into nursing homes. UDW believes 5-10% of current IHSS recipients may have to be institutionalized.

The ROI calculator estimates the additional costs relating to nursing home care for these 4,121 individuals would be \$165.9 million, of which \$82.9 million is general fund costs.

We believe the estimate of 4,121 (just over 1%) **may be low**, particularly as this projection ignores the impact of withdrawal of state support for benefits. Estimates for 5% and 10% are presented in Table 1, below.

**Table 1.**

<b>Increased Costs of Institutionalization Resulting from Reduction in State Support for IHSS Worker Wages and Benefits</b>		
<b><u>% INSTITUTIONALIZED</u></b>	<b><u>TOTAL COST</u></b>	<b><u>STATE COST</u></b>
1% (4,121 individuals)	\$165.9 million	\$82.9 million
5% (19,106 individuals)	\$769.2 million	\$384.6 million
10% (38,212 individuals)	\$1.538 billion	\$769.2 million

**B. Costs for community-based services will increase because insufficient workers will be available.** The ROI calculator projections also indicate

an estimated additional 16,485 clients will be unable to find caregivers at the \$6.75 wage level, and although they will not enter nursing homes, they will find alternative modes of survival.

The 16,485 IHSS recipients who are not institutionalized would require additional alternative care to remain safely at home. Calculating the cost of this additional care is very difficult, yet the need for these services is obvious and legally required. California, under its current Medi-Cal State Plan and amendments, is required by law to provide it.<sup>8</sup>

Using the average per-client cost for Regional Centers, which provides Community-Based Services for those IHSS recipients who are developmentally disabled, is one way to estimate the cost. These services are provided *in addition to* IHSS services as a *supplement*, and are *not* provided to IHSS recipients who are not developmentally disabled; for this reason the estimate is not precise. It is, however, the best estimate available, particularly since others have not been proffered for this need.

Regional Centers' average cost is \$14,200 per recipient. Based on this cost, providing legally required services for the 16,485 IHSS recipients projected to be without caregivers would cost \$234.1 million, of which \$150.6 million is general fund money.<sup>9</sup>

Again, it is unclear how these recipients would be cared for, because regional centers are only for developmentally disabled individuals; but **care has to be given to comply with Medicaid law, and IHSS is both the least costly and most consumer-friendly means of complying.** UDW believes the actual cost would be greater than this, particularly because of the start-up cost for new programs to care for workers who cannot find caregivers.

**C. Some workers would qualify for the CalWORKS program, adding state costs.** IHSS workers are already poor. Three-quarters have only IHSS earnings. The 2001 CDSS Provider Report, conducted before most worker wages exceeded \$7.11 per hour and before health insurance was available, indicated that only one-fourth of IHSS workers held jobs outside of IHSS and that few received Medi-Cal, SSI/SSP or CalWORKS funding. CDSS estimated in 2000 that 43% of providers work for immediate family members.<sup>10</sup> Howes estimates the number at about 70%.<sup>11</sup>

An additional 19,233 families, including 15,848 children, would be forced into poverty, generating additional costs. Some would qualify for CalWORKS training.<sup>12</sup> Cost per case is approximately \$13,500 per family, depending on which assumptions are made.

The ROI calculator estimates additional CalWORKS costs would be \$2.8 million, of which \$1.4 million would be state general fund costs.

**D. Medi-Cal and other health care costs for workers would increase.**

Since the enactment of AB 1682 in 1999, sponsored by UDW, 53,000 IHSS workers have acquired health insurance as part of their union contracts.<sup>13</sup> Many of these individuals supported unionization *primarily* because they were desperate for health insurance. Many of these individuals will become eligible for Medi-Cal coverage if state support for benefits is withdrawn.

Since the state match has been available for health insurance, the rate of utilization for Medi-Cal health programs by IHSS home care workers themselves has substantially declined. Howes reports that **Medi-Cal usage by IHSS home care workers considerably varies by county, from a low of 10 percent in San Francisco, where 98 percent of IHSS providers are eligible for IHSS insurance, to a high of 37 percent in Yuba and Sutter counties** (two counties chosen for her research because they have no IHSS health insurance).<sup>14</sup>

Based on Howes' research, we estimate 24,418 of the 53,000 individuals currently receiving health benefits through their IHSS employment would enroll in Medi-Cal.<sup>15</sup> Although Medi-Cal costs are the lowest in the nation at \$4,605 per enrollee, the addition of these new individuals on Medi-Cal rolls would mean an increase of \$120,316,032, 50% of which, or \$60.6 million, would be general fund costs.

**E. Summary of General Fund Savings and Expenditures from IHSS Proposals.** Based only on the above four considerations, it is clear the Administration has not fully calculated the **fiscal impact** of its proposal. As indicated in Table 2 below, **enactment of the proposal would cost an estimated \$100.7 million in additional General Fund monies.**

It is not surprising that decreasing the state match for IHSS services would incur additional cost. This is part of the reason the identical proposal was soundly rejected by the Legislature last year.

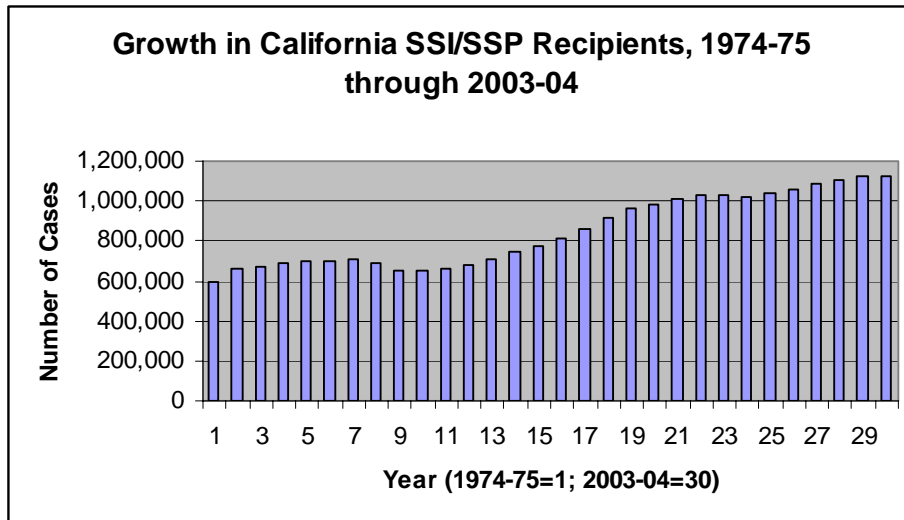
**Table 2.**

<b>General Fund Impact of Administration IHSS Proposal</b>	
<b>Projected Savings by Administration:</b>	<b>\$194.8 Million</b>
<b>Additional Costs:</b>	
Institutionalization for 4,121 Recipients	\$ 82.9 million
Increase in Regional Center-type Services	\$ 150.6 million
Additional CalWORKS caseload	\$ 1.4 million
Medi-Cal caseload increase	\$ 60.6 million
<b>Total Cost for alternative services:</b>	<b>\$295.5 million</b>
<b>Additional State General Fund Expenditures:</b>	<b>\$100.7 million</b>

**F. California's IHSS program has helped keep our Medi-Cal nursing home utilization low.** Under current law, Medicaid funds pay 50% of all covered expenses in California, including IHSS. Yet state general fund dollars spent on IHSS programs yield more federal funds, dollar for dollar, than the same number of dollars spent on nursing homes and some other Medi-Cal programs - \$100 in Medi-Cal match funds for each \$65 in general fund monies—because 17.5% of IHSS costs are paid via the state realignment program, rather than the General Fund.

State responsibility to care for California's very poor aged and disabled population is limited to those on SSI/SSP. The average annual increase is 2.3%.<sup>16</sup> The success of California's IHSS program has led to major savings in institutionalization costs and, with managed care, is a major factor in the fiscal efficiency of the California Medi-Cal program. Data from the Department of Social Services and the Office of Statewide Health Planning and Development indicate that while the SSI/SSP population and the IHSS caseload have steadily grown over the past decade, the number of individuals receiving care from nursing homes has remained remarkably flat. Figures 1, 2, 3 and the accompanying descriptions explain why.

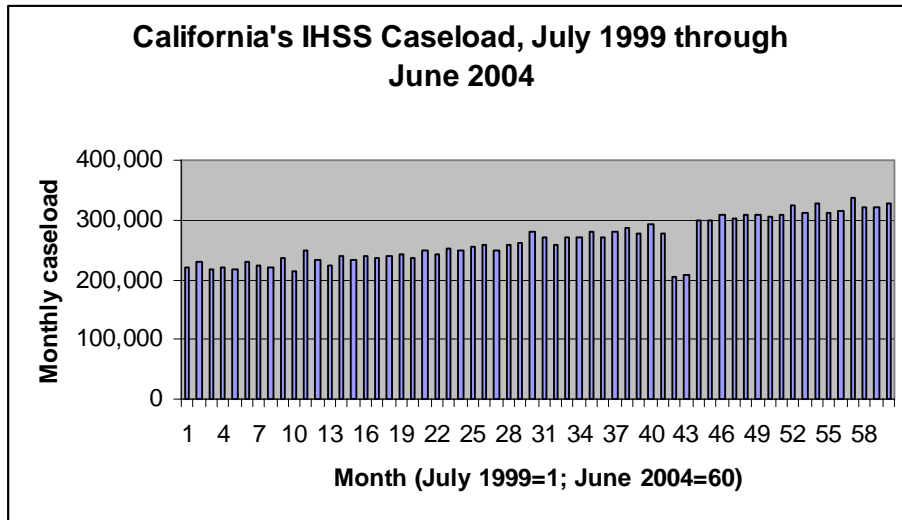
**Figure 1.**



The disabled portion of the caseload is the cause of the growth in California's SSI/SSP Population (see Figure 1). Almost the entire increase over the 30-year period is due to the tripling of this portion of the caseload.<sup>17</sup> In the same period, the aged proportion decreased from 53% to 31%.<sup>18</sup>

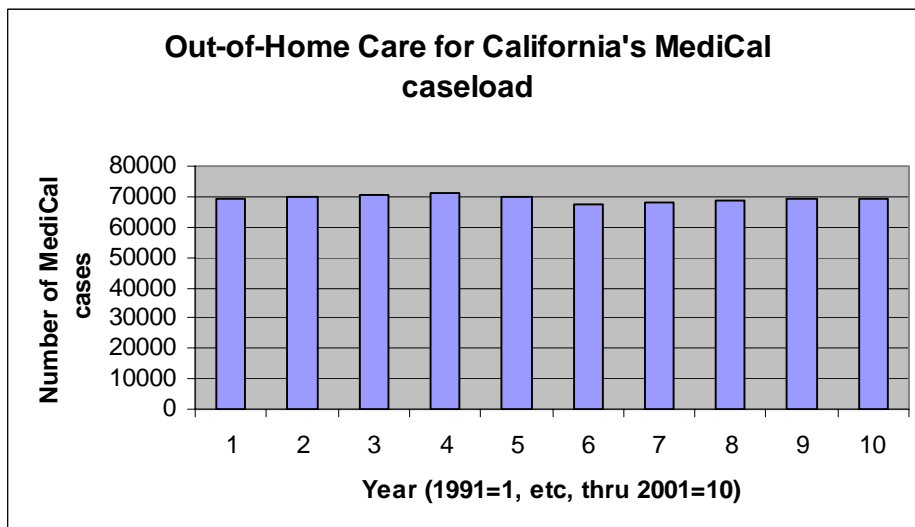
The SSI/SSP recipients who cannot remain safe without some assistance turned to California's In-Home Supportive Services program in preference to institutional care. **The average annual increase is 8.4% annually** over this 5-year period (see Figure 2).<sup>19</sup>

Figure 2.



As shown in the following chart (Figure 3), nursing home care has remained relatively constant. According to trend analyses published by California's Office of Statewide Health Planning and Development, the number of licensed beds has remained nearly constant, with an increase of less than 0.2% annually from 1992 through 2001. As shown in Figure 3, Out-of-Home hospital and nursing home utilization by SSI/SSP recipients remained constant over the period 1992-2001, despite the sizable increase in caseload.<sup>20</sup>

Figure 3.



**G. Bush Administration policies are designed to contribute to declining rates of institutionalization and to conserving taxpayer dollars.** Put simply, IHSS is the best and most economical way to care for this population. Examining both Democratic and Republican policies at the national level can illuminate the irrationality

of the Administration's proposal. Responding to *Olmstead* and the need to conserve tax dollars, several policies have been enacted to further community care.

- Federal coverage for protective supervision and for care by relatives has been authorized through Medi-Cal since 1997 (although California has only in the last year begun to take advantage of this possibility).<sup>21</sup>
- The Bush Administration's New Freedom Initiative, begun in 2001, amplified by the CMS Real Choices System Change Grants, is expanding home care. In addition to other programs (including the one which enabled the development of the ROI calculator above), it is expanding demonstration programs to recruit and retain home care workers for the disabled. **Since President Bush's initiative began, funding for expanded home care options, including paying relative providers, has increased from \$13.9 billion in FY 2001 to an estimated \$20.7 billion in FY 2004. More money was spent during Bush's first four years than was spent during the previous *eight* years combined (\$68.7 billion compared to \$56.6 billion).**<sup>22</sup>
- An integral part of the New Freedom Initiative is the maintenance of a sufficient pool of home care workers. According to CMS administrator Mark B. McClellan, M.D., Ph.D., "A compassionate and competent direct care workforce is an essential element of our community-based long term care system."<sup>23</sup>
- The Bush Administration recognizes the shortage of direct service workers. It has created a demonstration program to address the shortage of direct service workers. Some of these programs also offer health insurance to workers, testing whether this incentive assists in keeping workers in their positions for longer periods.<sup>24</sup>
- While the federal 2006 budget proposes reductions in several Medicaid areas, **Bush actually proposes expansion of funding to assist states in reducing nursing home utilization by providing 100% of the cost of in-home services for one year.**

## II. The Administration's Proposals Will Negatively Impact the State and Local Economies.

In addition to increasing state costs resulting from higher institutionalization rates, increased welfare costs, indigent health care and related expenditures, reducing 314,719 IHSS workers' wages to the state minimum wage will have far-reaching and severe economic consequences. California will lose millions of dollars in federal matching funds, which will have much larger aggregate effects to the state economy. In addition, further reducing the wages of already low-income workers will create increasing pressures on California's public assistance programs.

**A. Proposals would reduce Federal Medicaid support.** Funds spent on Medi-Cal programs, such as IHSS, are matched by Federal Medicaid funds. As reviewed above, the federal government pays for 50% of the cost of the IHSS program. The state and county governments divide the remaining costs by a formula that results in the state paying 32.5% of the total cost of the IHSS program, and county funds, later reimbursed, pay for the remaining 17.5% of program costs. Decreasing state participation in the cost of the IHSS program impacts the amount of money the state receives in federal and county funds. As a result, the total cuts to the IHSS program would be much larger than the estimated state savings.

The Governor's Budget proposes drastic cuts to the state's participation in IHSS worker wages, which are projected to save the state \$194.8 million. These reduced costs, however, will result in a loss of \$441.6 million in federal and county funds, **decreasing IHSS worker wages by a total of \$636.4 million.**

This loss will be devastating to IHSS workers. The data are detailed in Table 3, below.

**Table 3.**

<b>Total Impact of Administration Proposals</b>	
Reduced State Costs	\$194.8 million
Forfeit of Federal Funds	\$318.2 million
Forfeit of County Funds	<u>\$123.4 million</u>
<b>Total Loss in IHSS Worker Wages and Healthcare</b>	<b>\$636.4 million</b>

**Note:** The administration's budget proposal suggests counties could continue funding wages above \$6.75 by reinvesting the county savings from the Residual Waiver.<sup>25</sup> However, several counties have informed us they have already appropriated these savings for other programs. If counties do choose to maintain existing wage

levels, they will receive a 50% match from the federal government for wages above \$6.75, and **would qualify for a larger share of realignment sales tax funding.**

The total cost to the IHSS workforce of the administration's proposals thus far outweighs the reduction in state costs. Forfeiting more federal funds directly contradicts the administration's stated goal of obtaining more support from the federal government. During his gubernatorial campaign in 2003, Governor Schwarzenegger pointed out that California received less than our share of federal funds and vowed to change this situation. He fulfilled his campaign pledge during the 2004 budget session with the IHSS Independence Plus Waiver, bringing in an additional \$340 million in federal funds to California and saving IHSS care for the residual population. The Governor's 2005-06 budget proposals would give most of this money back, forfeiting \$318 million in IHSS wage support.

In addition, the loss of federal funds will have far reaching consequences for the state economy, as detailed below.

#### **B. Medicaid funds multiply economic benefits to California's economy.**

Reducing worker wages by \$636 million would have a much larger aggregate impact on state and local economies in terms of business activity, employment and earnings. The administration's budget proposals will result in the loss of \$318.2 million in federal funds toward IHSS worker wages. Not only would the workers be directly impacted by the wage reductions, but the ripple effects of decreased federal funds in the state economy would have measurable impacts statewide.

A nationwide study by Families USA explains the important role of Medicaid matching funds on state economies.<sup>26</sup> The federal money brought into the state through Medicaid programs, such as IHSS, create multiplier effects with the aggregate impact on the state economy being much larger than the value of the services alone.<sup>27</sup> Measurable impacts include the increase in the state business activity (increased output of goods and services), employment (number of new jobs created) and earnings (amount of new wages earned).

For every \$1 California invests in Medicaid spending; business activity increases by a factor of 2.29. Medicaid spending cuts will have a corresponding negative impact. **The forfeiture of \$318.2 million in federal funds for IHSS would have an aggregate negative impact on California's business activity of \$728.7 million.**

### **III. The Administration's Proposals Would Violate State and Federal Law.**

In addition to the negative economic consequences detailed above, UDW believes the administration's proposals pose legal problems. Below, we discuss several

legal precedents regarding home care and the potential ramifications of the administration's proposals.

**A. The enactment of this proposal would result in an *Olmstead* violation because the resulting impact on worker availability will force some individuals into nursing homes.** In *Olmstead v. L.C.*, the U. S. Supreme Court declared that failure to provide a community-based option for disabled clients violates their rights in those cases where institutional care was not required for their safety. The Court said, "Unjustified isolation, we hold, is properly regarded as discrimination based on disability."<sup>28</sup> Due to the exacerbation of worker shortages, many IHSS clients would no longer be able to live safely in their own homes. To the extent the administration fails to provide sufficient resources for home care, California will be inviting litigation per *Olmstead*.

**B. No one has conducted federally required studies to identify wage levels necessary to ensure client access.** Equal access to care is an important and mandatory provision of federal Medicaid law; state agencies that accept Medicaid funding must comply with the provisions of the Medicaid Act. In terms of IHSS recipients, this includes the ability to find and retain a home care worker. The federal government has explicit procedures requiring Medicaid agencies to determine wage levels necessary to ensure access.<sup>29</sup> Provisions included to implement this requirement are reflected in California's Medicaid State Plan. In 1994, California applied for and received federal Medicaid coverage for the PCSP portion of the IHSS population. The state plan amendment carries the required assurances that compensation levels will be sufficient to guarantee access to all IHSS recipients in California. This language requires:

*. . . an analysis of appropriate economic factors, on a geographic or statewide basis within the State of California. The primary objectives of the analysis will be (a) identification of rates sufficient to ensure adequate access to Personal Care Services, and (b) that the rates are consistent with efficiency, economy and quality of care.*<sup>30</sup>

This requirement is reflected in California's Welfare & Institutions code §§14075, 14079 and 14105. Despite these requirements, our information reveals that no study has been conducted. CDSS asserts this is a county responsibility; if so, to our knowledge it has never informed counties of this responsibility.

Three separate lawsuits demonstrate failure to conduct these studies would trigger judicial intervention to eliminate rate reductions.

1. In August of 2004, an Arizona District Court determined in *Ball v. Biedess* that equal access to IHSS care through Medicaid requires the responsible agency to " . . . pay a wage sufficient to attract enough health care workers to meet the Medicaid requirements." The court found that shortages of home care

workers in Arizona are directly related to low wage rates (\$6.25 to \$7.50 per hour), and ordered the Arizona Health Care Cost Containment System to provide a rate of pay to home care workers that will “attract enough health care workers to deliver all of the services for which an individual qualifies.”<sup>31</sup>

2. The 2003 federal Medi-Cal rate reduction case, *Clayworth v Bonta*, joined with *California Medical Association et al v. Bonta et al*. disallowed rate reductions mandated by the Legislature and Governor. The court based its decision on the Department of Health Service’s inability to ensure the reduced rates would not inhibit access to Medicaid services. In its opinion, the Court indicated the Department of Health Services has no continuous study of the adequacy of rates to meet these requirements. The *Clayworth* opinion cites a Legislative Analyst review of the rate study requirement, concluding that the Department “has no rational basis” for its rate system and has not for many years.<sup>32</sup> We understand this statement is based upon an Analyst report, which is several years old. However, to our knowledge these studies have not been conducted since that time.
3. Finally, in a Sacramento case, *Sobkey v. Smoley*, the Federal District court outlawed paying reduced rates for drugs as established in the 2000-2001 Budget Act because they violated the rate-setting methodology established by 22 CCR §51516.1(a) and 42 CFR §413.310(b), and WIC §14021.6(a).

**C. Even today, without the implementation of this proposal, California has failed to ensure access in some geographic areas by structuring IHSS worker wage rates differentially across the state in response to differential costs of living.** The rate studies required in federal law and regulation, and in the California State Plan Amendment cited above, appear to be prescribed in a manner that will identify cost variations in different regions of the state. Paragraph 1396(a) of the federal regulations requires that the state’s participation in Medi-Cal costs be provided “on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan . . .” Although this requirement has not been implemented with regard to IHSS provider rates, it is reflected in the Medi-Cal reimbursement rates for hospital stays, for which three different reimbursement rates exist in California.

Our review of IHSS funding indicates the Administration’s failure to conduct the required studies cited above inhibits access in some areas of California. There are two problems with the existing funding structure:

- First, some counties, through no fault of their own, have reserves that are so limited that they cannot provide the up-front funding for the local match of IHSS worker wage and benefit increases.

- Second, the failure of counties to pay wages above \$6.75 has had a demonstrable effect on access, at least in our Northern counties. State data revealing the utilization of authorized IHSS hours in these counties indicates clients are unable to find workers as readily as in counties with higher pay.<sup>33</sup> This phenomenon is reversed in a recent study of San Francisco, where higher wages have resulted in better access to services.<sup>34</sup>

**D. Reducing support for IHSS worker wages would result in a Proposition 1A challenge.** In addition to violating federal law (the Americans with Disabilities Act), this proposal would violate California’s recently amended constitution. Proposition 1A, supported by more than 70% of California voters, requires the state to pay local governments for all new mandates. This constitutional change explicitly includes a “higher level of service [including] a transfer by the Legislature from the State to cities, counties . . . of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility.”

Current law guarantees counties repayment of the county match for up to \$9.50 in IHSS worker wages, plus \$.60 for health care. Relying on this guarantee, dozens of California counties, with as many as 200,000 IHSS workers, currently have contracts to pay IHSS workers rates above this level. The abrupt withdrawal of state participation in the cost of wages above \$6.75 per hour would impose major additional uncompensated costs in violation of Proposition 1A. We anticipate a major legal challenge on this issue, with the disability community, counties and worker unions joining forces, should this proposal be enacted.

The Administration asserts it is not cutting actual wages, just the state’s contribution, pointing out that wage and benefit rates are voted by individual county boards of supervisors. This is correct. However, counties voted increased wages when legislation was in place setting the state match at the higher level. If the Administration’s expectation is for the counties to maintain the wages negotiated before any state wage match is reduced, it is clearly a shift of partial financial responsibility under the new definition of ‘mandate’ and a violation of this provision of the California constitution.<sup>35</sup>

**IV. Conclusion: Administration Proposals would raise costs, damage local economies, invite litigation, are contrary to federal policy initiatives, and would not achieve needed structural reforms**

**A. Reducing state support for worker wages and health insurance will not save taxpayer dollars. Instead, it will raise costs due to increased institutionalization, CalWORKS and Medi-Cal utilization.**

**B. The reduction in IHSS worker wages would have greater aggregate impacts than the savings accruing to the state. As a result, the state and local economies will suffer.**

**C. Legislation to void reduced state support for IHSS wages and benefits would invite litigation.**

**D. Administration IHSS Proposals are contrary to President Bush's Olmstead Initiatives.**

**E. Finally, structural reform is not accomplished by reducing the state match for IHSS wages and benefits.** In testimony before the Assembly Committee on Budget and Fiscal Review, the administration asserted that part of the rationale for reducing state participation in worker wages lies in the fact that the counties, not the state, negotiate worker wages, while the state government bears a large portion of the costs. While UDW agrees the IHSS program may benefit from structural adjustments, we maintain not only is this an insufficient and illogical rationale for proposing to dramatically reduce the wages of already low-income home care workers, but it also is of questionable legality.

The application for Medicaid money is submitted by the state, not the counties. We believe the responsibility for ensuring compliance with Federal law lies with the applicant agency, and the state is therefore legally liable for ensuring access to IHSS care and a sufficient pool of workers to provide care. Current law recognizes that obligation by committing the state to participate to the extent of 32.5% in wages up to \$9.50 per hour and health care benefits of \$.60 per hour. Counties are thereby supported in efforts to assure adequate access to IHSS care.

Furthermore, **the state is the primary beneficiary** from the declining institutionalization rates in California; as **counties do not pay a share** of nursing home costs. Thus, even while wages are negotiated at the county level, the state is benefiting through the diversion of many elderly and disabled from more expensive nursing home care.

## **V. Policy Alternatives**

California's fiscal situation is serious and must be addressed. Although UDW disagrees with these particular recommendations, alternative measures are available.

**Continue to press for increased federal funding.** As noted in a long article in the January 20 Wall Street Journal, the Governor is the Republican Party's brightest new star. Demonstrating that the Governor campaigned on a pledge to secure more federal funds, the Journal suggests that Schwarzenegger's support of federal health programs is a part of this pledge. UDW believes the Governor will continue to fight for

California's share of federal dollars and his stature will enable us to solve the budget dilemma without crushing attacks on California's most vulnerable citizens.

**Complete the IHSS Quality Assurance (QA) process.** It appears some Administration policy analysts believe IHSS costs have increased in part because of abuse on the part of clients and home care workers. UDW believes, instead, the growth is due in large part to the availability of better and less expensive in-home care. This argument is buttressed by the lack of growth in out-of-home care over the previous decade, in comparison to consistent growth of the client population. The current QA process will resolve this issue (which includes the Administration's assertion that "waste, fraud and abuse" would yield a 10%-25% reduction in IHSS hours). Clearing up any problems will enable policymakers to focus on true costs and refine proposals leading to fiscal efficiency.<sup>36</sup>

**Conduct the federally required rate studies.** The results of these studies will enable Californians to assure access to all eligible participants, eliminate the danger of costly litigation, and assure taxpayers that costs of institutionalization are minimal.

**Consider recommendations of the California Performance Review, including assigning client assessments to the Department of Health Services.**

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In 1999, after many years of public debate, legal challenge and policy action regarding the employee status of IHSS workers and the severe fragmentation of responsibility within the IHSS program, **more than a two-thirds bipartisan majority** of the Legislature signed AB 1682 into law. This measure was designed to improve access to care by stabilizing and improving the IHSS workforce, and address the federal requirements discussed above. The governor's proposals would seriously undercut these efforts.

The administration's proposal to roll back current participation to **the minimum wage and eliminate health insurance** would only jeopardize the ability of recipients to find and retain a home care worker, thus leaving the state legally vulnerable. Implementing a policy that would take away health insurance and effectively reduce IHSS worker wages to minimum wage is not an appropriate, or responsible, method to address structural problems within the IHSS program.

UDW looks forward to the dialogue with the Administration and Legislature as we jointly search for solutions to the situation.

## Endnotes

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<sup>1</sup> Paraprofessional Healthcare Institute, “Return on Investment Calculator.” Data is for California and measures the impact of reducing the worker wages from \$7.82, the current statewide average, to \$6.75. The workforce projection is based on a statewide IHSS workforce of 314,719 for 2005-06, calculated by applying a 7.7% inflation factor to the 2004 workforce of 292,218 obtained from the California Department of Social Services by the California Budget Project. See CBP, “Budget Backgrounder: Making Dollars Make Sense: In-Home Supportive Services Program” March, 2005. Lead author is Agnes Lee, now with the Senate Office of Research.

The impact of eliminating health care coverage is not included in this analysis; this impact would **add** to the impact given here. The Paraprofessional Healthcare Institute’s ROI calculator is at: <http://www.directcareclearinghouse.org/roi/index.html>

Also, the calculator currently does not provide for entering the county match (currently 17.5%). In some cases, there is a county match; in others (such as the nursing home costs), there is none.

<sup>2</sup> Ibid.

<sup>3</sup> Legislative Analyst’s Office, “Cal Facts 2004” gives costs for institutional care for disabled patients. Our estimate of nursing home costs for non-disabled IHSS recipients is based on the 2003 number of approximately \$43,000, with some inflation; we do not have the exact figure for 2005-06.

<sup>4</sup> “Ask Personal Journal,” Wall Street Journal, March 11, 2005, p. D1. The Journal figures are taken from a 2004 MetLife study and are average figures nationally. According to the study, costs in San Diego are \$217 per day, in San Francisco \$293 per day and in Los Angeles, \$160 per day. By contrast, in California Medi-Cal nursing costs for 2003 were about \$118 per day, on average.

<sup>5</sup> This study revealed the current ratio of recipients to providers in California is roughly 1.2 to 1. CDSS estimates that by the year 2020, “the ratio will likely increase to 1.4 to 1, and by 2040 may further increase to 1.8 to 1.” California Department of Social Services, California IHSS Provider Characteristics. Sacramento: CDSS Research & Development Division, October, 2001, p. 17.

<sup>6</sup> United Domestic Workers of America, “Access in California’s Northern Counties,” December 2004. Unpublished. This paper shows poverty levels result in higher IHSS client rates and the percentage of paid to authorized IHSS hours is lower in these counties than statewide.

<sup>7</sup> The impact of improved wages has already been demonstrated. San Francisco experienced a 47% increase in its workforce when local officials increased the wages from \$6.00 to near \$9.00. This shows that improved wages have begun to improve worker retention, but statewide turnover is still very high among IHSS workers—about 50% according to the Paraprofessional Health Institute Data. As the Legislative Analyst’s Office indicated last year, IHSS wage reductions would result in a smaller pool of labor, and recipients would have even greater difficulty finding a home care worker. The Health Institute projects a 13,000-worker decline in the available workforce (about 5%)—and a decrease in the retention rate from 50% to 44%.

<sup>8</sup> By law, IHSS is available only to those who otherwise would be unable to remain safely in their own homes; and the number of hours authorized is limited to that number needed to keep the client safe.

<sup>9</sup> This calculation is based on figures for the Regional Centers published by the Senate Committee on Budget and Fiscal Review, “Overview of the 2005-06 Budget Bill,” p. 3-31. It includes both administrative and direct service expenses. Overhead is 15.6% of the total cost.

<sup>10</sup> CDSS RADD, California IHSS Provider Characteristics, October 2000, p. 4.

<sup>11</sup> Candace Howes, personal communication, March 2005.

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<sup>12</sup> CalWORKS benefits are restricted to those having less than \$2,000 in resources, plus a car valued at \$4,650 or less. Income limitations are based on family size; for a family of three it is \$12,066, 77% of the federal poverty level.

<sup>13</sup> Candace Howes, Ph.D., “Impact of Proposed Cut in State match to IHSS Wage and Benefit Costs on Worker Income, Health Insurance Coverage and Medi-Cal Costs,” prepared for the California State Senate Budget and Fiscal Review Committee, March 14, 2005.

<sup>14</sup> Howes, op. cit.

<sup>15</sup> Ibid. Our estimate of the number of new Medi-Cal recipients is based upon Howes’ work. However, our estimate of the number of 2005-06 caregivers is 314,700, higher than the 290,000 number estimated by Howes. Thus our 24,418 Medi-Cal caseload is higher than her 22,500 estimate. (We employ the 314,700 number because it is based on the average number for the entire 2004 year, rather than on a single month data point.)

<sup>16</sup> This population has changed from 592,977 persons in 1974-75 to 1,121,282 in 2003-04, or by over 500,000 individuals.

<sup>17</sup> From 267,169 to 726,690 individuals. California Department of Social Services, Research and Development Division, SSI/SSP Recipients: Characteristics of California’s Recipients in the Supplemental Security Income and State Supplementary Payment Program. Sacramento, Author, January 2003, p. 8. According to the October 18<sup>th</sup> Time magazine, one in eight children are now born at least three weeks early, a 26% increase since 1980. (pp. 73-74).

<sup>18</sup> 2% of the caseload is blind. The increase in the disabled population as well as the increase, proportionately, of the SSI/SSP caseload, is due to federal Social Security Administration regulatory revisions and outreach, plus the 1990 U.S. Supreme Court decision, Sullivan v. Zebley, which loosened disability standards for children. California Department of Social Services, RADD, January, 2003, “SSI/SSP Recipients, February 2002: Characteristics of California’s Recipients in the SSI/SSP program.” Although CDSS’s report does not mention it, increases in medical care for newborns also contributed to the increased caseload.

<sup>19</sup> This caseload has grown from 220,024 individuals in July of 1999 to 328,502 individuals in June of 2004.

<sup>20</sup> In December of 1992 there were 69,279 cases; by December of 2001 the number had increased to 69,333 OSHPD, “Patients by Payment Source—December 31 Census.” <http://www.oshpd.ca.gov/hqad/lrc/util/trends/lrtrend01.pdf>

<sup>21</sup> Debi Waterstone, et al., “California’s In-Home Supportive Services Program: Who is Served.” Prepared for the California Healthcare Foundation. Center for Personal Assistance Services, University of California, San Francisco, September 2004, p. 8.

<sup>22</sup> “Opening Doors to Independence: CMS Accomplishments in Support of the Presidential New Freedom Initiative.” Public Affairs Office, Centers for Medicare & Medicaid Services, n.d.

<sup>23</sup> U.S. Department of Health and Human Services, HHS News. *HHS Expands Demonstrations to Recruit and Retain Personal Assistance Workers for People With Disabilities*. 28, May, 2004.

<sup>24</sup> Ibid.

<sup>25</sup> Administration documents give this figure as \$112 million; the Department of Finance (and the Assembly Budget and Fiscal Review analysis) indicates the savings is \$123.9 million.

<sup>26</sup> Families USA, Medicaid: Good Medicine for State Economies. (Washington, DC: May 2004) available at [http://www.familiesusa.org/site/DocServer/Good\\_Medicine\\_2004\\_update.pdf?docID=3381](http://www.familiesusa.org/site/DocServer/Good_Medicine_2004_update.pdf?docID=3381)

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<sup>27</sup> The Families USA study used a RIMS II input-output model created by the U.S. Dept. of Commerce, Bureau of Economic Analysis to capture state-specific economic calculations and calculate economic activity generated by Medicaid dollars. These numbers are based on projections for FY 2005; we have inquired about an update for FY 2006 and will adjust our analysis accordingly when these numbers are available.

<sup>28</sup> *Olmstead v. L.C.* 527 U.S. 581 (1999).

<sup>29</sup> In essence, this is a property right, conferred by the U.S. Constitution. The applicable regulation is 42 USC §1396a(a)(8), 42CFR §435.930.

<sup>30</sup> “Reimbursement for Medi-Cal Personal Care Services,” State Plan Under Title XIX of the Social Security Act. State: California, TN 94-006, effective April 01, 1994, Attachment 4.19-B, Section H, pp. 34-36. It is unclear whether this language applies to Public Authorities or Non-profit consortia. We include it because it implements federal law. Section J, which does apply here, refers to Section H language and requires public hearings on the rate setting process, including the participation of various parties, including unions.

<sup>31</sup> *Ball v. Biedess*, Case No. PBVPB128711 U.S. (2004).

<sup>32</sup> *Clayworth v. Bonta*, CIV-S-03-2110 DFL/PAN, Memorandum of Opinion and Order, p. 7.

<sup>33</sup> United Domestic Workers of America, “Access in California’s Northern Counties,” unpublished analysis, December 2004. This review indicates that in 12 Northern California rural counties, all paying \$6.75 per hour and offering no benefits, the utilization rate of IHSS services is 2% lower than in the state as a whole.

<sup>34</sup> Dr. Candace Howes, Testimony before California State Senate Health and Human Services Budget Committee, April 22, 2004. Professor Howes is Associate Professor of Economics, Connecticut College, and Principal Investigator, “Making Homecare a Better Job” study, funded by the Robert Wood Johnson Foundation. Dr. Howes is currently a visiting scholar at the University of California, Berkeley, extending her research into the San Francisco situation throughout California.

<sup>35</sup> Rachel Osterman, “Home Care Standoff,” Sacramento Bee Business Section.

<sup>36</sup> Based on the 2005-06 budget, this would reduce state expenditures from \$138.8 to \$346.9 million. Both the Legislative Analyst and the Senate Budget Committee staff have expressed skepticism that this level of savings could be achieved. Whatever the potential savings, this important reform is moving more slowly than originally anticipated. The 2004 May Revise reduced the projected savings from the original budget amount to \$57.9 million (\$36.7 million general fund) in the current year. The 2005-06 budget reduces this projection further to \$2.3 million (\$0.7 million general fund).