In-Home Supportive Services Program

It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers

February 2021

REPORT 2020-109

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Elaine M. Howle *State Auditor*

February 25, 2021
2020-109

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of the In-Home Supportive Services (IHSS) program. Our assessment focused on the California Department of Social Services (Social Services) and four counties: Butte, Kern, San Diego, and Stanislaus. The following report details the audit's findings and our conclusion that the State and these counties must take action to ensure that all Californians who are elderly and of low income or who are disabled (recipients) receive authorized IHSS services.

Our review found that the IHSS program serves more than 591,000 recipients, helping them live independently in their own homes and avoiding long-term care arrangements that would be much more costly to the State. However, a growing number of recipients—tens of thousands each month—do not receive the services for which they qualify because the State and counties alike have failed to complete mandatory annual planning activities intended to ensure care for all recipients. We further found that the counties generally do not process IHSS applications in a timely manner, nor do they ensure the timely provision of care for all recipients. Unless the State and counties address these deficiencies, the number of recipients who lack care will likely increase as the need for IHSS services grows.

Additionally, we found that caregivers throughout the State receive pay that is at or near minimum wage, and caregivers earn significantly less than a living wage in each county. In fact, many caregivers who work full time would qualify for public assistance. Moreover, the IHSS program's funding structure is inequitable and discourages counties from significantly raising wages. These low wages could make recruiting a sufficient number of caregivers challenging both currently and in the future, especially when 32 of the 51 counties that responded to our survey indicate that they already lack enough caregivers to provide each qualified recipient with all approved services.

Respectfully submitted,

Elaine M. Howle

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Selected Abbreviations Used in This Report

Abbreviation	Meaning
CMIPS II	Case Management Information and Payrolling System
IHSS	In-Home Supportive Services program
Social Services	California Department of Social Services

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Summary

Results in Brief

The In-Home Supportive Services (IHSS) program of the California Department of Social Services (Social Services) provides care to more than 591,000 lower-income elderly or disabled Californians (recipients), helping them to live independently in their homes.[1] This assistance saves the State a significant amount of money, as without IHSS many recipients would require more expensive out of home care. Even so, some recipients are not able to get the care they need. In 2019 for example, more than 40,000 recipients on average did not receive needed in-home care each month, and that number is likely to grow. California's population of those age 65 and older (seniors) will grow by several million in the coming decade, which will likely increase the demand for IHSS assistance. The gap between the number of recipients and the number of caregivers is widening and will likely increase the number of recipients who go without services. In addition, caregivers in IHSS are largely paid minimum or near-minimum wage. The low wages caregivers earn—far below a living wage—will make recruiting additional workers difficult.

State law requires counties to ensure that services are provided to all IHSS recipients each month; however, that is not always happening. From January 2015 through December 2019, the number of recipients statewide who lacked care grew from 33,000 to more than 40,000 on average each month. Over the five-year period, this equates to more than 130 million hours of services IHSS recipients needed but did not receive. County administrators provided several reasons why a recipient would not receive services, including extended hospitalizations, the inability to hire a provider, and recipients moving to a new location and requiring a new provider. These gaps in care can represent periods of increased risk of injury or other hardships for IHSS's elderly and disabled beneficiaries. However, none of the counties we reviewed—Butte, Kern, San Diego, and Stanislaus—created the required annual county plans that would describe to Social Services how the counties would ensure services to all those eligible for the IHSS program. According to Social Services, it has not required—and counties have not created—such plans for at least 20 years.

Expected rapid growth in the number of recipients will likely place more strain on the IHSS program. According to the Department of Finance, the number of California seniors will increase from 6 million in 2019 to 8.5 million by 2030. Because seniors currently

Audit Highlights . . .

Our audit of the Department of Social Services' IHSS program highlighted the following:

- *While the IHSS program helps more than 591,000 lower-income elderly or disabled Californians, some recipients are not able to get the care they need.*
  - *From January 2015 through December 2019, the number of recipients statewide who lacked care grew on average from 33,000 to more than 40,000 each month.*
  - *The number of seniors is expected to grow by over two million in this decade and will likely increase the demand for both IHSS assistance and caregivers.*
- *None of the four counties we reviewed created the required annual county plans for providing services to all IHSS recipients each month—in fact, no county has done so for 20 years.*
- *IHSS caregivers earn minimum or near-minimum wage and no county in the State pays IHSS caregivers a living wage, making it difficult to recruit caregivers.*
- *Although caregiver wages and benefits are bargained for locally, the program's funding structure discourages increasing caregiver wages.*

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1 Throughout the report we refer to the approved beneficiaries of IHSS care as recipients even in instances where they have not received care in a particular month.

make up the majority of recipients, we expect demand for IHSS services to increase significantly. Counties are already not providing timely IHSS approval to all eligible applicants and timely initial services to many recipients, and they will face increasing strain to do so as the number of applicants increases. Further, although most IHSS recipients come to the program with a caregiver—usually a family member—and are therefore receiving assistance before entering the program, about 58,000 did not during the period we reviewed. Those recipients who only begin receiving services after they enter the program usually hire a nonfamily caregiver. The Public Policy Institute of California has noted that in the future seniors will be less likely to have family support because they have never married or had children. Thus, counties will need to work harder to ensure the availability of nonfamily caregivers.

Recruiting a sufficient number of caregivers will be difficult because the job pays minimum or near-minimum wage, below a living wage in even the State's most affordable counties.[2] Living-wage calculations represent the wages necessary for a full-time worker to afford basic necessities without public assistance. For example, a living wage in Modoc County, a rural county in the northeastern part of the State, is about $18 per hour. However, IHSS workers in that county earn the state minimum wage of $12 per hour.[3] No county in the State pays IHSS caregivers a living wage. In fact, wages in many counties are so low that caregivers without other sources of income would be eligible for public assistance, such as CalFresh, California's food assistance program. In addition, caregivers in the city of San Diego actually earned less than the local minimum wage because the city exempted IHSS caregivers from receiving its minimum wage increase.

Although caregiver wages and benefits are bargained for locally in each county in accordance with state law, we found the program's funding structure discourages raising IHSS worker wages. IHSS is funded through a combination of federal, state, and county funds. State law contains requirements for establishing a county's share of the cost of providing IHSS services. In 2012 state law established this share based on the actual cost of the program in fiscal year 2011–12, with future adjustments to be updated periodically, based on an inflation factor specified in the law. In addition, a county that chooses to increase caregiver wages has its share permanently increased. Further, a county must pay an even greater share of the increase if the raises it provides collectively equate to more than a 10 percent raise over three years, which we refer to

2 The State's minimum wage ranged from $9 per hour in 2015 to $12 per hour in 2019.

3 For purposes of our report, we reference the minimum wage required for employers who employ 26 or more people.

as the *limit*. For example, between 2018 and 2019, San Francisco increased IHSS caregiver wages by a total of $2 per hour. These raises increased San Francisco's contribution to the program by a total of $21 million because the total wage increases exceeded the 10 percent limit.

These increased costs remain a component of a county's share of its IHSS expenses indefinitely, even in cases where the state minimum wage surpasses the locally negotiated wage. Unless state law is updated, this means that counties that raise caregiver wages may pay millions more than they would have if they had kept caregivers at the state minimum wage. As a result, counties must balance the impact wage increases have on their finances against the benefit they offer caregivers in light of these increased costs. Given this funding structure, it is not surprising that the number of counties paying caregivers above the minimum wage has shrunk. In 2014, 52 counties paid more than the minimum wage; in 2019 only 20 counties did so. Although low wages act to control costs associated with the IHSS program, they also make recruiting caregivers more difficult.

Selected Recommendations

To help ensure that all recipients throughout the State receive the services they need, Social Services should enforce its requirement that counties submit annual plans. These plans should include, at a minimum, a description of how each county will ensure that all recipients receive the services for which they have been approved.

To limit the disincentive for counties to provide wage increases, the Legislature should modify the State's cost-sharing system to eliminate the ongoing costs that counties pay for local wage increases that are surpassed by increases to the State's minimum wage.

Agency Comments

Butte, Kern, San Diego, and Stanislaus counties generally agreed with our recommendations. Social Services disagreed with a number of our conclusions, including those related to recipient care, county contributions to the IHSS program, and the effect of state law on caregiver wages. Social Services also raised concerns with our analysis of its data and indicated that it would not implement our recommendations. We address Social Services' response beginning on page 69.

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Introduction

Background

The In-Home Supportive Services (IHSS) program of the California Department of Social Services (Social Services) provides assistance to eligible California residents who are 65 years of age or older (seniors), blind, or disabled (collectively referred to as *recipients*) to enable them to live safely in their own homes.[4] As of December 2019, IHSS provided in-home care to more than 591,000 Californians. This in-home care serves as an alternative to more intensive and costly out-of-home care, such as assisted living or skilled nursing facilities (long-term care). IHSS provides services based upon the needs of each recipient, which may include bathing, bowel and bladder care, feeding, and accompaniment to health-related appointments. According to Social Services, nearly all IHSS recipients are also beneficiaries of the California Medical Assistance Program (Medi-Cal)—California's implementation of the federal Medicaid program—which the State provides to Californians who have minimal assets and an annual income of less than $23,500 for a family of two or who meet certain requirements. IHSS recipients receive an average of about 100 hours of services per month. State law allows up to 195 hours per month of care, or 283 hours of services each month for severely impaired individuals.

As of December 2019, more than 520,000 individuals provided supportive services (caregivers) through the IHSS program. The majority of these caregivers—74 percent—provide services to a family member. However, recipients retain the right to hire a caregiver or caregivers of their choice, as long as the caregiver meets certain basic requirements, such as securing a criminal background check clearance.

Importance of the IHSS Program

The IHSS program allows hundreds of thousands of low-income Californians to remain safely in their homes, saving the State millions of dollars compared to the expense of providing care in long-term care facilities. More than 45 percent of recipients enter the IHSS program because they qualify for a nursing home level of care.[5] Long-term care expenses average from about $39,000

[4] Throughout the report we refer to the approved beneficiaries of IHSS care as recipients even in instances where they have not received care in a particular month.

[5] Social Services defines recipients as requiring nursing home levels of care when they need help with specific activities, such as routine bodily functions; when they have significant memory impairments; or when they require more than 195 hours of care per month. Recipients' doctors train and certify IHSS caregivers to provide any necessary paramedical services those recipients need, such as administering medication or giving injections, blood testing, and wound care.

to $170,000 annually, depending on the level of care needed, compared to average IHSS expenses of about $17,000 per year. As a result, the IHSS program saves the State between $22,000 and $153,000 annually for every recipient who would otherwise have transitioned to long-term care provided through Medi-Cal.

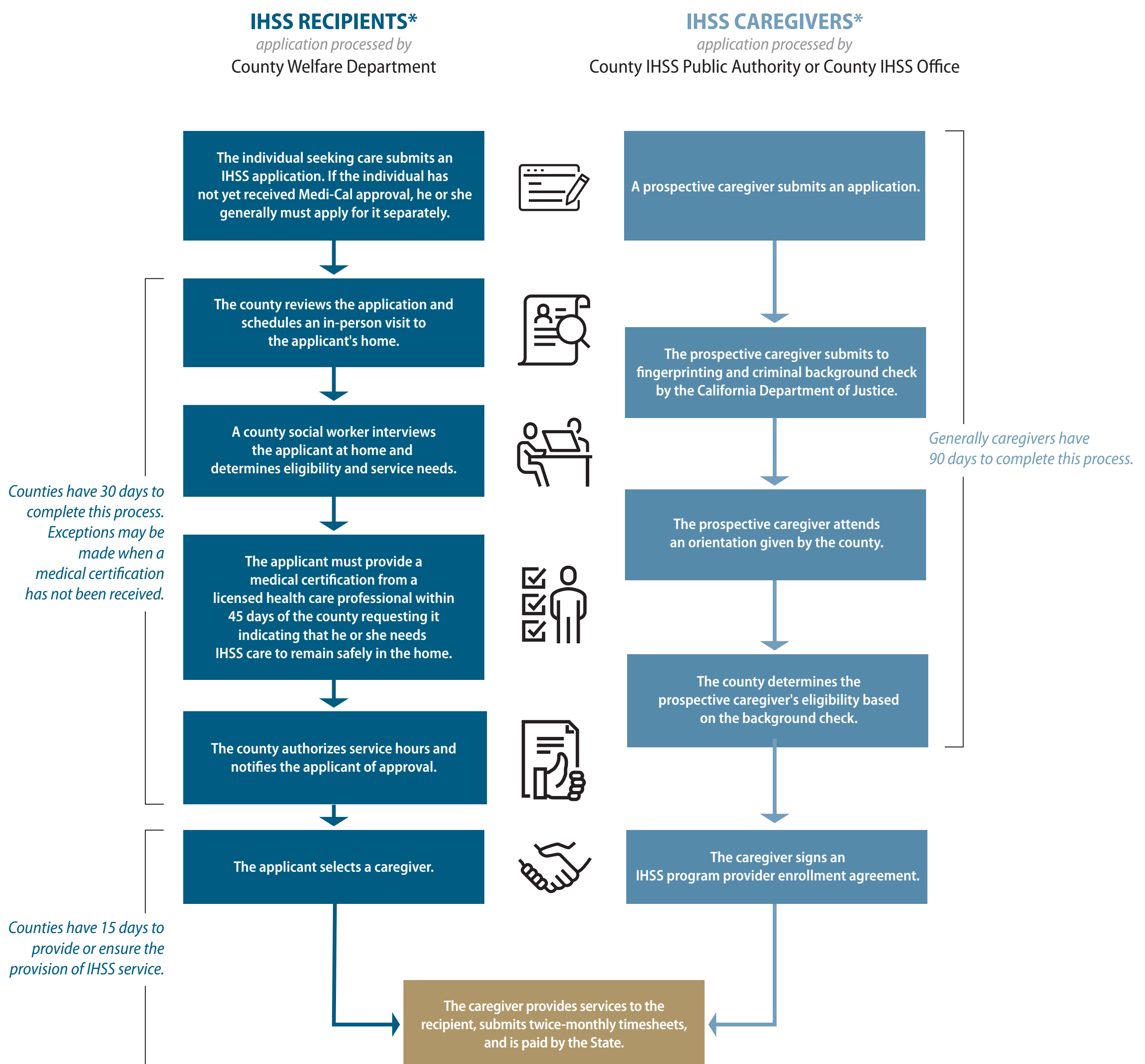
Demand for IHSS services will increase further in the next 10 years as the number of eligible California seniors grows. The Department of Finance (Finance) projects that California's senior population will grow from 6 million in 2019 to nearly 8.5 million by 2030—an increase of more than 40 percent. Because the majority of IHSS recipients—55 percent as of 2019—are seniors, this will result in a growing number of people needing IHSS care. Anticipating this impending shift in California's population, in June 2019, the Governor issued an executive order indicating that the State is committed to helping all Californians age with dignity and independence, and that all older adults should be able to choose to remain in their communities as they age. As the goal of the IHSS program is to provide recipients the assistance necessary to remain safely in their homes, ensuring an effective program is critical to meeting the State's commitment to its seniors. Further, a 2013 study by the National Institutes of Health found that many low-income disabled seniors who rely on IHSS have few or no other options for their care. The study also found that disabled older adults often have changing needs for assistance, which the IHSS program's design supports.

IHSS Program Administration and Oversight

Counties and the State share responsibility for administering the IHSS program. Under state law each county is obligated to ensure that services are provided to all recipients during each month of the year. As indicated in Figure 1, after a person submits an application for the program, county social workers determine whether the person is eligible and generally determine the need for services following a face-to-face meeting. Counties identify the number of hours of services needed and the services that the IHSS program will pay for based on regulations issued by Social Services that govern authorized services. For example, a county can approve hours for assisting a recipient with personal care, such as showering or toileting, but it is not able to approve other services, such as caring for pets. Counties also accept caregiver applications to provide services and provide training for prospective caregivers. Most counties have established public authorities—entities separate from the counties—to perform various functions related to caregivers, such as investigating the qualifications of potential personnel. Figure 1 details the caregiver enrollment process. Social Services administers the IHSS program at the state level and is

generally responsible for its oversight. It issues guidance to counties and develops training materials for caregivers. It also generally has the authority to adopt regulations regarding the IHSS program.

Figure 1
State Regulations Specify the Amount of Time Counties Have to Enroll IHSS Recipients and Caregivers



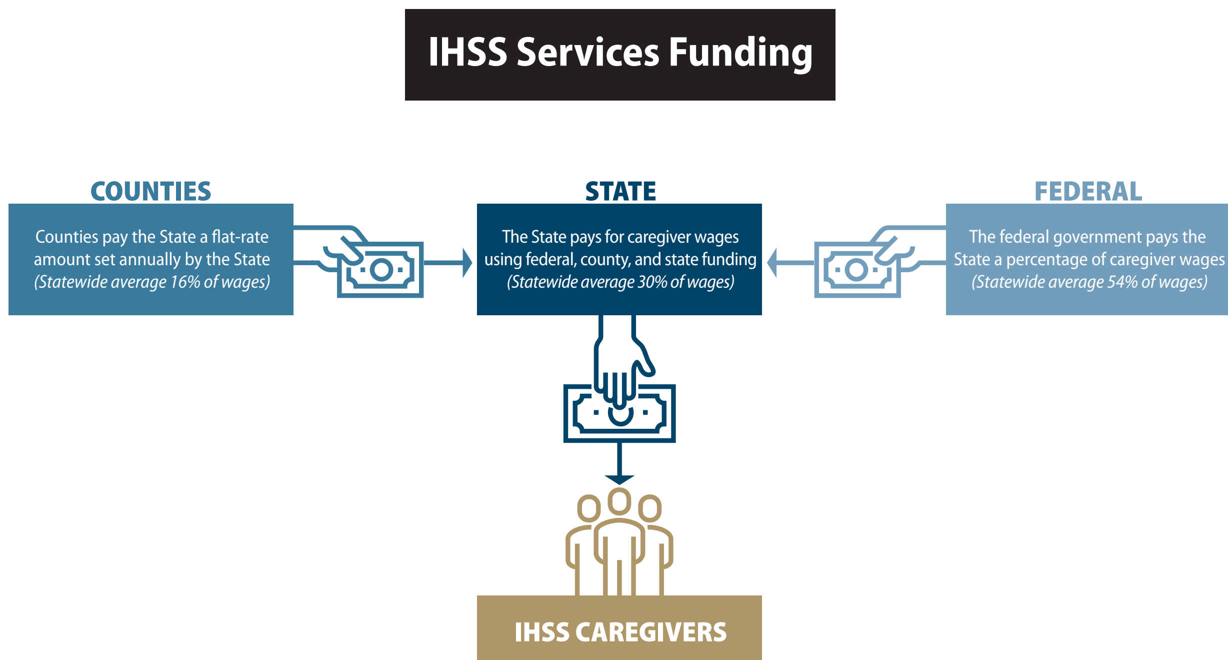
Source: Social Services IHSS regulations and documents.

* The steps shown here do not need to be completed in this specific order although all must be completed within the set time frame.

IHSS Program Funding

The IHSS program operates using a mix of federal, state, and county funds. In fiscal year 2019–20, California budgeted $4.5 billion for its share of the program, counties contributed $1.6 billion, and the federal government provided $7.2 billion, for a total of $13.3 billion. County funds for IHSS come primarily from revenue from vehicle licensing fees and a sales tax allocated to the counties to fund various programs, including IHSS. Counties use general-purpose funds to cover any remaining funding needs. Figure 2 illustrates the sources of funds for IHSS.

Figure 2
The State Pays For IHSS Caregiver Wages Using Federal, State, and County Funds



Source: State law, Social Services IHSS program documents.

Beginning July 1, 2012, changes in state law outlined new requirements regarding the counties' share of IHSS costs. Rather than paying a set percentage of the cost of providing caregiver services, as they had done previously, counties were required to pay a portion of the IHSS program costs in a specified amount called a *maintenance of effort* (county contribution). This county contribution was originally based on the amount expended by each county during fiscal year 2011–12. Beginning in 2014, state law adjusted county contributions by a flat percentage rate, known as the *inflation factor*. In 2017, Finance found that the method for

determining county contributions was leading to increased costs for the State's General Fund; in response, beginning July 1, 2017, the Legislature increased the total amount of county contributions by almost $600 million and, beginning July 1, 2018, it increased the inflation factor from 3.5 percent to 5 percent. Although state law reduced the amounts counties would be responsible for by appropriating a series of offsets—additional state funds appropriated to IHSS—a follow-up report by Finance in 2019 noted that the revenue sources set aside for counties to pay their IHSS contribution were not sufficient to cover this level of increased costs. Beginning July 1, 2019, state law reduced total county contributions by $500 million and beginning in July 2020, it lowered the inflation factor to 4 percent. Table 1 shows an example of the county contribution Kern County paid from fiscal years 2012–13 through 2018–19 as well as the inflation factor set by the State in each year. We found counties that locally negotiate caregiver wage increases pay a greater contribution, as we discuss in more detail in Chapter 1.

Table 1
Kern County's Contribution Increased Based on the State's Inflation Factor, a Locally Negotiated Wage Increase, and Changes to State Law

FISCAL YEAR	INFLATION FACTOR	KERN COUNTY CONTRIBUTION *(millions of dollars)*
2012–13	N/A	$7.46
2013–14	N/A	$7.52*
2014–15	3.5%	$7.88*
2015–16	3.5%	$8.15
2016–17	3.5%	$8.44
2017–18	3.5%	{$12.60†} $10.18
2018–19	5%	{$13.23†} $11.16

Source: State law, Social Services' communication with counties.

* County contribution includes increases of $61,000 in fiscal year 2013–14 and $154,000 in fiscal year 2014–15 for a locally negotiated wage increase in fiscal year 2013–14.

† In 2017, the Legislature increased the amount of county contributions, then provided counties with state general funds to reduce the amounts counties would pay. The amounts in brackets show the county contribution before the reductions. The reductions continued during fiscal year 2018–19.

Concerns Leading to the Audit

Various groups, including the Public Policy Institute of California; the University of California, Berkeley, Center for Labor Research and Education; and the Legislative Analyst's Office have expressed

concerns with the IHSS program, including concerns related to caregiver shortages, the effect that rapid growth in California's senior population could have on the program, and the negative financial impact low wages can have on most caregivers. For example, in 2017 the Center for Labor Research and Education noted that low caregiver wages in the home care industry, which includes IHSS, make it difficult to recruit enough workers to meet rapidly growing demand. The report concluded that, unless California addresses low caregiver wages, the elderly and people with disabilities will not get the care they require, caregivers will continue to live in poverty, and the public cost of long-term care will increase. As a result of concerns related to the IHSS program, the Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor's Office (State Auditor) to perform an audit of the IHSS program. Appendix E outlines the Audit Committee's objectives and the methods we used to address them.

Chapter 1

LACK OF PREPARATION FOR FUTURE IHSS NEEDS AND LOW CAREGIVER WAGES COULD RESULT IN MORE RECIPIENTS NOT RECEIVING SERVICES

Chapter Summary

Although the IHSS program provides services to the vast majority of its recipients, tens of thousands of recipients lack care each month. In fact, although state law requires counties to ensure that services are provided to recipients during each month, the number of recipients who lacked care grew from 33,000 on average each month in 2015 to more than 40,000 in 2019. Further, counties did not always approve applicants for the program in a timely manner nor ensure that newly approved recipients who came into the program without a chosen caregiver received timely care. Ensuring timely and consistent care is central to the program's goal of allowing recipients to live safely in their own homes. However, providing timely IHSS care may become more difficult, as the number of recipients is expected to increase dramatically over the next 10 years. Despite the pending increase, the counties and Social Services have not planned for this influx of older Californians needing care.

Our projections indicate that a substantial increase in the number of IHSS caregivers will be necessary in the future. However, caregivers throughout the State earn far less than a living wage, and many likely qualify for public assistance. These low wages likely will affect the ability of counties to recruit caregivers to respond to current and future demand for their services. Although counties can negotiate higher caregiver wages, state law creates disincentives for them to do so, as increases in provider wages have an outsized financial impact on the counties that provide them.

A Growing Number of Recipients Lack Necessary IHSS Care Each Month

State law obligates each county to ensure that services are provided to all eligible recipients during each month of the year in accordance with a county plan. Although the IHSS program was largely effective in meeting this requirement, ensuring that 544,000 recipients (approximately 94 percent of recipients) on average received services each month from 2015 to 2019, the program's vast size means that when even a small percentage of recipients lack care, thousands of Californians are affected. Specifically, the number of recipients statewide who did not receive

services in a given month increased from about 33,000 per month on average in 2015 to more than 40,000 in 2019. Over the course of the period we reviewed, this represented 132 million hours of services approved but not provided. Appendix B, Table B.1, compares the number of hours approved versus hours not provided in 2015 and 2019. Varying numbers of recipients in all counties experienced these gaps in care, as shown in Appendix B, Table B.2. We surveyed all counties in the State regarding their IHSS programs and their ability to provide caregivers for recipients. With 51 of 58 counties responding, 32 reported that they did not have a sufficient number of caregivers to provide all approved services. The two most common barriers those counties reported were finding caregivers who could provide specific or challenging services, such as bowel and bladder care, and difficulty in matching caregivers with recipients in isolated areas. Appendix A provides selected survey responses by counties throughout the State.

The four counties we reviewed—Butte, Kern, San Diego, and Stanislaus—did not ensure that all recipients received services each month. In fact, the average number of recipients who did not receive monthly services in these four counties generally increased over our review period, as Table 2 shows. For example, the average number of recipients who lacked services in Kern County increased from 296 per month in 2015 on average to 923 in 2019, representing an increase from 6.8 percent to 11.1 percent of recipients in the program. The counties provided several reasons why a recipient might not receive services, including extended hospitalizations, an inability to hire a provider, and a move to a new location, requiring a new provider. These gaps in care can represent periods of increased risk of injury or other hardships for IHSS's elderly and disabled recipients.

Table 2
The Average Number of Recipients Who Did Not Receive Services Each Month Increased During Our Testing Period

COUNTY	MONTHLY AVERAGE NUMBER OF RECIPIENTS WHO DID NOT RECEIVE SERVICES				
	2015	2016	2017	2018	2019
Butte	378	407	373	384	406
Kern	296	406	531	738	923
San Diego	1,811	1,957	2,042	2,069	2,194
Stanislaus	436	546	649	698	679
STATEWIDE*	32,589	33,674	35,104	36,655	40,290

Source: Auditor analysis of Social Services' CMIPS II data.

* Statewide average number of recipients who did not receive services each month.

Some counties took greater steps than others to ensure that recipients received care. About half of the counties that responded to our survey indicated that they assist recipients in interviewing caregivers, and three of the four counties we reviewed stated that they arrange for short-term care through contracts with local care providers, as we describe below. These additional services are an important stopgap for recipients when caregivers are ill or temporarily unavailable. For example, San Diego has a contract with a service provider to render care when a recipient's regular caregiver is unavailable. Butte stated that it has arranged care, through short-term contracts with local providers, for recipients in hard-to-serve portions of the county and those who require care—such as bowel and bladder care—that makes recruiting a caregiver difficult. If a recipient requests a caregiver and does not wish to participate in the selection process, upon request Stanislaus County will send a caregiver from its registry to that recipient. Kern County informed us that it does not provide these services as they are cost-prohibitive; instead it refers recipients to the registry of caregivers so that recipients can make their own hiring decisions.

Despite these efforts, a lack of planning by the counties has contributed to ongoing gaps in care. State law requires that each county develop an annual county plan that specifies the means by which IHSS services will be provided and submit that plan to Social Services for review and, when appropriate, approval. However, according to Social Services, none of the State's 58 counties have submitted plans for decades. Further, the counties we reviewed could not provide evidence of having created any county plans. The counties that responded to our survey generally indicated that they had performed no analysis to determine their future provider needs. Only two counties indicated that they have performed analysis to determine the number of caregivers they require, either currently or in the future, and only four counties had created a plan to account for future growth in the number of recipients. If counties had completed their mandated care planning, they might have identified care gaps and been able to alleviate or eliminate them.

Inaction by Social Services has contributed to the lack of planning throughout the State. Social Services' own regulations require that it develop a county plan for counties that have not submitted plans within the required time frame. However, for at least 20 years, Social Services has neither enforced the legal requirements that counties develop and submit annual county plans nor created county plans for counties that did not do so. As the single state agency with full power to supervise every phase of the administration of the IHSS program, Social Services has failed to comply with its own regulations meant to ensure the safety of Californians. When we brought this omission to their attention, Social Services' representatives indicated that the requirement is outdated and that it is the recipient's duty to ensure that they receive care. However,

For at least 20 years, Social Services has neither enforced the legal requirements that counties develop and submit annual county plans nor created county plans for counties that did not do so.

Social Services' responsibility to ensure proper planning is clear; moreover, this lack of attention to planning increases health risks for individuals who should receive care but do not.

Counties Generally Did Not Meet Deadlines for Approving Program Services and Ensuring That Services Were Provided

From January 2015 through December 2019, counties throughout the State failed to process applications for the IHSS program in a timely manner, delaying services for thousands of applicants. For recipients to receive necessary services under the IHSS program, a county must make an initial determination of an applicant's eligibility, generally within 30 days following the date of an application, as required by Social Services' regulations. The application must include all information necessary to establish eligibility, as noted in the text box. Despite this requirement, applicants approved in 2019 waited more than 72 days on average for counties to approve participation in the program. This represents an improvement from the statewide average of 82 days in 2015, but it is still well above the regulatory requirement.

General IHSS Eligibility Requirements

Applicant must:

- Be eligible for Medi-Cal benefits.*
- Obtain a health care certification, which must, among other things, be signed by a licensed health care professional.

Counties must:

- Conduct an assessment of the recipient's needs for supportive services. This needs assessment must generally identify the types of services and number of hours of services the recipient needs.

Source: Social Services guidance.

* While most recipients receive services through Medi-Cal, about 1.5 percent of recipients participate in IHSS-residual, a non-Medi-Cal IHSS program.

In 2019 the four counties we reviewed took between 55 and 117 days on average to approve applications, and they provided several explanations for the delays. For example, Butte and Stanislaus counties told us that their delays were caused by a lack of social workers, and all four counties said that getting completed disability determinations from applicants was challenging. However, because the purpose of the IHSS program is to provide the care necessary for recipients to remain safely in their homes, delays in approving them for care increase the risk that they will suffer an injury or other hardship. Table 3 demonstrates that no county met this timing requirement in 2019.

We identified a number of counties, including two of the counties we reviewed, that took significantly longer than 72 days on average to approve applicants. For example, seven counties took 90 days or longer to process applications in 2019. Stanislaus County took 117 days on average before approving applicants for service, while Kern County took 83. According to Stanislaus County, its significant delays were the result of a backlog of applications and high turnover in its social worker positions. The county stated that it has worked to overcome these obstacles in 2020 by reassigning social workers to the IHSS program and adjusting social worker responsibilities so they can focus on assessing the care needs of applicants and

approving services. However, these changes are recent, and it is too soon to assess whether they have had a positive effect on Stanislaus' ability to process applications. Appendix B, Table B.3, provides a breakdown of applicant approval delays by county for 2015 and 2019.

Table 3
No Counties, on Average, Approved Applications In a Timely Manner in 2019

AVERAGE DAYS TO APPROVAL	NUMBER OF COUNTIES
Less than 30	0
31–60	24
61–90	27
More than 91	7

Source: Auditor analysis of Social Services' CMIPS II data.

Although Social Services' regulations generally requires that applications be processed in no more than 30 days, Social Services instead considers 90 days to be a reasonable time frame for processing applications. Social Services said that it based the 90-day timeline on its 30-day regulation, added 45 days for recipients to submit documentation, and "rounded up to the month." The agency stated that the 30-day requirement is more than 20 years old and does not incorporate more recent changes to the application process, including the requirement added in 2011 for recipients to obtain a health care certification. Social Services stated that it has begun the process of revising its regulations and hopes to complete them in 2021. However, we believe that given the critical nature of these services, 90 days—nearly three months—is too long. First, "rounding up" from 75 days to 90 days does not demonstrate an appropriate level of urgency. Second, Social Services' calculations assume that two steps—the submission of the application and the health care certification—happen sequentially; however, these steps can happen concurrently; therefore, not all applications require a full 75 days to complete. Until Social Services begins monitoring compliance with its 30-day requirement and the 45-day exception, it will not have sufficient information to establish what a more reasonable regulatory timeline may be.

Most recipients were receiving services from a caregiver before entering the IHSS program and being approved for services, more frequently than not from a relative, according to Social Services' data. However, 18 percent of recipients did not receive services until after they entered the program, and these recipients usually had a nonfamily caregiver. Social Services' regulations require that services be provided, or arrangements for their provision

Almost 58,000 applicants who entered the program without a caregiver and who received service for the first time in 2015 through 2019 did not receive services for an average of 108 days after their county approved their application.

made, within 15 days after an approval notice is mailed. However, no county met this requirement for all approved applicants.[6] In fact, almost 58,000 applicants who entered the program without a caregiver and who received service for the first time in 2015 through 2019 did not receive services for 108 days, on average, after their county approved their application. Although recipients retain the right to hire a caregiver, state law obligates each county to ensure that services are provided to all eligible recipients. Thus, counties and recipients share in the responsibility to ensure that required services are provided. Like delays in the approval of applicants, delays in care subject Californians to increased risk of injury or loss of autonomy, as recipients require care to remain safely in their homes. Social Services indicated that it does not monitor counties' compliance with requirements related to the time it takes for new recipients to receive care. Although the data to perform this monitoring are readily available in its database, Social Services indicated that it is the recipient's duty to choose and hire his or her own caregiver.

The State and Counties Have Not Prepared for Rapid Increases in the Number of IHSS Recipients

As we have noted, California is experiencing substantial growth in its senior population, which will significantly increase demand for IHSS services. Already seniors make up the majority—55 percent—of IHSS recipients. According to Finance, the number of seniors in California will increase from 6 million in 2019 to 8.5 million by 2030. In fact, according to Finance projections, individuals 75 years or older will be the fastest-growing age group in the State in the coming decade. As this population continues to age, its members will likely require additional assistance, driving an increase in the need for care hours and caregivers. However, when we surveyed the counties, 49 of the 51 respondents said they had not performed any analysis to identify how many providers they would need in the future and 47 said they had not planned for future recipient growth as we show in Appendix A, Table A. The counties' lack of planning is of concern in light of the coming increases in the number of IHSS recipients and the current caregiver shortfalls reported by counties.

Among the counties responding to our survey, 32 indicated that they currently lack a sufficient number of caregivers to provide each recipient with all of his or her approved services. Because counties assign recipients' care hours based on the services necessary for them to remain safely in their homes, this existing deficit is already

6 Appendix B, Table B.4 provides a county-level breakdown of the time from approval to service for this population.

troubling because a lack of sufficient caregivers increases the risk to recipients who rely on services for their safety. Adding to this concern is the fact that the number of IHSS recipients is growing significantly. Between 2015 and 2019, the number of recipients increased by 18 percent statewide.[7] Further, based on current trends, we estimate that the number of IHSS recipients could grow to 951,000 by 2030, a 52 percent increase. According to the Public Policy Institute of California, this rapid growth will occur during a period when family members—the most common type of caregiver—are less available to provide care because more seniors than in previous generations are divorced, never married, or never had children. As a result, the IHSS program will have to plan to address existing gaps in care while simultaneously preparing for a significantly expanded program. Failing to address these issues could result in rapid increases in the number of recipients who need and do not receive care.

As we discuss earlier, for decades counties have failed to develop and use annual county plans to ensure that all recipients receive care, despite being required to do so. Although not required, we also would have expected counties throughout the State to have analyzed the needs of their IHSS programs and created strategies to ensure that services are being provided to all eligible recipients during each month of the year. However, they have not. Only two of the 51 counties responding to our survey had performed an analysis to identify how many caregivers they need. Of the four counties we reviewed, only Butte County indicated that it had performed this needs analysis although it was unable to provide documentation.

Only two of the 51 counties responding to our survey had performed an analysis to identify how many caregivers they need.

Only four of the responding counties have created a plan to account for future growth in the number of recipients. Of the four counties we reviewed, only San Diego County has created such a plan. San Diego's plan has objectives aimed at building better health in its elderly population and includes performance measures that are specific to the IHSS program, such as the percentage of initial assessments it plans to complete within 45 days through fiscal year 2021–22. Such planning will be critical to ensure that all eligible recipients receive services each month.

Counties Do Not Pay Caregivers a Living Wage

IHSS caregiver wages vary significantly across California. However, no county paid caregivers a living wage between 2015 and 2019; instead, caregiver wages averaged between 42 percent and 62 percent of a living wage. According to researchers at

7 Appendix B, Table B.5, provides a breakdown of IHSS population changes by county and statewide.

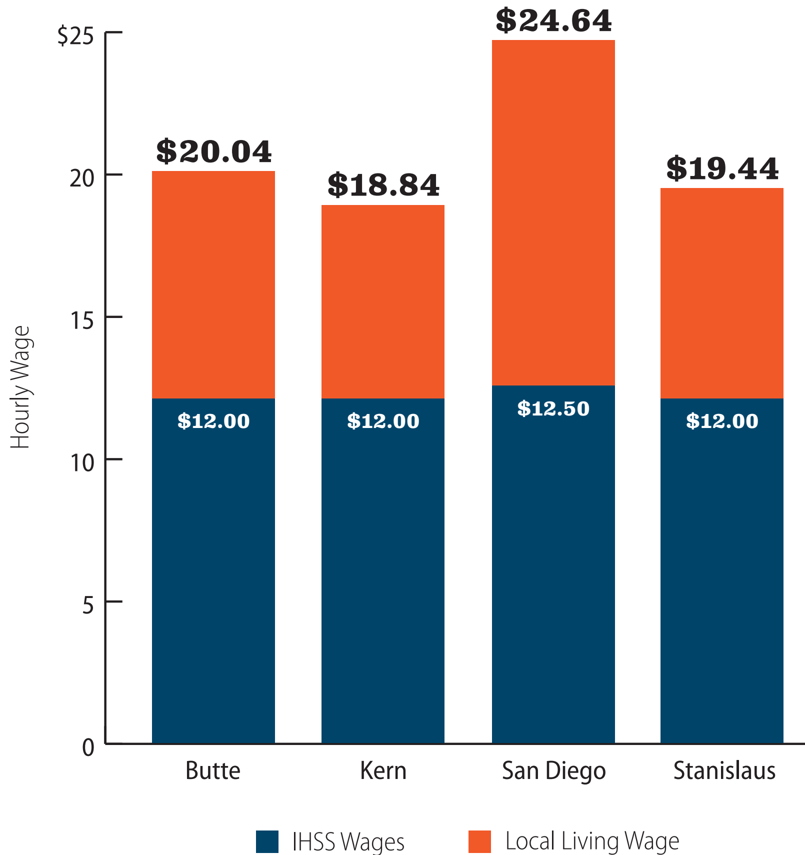
No county paid caregivers a living wage between 2015 and 2019; instead, caregiver wages averaged between 42 percent and 62 percent of a living wage.

the Massachusetts Institute of Technology (MIT), living wage calculations represent the salary necessary for a full-time worker to afford basic necessities without public assistance. To determine whether caregivers earned a living wage in each of California's counties, we used calculations from a model developed at MIT that relies primarily on federal data. The living wage amounts we reference represent costs for a family of two adults with one worker, including those related to food, housing, transportation, and other basic needs such as clothing. The model makes conservative assumptions, including that all meals are prepared in the home using lower-cost food options. Further, the living wage we reference excludes nonessential items such as vacations, entertainment, and all savings. In 2019 the living wage in California ranged from $17.64 an hour in Modoc County to $31 in Marin, San Francisco, and San Mateo counties.

We compared the gap between the hourly caregiver earnings in the four counties we reviewed and their respective living wage. As indicated in Figure 3, all four counties established IHSS wages that were well below their living wage. For example, in 2019 the living wage in Kern County was $18.84 per hour, while a caregiver earned $12 per hour, the state minimum wage. In San Diego County, the disparity was greater, with a living wage of $24.62 compared to hourly caregiver wages of $12.50. Appendix C compares the living wage to the caregiver wage in each of the State's counties.

Without access to a living wage, many caregivers and their families may experience food or housing insecurity. In fact, caregiver wages generally satisfy income eligibility requirements for public assistance. The U.S. Department of Health and Human Services revises annually the poverty line and issues poverty guidelines, which were originally calculated in the 1960s and based primarily on the cost of food. Since that time, the guidelines have been determined by multiplying that original calculation by the Consumer Price Index. In 2019 caregivers earned an average of $15,920, about $1,000 less than the federal poverty guideline of $16,910 for a family of two. According to Social Services, California provides CalFresh—the new name for its food stamp program—to residents who earn less than 200 percent of the federal poverty guideline; thus, caregivers throughout the State would generally qualify for food stamps even if they received a 30 percent raise. Because the poverty guidelines are based on 1960s costs and do not fully account for changes in basic expenses or family needs, any caregiver whose compensation is below the poverty line would likely lack sufficient earnings to pay for needs such as rent, transportation, or clothing and would likely have to rely on charitable or public assistance.

Figure 3
In 2019 Caregivers Earned a Fraction of the Local Living Wage



Source: Social Services and MIT's Living Wage Model.

Although some caregivers may obtain additional part-time work, the demands associated with working as a caregiver make obtaining alternative full-time employment in addition to caregiving unlikely. On average, caregivers work 23 hours per week. Caregiver workloads reflect the number of hours a county has authorized the recipient to receive, the recipient's schedule, and the caregiver's availability. This makes finding multiple caregiving positions difficult. Further, it is unlikely that a caregiver would obtain a full-time position elsewhere for 40 hours per week and retain his or her role in the IHSS program. Doing so would effectively require the caregiver to work 63 hours a week on average. Instead, because the majority of caregivers serve a family member, they must choose between family obligations and full-time employment.

Caregivers in certain localities earn less than the local minimum wage.

Compounding these issues, caregivers in certain localities earn less than the local minimum wage. For example, caregivers in the city of San Diego earned less than the local minimum wage for a part of 2016 and all of 2017. A City of San Diego ordinance set the

Between 2014 and 2019, localities in seven counties passed ordinances that raised local minimum wages by varying amounts; however, these localities declined to grant the increase to local IHSS caregivers.

minimum wage within the city at $10.50 and $11.50, respectively, in these years. However, after the city of San Diego established its local minimum wage, Social Services offered guidance to San Diego's public authority that the ordinance did not apply to IHSS although the guidance did not explain why.[8] As a result, IHSS caregivers in the city of San Diego received wages that were between 50 cents and $1 per hour less than the pay of other minimum-wage workers in that city. Had this local minimum wage applied to IHSS workers, they would collectively have been paid about $19 million more over the two-year period. In 2019 the Legislature increased the statewide minimum wage to be no less than $12 per hour, an amount equal to the local minimum wage. Between 2014 and 2019, localities in seven counties passed ordinances that raised local minimum wages by varying amounts; however, these localities declined to grant the increase to local IHSS caregivers. Although this may be permissible, it creates a situation in which IHSS work is not as competitive with positions that pay the local minimum wage.

The State's Funding Structure and Recent Shortfalls in County Funding Sources Create a Disincentive to Increase Caregiver Pay

Many counties and their associated entities, such as public authorities, did not negotiate new caregiver wage increases during the period we reviewed, and we found that the counties that did provide increases were penalized due to changes in state law. Since 2012 state law has treated caregiver wage increases differently than other county IHSS expenditures. From 1991 to 2012, state law required counties to pay a set percentage of the cost of providing IHSS services, and caregiver wage increases were no different from other program expenses that gradually grew in cost. The number of IHSS recipients in a county, the hours of care it authorized, and the amount it paid caregivers all affected how much the county would pay. However, as we describe in the Introduction, state law established a different method of calculating county contributions, based on the actual cost of the program in fiscal year 2011–12, with future adjustments using an inflation factor that the Legislature updates periodically. The Legislature made additional systemwide changes in 2017 and 2019; however, generally only increases to caregiver wages resulting from collective bargaining require an additional increase to the county's contribution.

Furthermore, due to the adjustments to these contributions required by state law, counties that increase caregiver wages continue to pay the increased contribution, even when the State's

[8] As we explain in the Introduction, the public authority performs administrative functions related to caregivers, such as negotiating caregiver wages.

minimum wage surpasses their locally negotiated wage. Generally, the amount a county contributes is based on the amount it paid in the prior fiscal year plus the current inflation factor. Counties that do not negotiate wage increases generally do not have their contribution changed when the state minimum wage increases, even if such an increase results in higher caregiver wages in those counties. However, when a county negotiates a local caregiver wage increase, a portion of the cost of that negotiated increase is added to the amount the county must pay each year. Thus, when a county contribution is raised for increased caregiver wages in one year, it is also increasing the amount the county must contribute in every future year, even if the state minimum wage increases.[9]

For example, in 2016 Contra Costa County increased its caregiver wages to $12 per hour, an increase of 50 cents that brought the pay to $2 above the State's minimum wage at the time. When the state minimum wage increased to $10.50 an hour in 2017, Contra Costa increased its caregiver wages by another 25 cents to $12.25. Together these two increases by Contra Costa added $2.8 million to the annual amount the county had to pay in fiscal year 2017–18, as we show in Table 4. However, by 2020, the statewide minimum wage had generally increased to $13 per hour, making the previous negotiated wage increases obsolete. Nevertheless, Contra Costa will continue to contribute almost $3 million more annually because its wage increases in 2016 and 2017 created a permanent increase in its contribution. As a result, counties must weigh the impact caregiver wage increases will have on their long-term finances against the benefit they provide caregivers.

Moreover, counties that choose to pay caregivers significantly more than the state minimum wage face substantial increases in cost. To limit the State's share of the costs for locally negotiated wage increases, state law since 1999 has limited the State's required contribution for such increases to a specified dollar amount. The law initially limited the State's share to 50 cents above the hourly statewide minimum wage for fiscal year 1999–2000. Changes to the law in 2000 generally increased the limit to up to $7.50 per hour, which was $1.75 per hour above the minimum wage at the time. The Legislature continued to increase the limit until it was up to $12.10 per hour by 2007, which was $4.60 per hour above the minimum wage. However, as the state minimum wage increased, the limit did not, and by 2018 the limit was just $1.10 above the general state minimum wage. In 2017 state law generally set future limits to be either $1.10 above specific state minimum wage rates or a cumulative total of up to 10 percent within any three-year

Counties that choose to pay caregivers significantly more than the state minimum wage face substantial increases in cost.

[9] The increased amount counties must pay when providing a wage increase is governed by the requirements of the State's Welfare and Institutions Code.

period. Thus, if caregiver wages increased to more than $1.10 above specified state minimum wage rates in a given year or totaled more than 10 percent within three years, the counties would pay the increased share of those wages.

Table 4
Contra Costa Continues to Pay a Larger County Contribution Because of Wage Increases in 2016 and 2017

YEAR	2016	2017	2018	2019	2020
State minimum wage	$10.00	$10.50	$11.00	$12.00	$13.00
Contra Costa's wage	12.00	12.25	12.25	12.25	13.00

(In millions)

FISCAL YEAR	2016–17	2017–18	2018–19	2019–20
County contribution*	$22.0	$27.2	$29.8	$28.9
County contribution if no wage increases	19.8	24.4	26.9	26.0
Additional amount Contra Costa paid	2.2	2.8	2.9	2.9

Source: State law, Social Services' communications with counties, IHSS program documents.

* In 2017 the Legislature increased the amount of county contributions beginning in fiscal year 2017–18, then in 2019 reduced the amounts beginning in fiscal year 2019–20. Final county contribution amounts for fiscal year 2019–20 were not available as of December 2020. The county contribution amount shown for fiscal year 2019–20 is preliminary, and does not include county funds for administration.

For example, in 2018 and 2019, the City and County of San Francisco increased caregiver wages with two $1 raises, to $16 per hour; at that time, the state minimum wage increased from $11 to $12 per hour. The first $1 raise exceeded the 10 percent limit we describe above, and it increased San Francisco's annual contribution to the State by $8 million. The second $1 also exceeded the 10 percent limit and increased San Francisco's annual contribution to the State by an additional $13 million. Thus, San Francisco is paying the State $21 million per year because of these raises. Overall, caregiver wages in 2018 and 2019 increased by 14 percent, but San Francisco's ongoing contributions to the State increased by 20 percent.

In addition to the initial and long-term expenses related to hourly rate increases, counties are experiencing shortfalls in the funds they use to pay IHSS costs. For decades, counties have primarily used funds from state sales taxes and vehicle licensing fees to pay their share of IHSS funding. State law allocates the use of these funds to certain purposes, including social services programs such as IHSS. However, according to Finance, as of 2017, revenue from these funds is no longer sufficient to cover counties' IHSS costs. As a result, any increases to IHSS caregiver wages have to compete with other county priorities for unrestricted county general funds. For

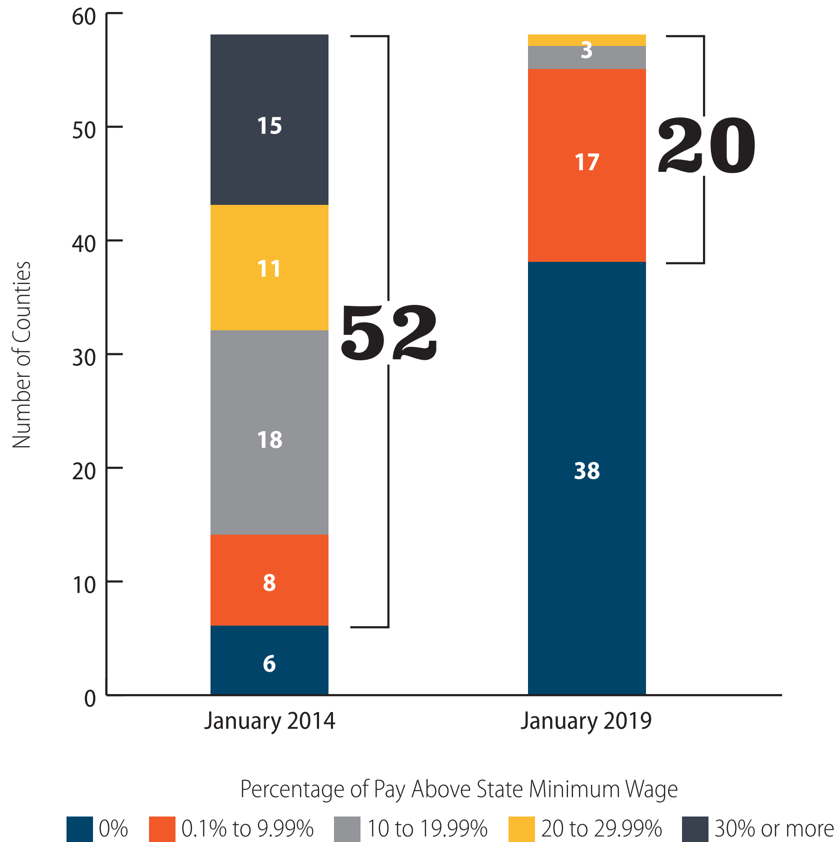
example, in 2019 Kern County offered to increase its IHSS caregiver wages by 25 cents an hour and determined that it could bear the more than $400,000 in additional annual cost. However, according to the chief human resources officer (chief) at Kern, the COVID‑19 pandemic led the county to withdraw its offer. The chief stated that the emergency forced the county to reduce its discretionary spending, and any additional county spending on IHSS wages would have led to a corresponding decrease in other programs.

Because of these factors, coupled with increases to the state minimum wage, by 2019 IHSS caregivers in the majority of counties were working for minimum wage. The number of counties paying more than the minimum wage has decreased substantially since state law changed the required county contributions and increased the minimum wage. As Figure 4 shows, in 2014 52 counties paid caregivers above the state minimum wage. In 2019 the number of counties paying above the state minimum wage had decreased to 20. In 2019 this meant that more than 200,000 IHSS caregivers were no longer paid more than the state minimum wage. Further, in 2019 only two counties paid caregivers more than $2 above the minimum wage, compared to 16 counties in 2014. Without additional action by the State, low caregiver pay will remain a persistent issue that counties will struggle to address.

In 2019 only two counties paid caregivers more than $2 above the minimum wage, compared to 16 counties in 2014.

As a way to provide incentive to counties to increase wages above the state minimum wage, the Legislature recently amended state law in a manner that assists counties in increasing caregiver pay; however, the effects of the change are limited. Passed in 2017, the law exempts from county contribution adjustments those locally negotiated wage increases contingent on state minimum wage increases. These increases, which we refer to as *wage supplements*, increase caregiver wages by a negotiated amount whenever the State raises its minimum wage, so that IHSS wages remain above the minimum wage. By treating wage supplements as one‑time events and not as a series of subsequent pay increases, the 2017 law allows counties to have their contribution increased only once and not each time the state minimum wage increases. This option limits additional contributions required of counties and, as of December 2020, 44 counties had negotiated wage supplements under the 2017 law.

Figure 4
Between 2014 and 2019, the Number of Counties Paying Above the State Minimum Wage Decreased by More than Half



Source: Auditor analysis of Social Services' data and state law.

However, changes to state law added in 2019 will require counties that are below the $1.10 or 10 percent limit that we describe previously to pay a significantly larger contribution—nearly double the existing percentage—for any caregiver wage increases locally negotiated beginning January 1, 2022. Although wage increases could still be negotiated, this change will make such increases vastly more expensive for many counties, some of which already lack sufficient funds to support their share of the IHSS program. As such, it will likely be increasingly difficult to recruit a sufficient number of caregivers to provide services to the expanding IHSS program and counties will struggle to fully serve their recipients.

Recommendations

The Legislature

To balance the need to attract a sufficient number of caregivers into the IHSS program with the need to maintain control over the State's costs, the Legislature should consider using the annual budget process to allocate additional funds to counties to enable counties to better afford increasing caregiver wages.

To ensure that these offset funds are used to best address wage disparities, the Legislature should prioritize their availability to counties where caregivers earn the least, relative to a living wage, and should exempt these wage increases from Welfare and Institutions Code 12306.16, subdivision (d), so that the amounts allocated are not included in adjustments to the county contribution.

To limit the disincentive for counties to provide caregiver wage increases, the Legislature should modify the State's cost-sharing system to eliminate the ongoing costs that counties pay for local wage increases that are nullified by increases to the State's minimum wage.

Social Services

To help ensure that all recipients throughout the State receive prompt approval for services and receive all approved services, by August 2021 and annually thereafter, Social Services should require counties to submit required annual plans. These plans should include, at a minimum, a description of how each county will ensure that services are promptly approved and that recipients promptly receive the approved services.

To help counties prepare to meet future needs for IHSS services, Social Services should revise its regulations to require counties to include long-range projections and strategies in their annual plans.

To help ensure that recipients receive timely care, Social Services should, by August 2021, begin monitoring counties' compliance with the following:

- Approval of IHSS applications within 30 days, unless an extension for obtaining a medical certification applies.
- Prompt approval of IHSS applications for which the 45-day extension for a medical certification applies.
- Provision of services within 15 days of application approval.

For counties that struggle to comply with its regulations regarding providing timely services, Social Services should require—and regularly follow up on—corrective action plans from these counties.

Counties

To help ensure that recipients at each county receive prompt approval for services and also receive all approved services, Butte, Kern, San Diego, and Stanislaus counties should, by August 2021 and annually thereafter, complete required plans that include, at a minimum, specific provisions for how each county will ensure prompt approval of services and that recipients promptly receive the approved services.

Chapter 2

CHANGES TO THE IHSS FUNDING STRUCTURE AT BOTH THE STATE AND COUNTY LEVELS COULD ADDRESS FUNDING DISPARITIES AMONG COUNTIES

Chapter Summary

The State's decision in fiscal year 2012–13 to adjust the contribution each county pays toward the IHSS program by a set percentage—or inflation factor—each year rather than updating each county's contribution based on its proportion of the IHSS program's costs has resulted in some counties paying significantly more than their proportional share while others pay less. This approach has effectively increased the State's share of program costs and penalized counties whose programs did not expand as rapidly as others did. Although in 2017 the State attempted to increase the share all counties paid, its efforts were unsuccessful because counties were unable to rapidly increase their support of the program without state assistance. However, if the State incorporates more modest changes to the way that counties contribute to the IHSS program, it may be able to establish more equitable results.

Although we identified issues with the formula used to determine county support of the IHSS program, we found that counties are using their administrative funds for allowable purposes. Further, counties generally spent what they budgeted and used their administrative funds in part to provide mandated training to caregivers.

The State's Formula for IHSS Cost-Sharing Has Led to Inequitable County Contributions and Statewide Funding Disparities

The way the State calculates the amount of IHSS costs that counties pay does not account for varying rates of growth among the counties. As we describe in Chapter 1, counties' contributions to IHSS costs are based on costs incurred in a set fiscal year, and they increase annually at a rate the Legislature sets. By using a set inflation factor across all counties in the State, state law does not account for varying rates of growth in the number of IHSS recipients each county serves or in the number of hours of care those recipients receive. For example, because of the State's formula, Kern and Butte paid similar county contributions in fiscal year 2018–19, even though the total costs for Kern's IHSS program were more than $30 million higher than Butte's, as shown in Table 5. Thus, Kern is receiving a proportionally greater state subsidy for its program and Butte is paying disproportionally more.

Table 5
The State's Formula for Calculating Counties' Shares of IHSS Costs Has Led to Inequities
(Dollars in Millions)

	BUTTE'S IHSS COSTS, COUNTY CONTRIBUTION, AND STATE SHARE			KERN'S IHSS COSTS, COUNTY CONTRIBUTION, AND STATE SHARE		
FISCAL YEAR	COST	COUNTY CONTRIBUTION	STATE SHARE	COST	COUNTY CONTRIBUTION	STATE SHARE
2012–13	$40.5	$6.8	$12.5	$45.2	$7.5	$14.2
2018–19	$66.6	$10.6	$20.0	$98.6	$11.2	$34.2
Percent Change	+65%	+57%	+60%	+118%	+50%	+142%

Source: State law, Social Services' communication with counties, county budget documents, IHSS program documents.

Note: Costs shown for fiscal year 2012–13 are from fiscal year 2011–12. State law specified that county contributions in fiscal year 2012–13 be based on fiscal year 2011–12 costs. State share amounts for fiscal year 2018–19 are estimated based on statewide averages.

The State's formula for calculating county contributions has created a significant funding disparity at both the state and county levels. Before the 2012 changes to the State's formula, each county paid the State a set proportion of about 18 percent of their overall IHSS program costs. However, by fiscal year 2018–19, counties paid between 6 percent and 29 percent of their costs, depending on how fast or slow their program costs grew compared to the State's annual inflation factor. For example, 21 counties paid more than their proportional share of IHSS costs in fiscal year 2018–19 because of the State's outdated formula. Collectively, these counties paid the State $86 million more that year than their IHSS costs and caregiver wages would have indicated. Some of these counties, including Yuba and Mendocino, paid more because the IHSS costs associated with their programs—for the number of recipients, authorized hours, and caregiver wages—grew more slowly than the inflation factor. Other counties paid more because they increased caregiver wages. For example, even though Marin County increased caregiver wages each year, its actual IHSS costs increased by only 38 percent—5 percent annually—compared to the statewide average of 78 percent from fiscal years 2011–12 through 2018–19. However, because of the State's formula, Marin paid $1.1 million more in fiscal year 2018–19 than it would have had its contribution been based on its program growth and caregiver wages.

Collectively, the remaining 37 counties paid the State $102 million less than they would have if their contributions had been calculated based on actual program costs. In these 37 counties, the growth in the cost of their IHSS programs—from increases in IHSS enrollment, in authorized hours of care, and in the state minimum wage—outpaced the inflation factor that the State's formula required them to pay. For example, from fiscal years 2011–12 through 2018–19, the costs associated with the IHSS programs at five large counties grew by an average of 11 percent to 14 percent

annually while the inflation factor in state law ranged between only 3.5 percent and 5 percent. As a result, by fiscal year 2018–19 these five counties collectively paid $76 million less per year than if their contribution was based on their actual costs. Moreover, because of the continued use of a set inflation factor for all counties, the funding disparity between slow-growing and fast-growing counties is widening each year.

The State's current formula for calculating county contributions has also created a significant funding disparity at the state level. In the last decade, the proportional share of IHSS costs paid by many counties decreased as the State's formula has not kept pace with their IHSS programs' growth. Table 6 compares the annual inflation amount to the average statewide growth in program costs. When a county's IHSS program costs grow faster than the inflation factor, the contribution the county pays the State decreases proportionally. During fiscal years 2012–13 through 2016–17, the first five years the funding formula was in effect, the number of recipients in the IHSS program grew by almost 30 percent as the federal Affordable Care Act and the State's expansion of Medi-Cal led to expanded eligibility. At the same time, increases in the number of authorized hours per recipient and the state minimum wage added to the overall cost of care. As a result, although many counties pay more than their fair share, in January 2017, Finance estimated that collectively counties would be paying the State about $600 million less in fiscal year 2017–18 than they would have if the State had continued to base their contributions on a percentage of their costs rather than on their fiscal year 2011–12 costs plus the inflation factor.

Table 6
Growth in IHSS Program Costs Has Exceeded the Inflation Factor Used to Calculate County Contributions

FISCAL YEAR	INFLATION FACTOR	IHSS PROGRAM COST GROWTH
2012–13	N/A	12%
2013–14	N/A	3%
2014–15	3.5%	24%
2015–16	3.5%	12%
2016–17	3.5%	19%
2017–18	3.5%	7%
2018–19	5%	11%
2019–20	N/A	14%
2020–21	4%	14%

Source: State law, Social Services' local assistance appropriations tables, communication with counties, IHSS program documents, and interviews with Social Services' staff.

Note: Cost growth is based on Social Services local assistance appropriations for IHSS services and administration. IHSS program costs grew significantly in fiscal year 2014–15 due to increased caseload from implementation of the Affordable Care Act and new federal overtime and labor rules.

In recent years the Legislature has attempted to modify the county contribution, but the discrepancies among counties persist. As a result of changes to state law in 2017, the amount counties were to contribute to the IHSS program collectively increased by about $600 million. However, as we mention earlier, the vehicle fees and sales taxes that counties rely on to pay their contributions have not provided sufficient revenue to cover these increases. To offset the additional cost to the counties, the Legislature appropriated funds—almost $400 million in fiscal year 2017–18 and lower amounts in later years. The Legislature made additional changes in 2019 that lowered the inflation factor and made some of its 2017 changes inoperative. In essence, the calculations for county contributions returned to a statewide inflation factor applied to the costs in a base year. Despite these modifications to the county contribution in recent fiscal years, the differences in the shares counties pay persist.

Modest adjustments to the State's IHSS funding formula could result in more predictable and equitable program funding.

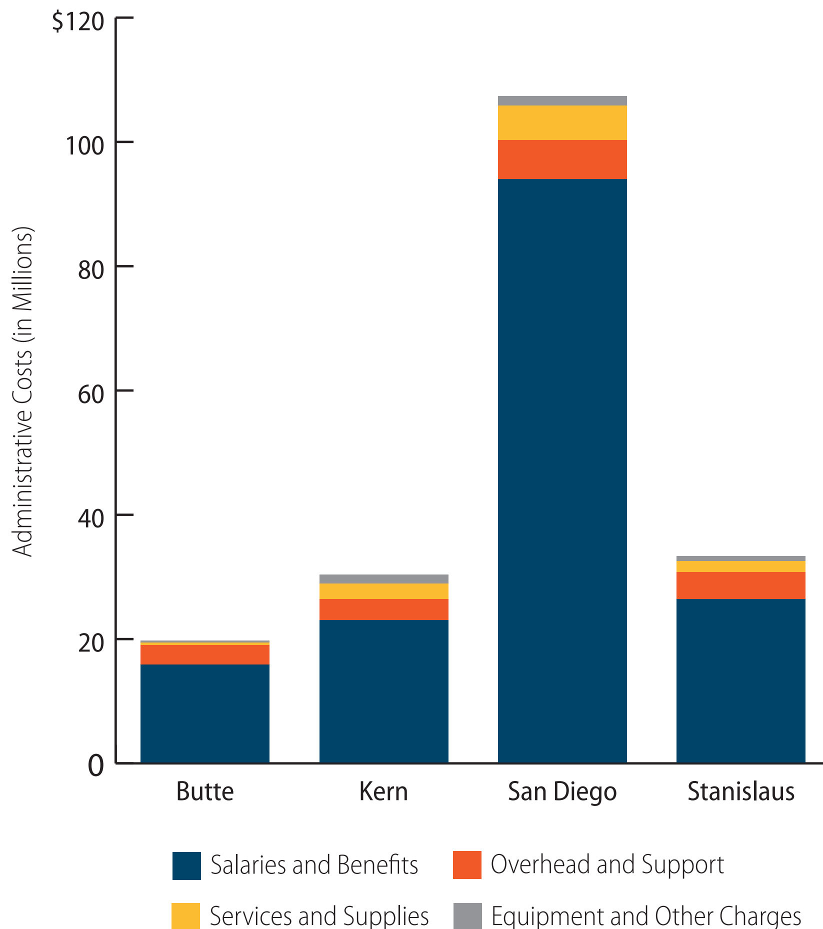
However, modest adjustments to the State's IHSS funding formula could result in more predictable and equitable program funding. The current contributions state law requires from counties do not consider changes in IHSS enrollment or the increased costs associated with state minimum wage increases, leading, as noted, to inequitable county contributions. However, if the funding formula took into account actual county IHSS costs, the county contributions would become more equitable. Likewise, if county contributions took into account the availability of the specific funds counties receive through sales taxes and vehicle registration, many counties would more likely be able to pay their proportional contributions. The Legislature could then use the remaining offsets to assist specific counties when the funds are insufficient to cover their proportional share. Taking steps to correct this deficiency now is important because Finance has projected that IHSS expenses will continue to outpace available funds in the future. Appendix D demonstrates the effect reducing the inflation rate could have on counties currently paying more than their proportional share. For example, temporarily eliminating the inflation factor for the 18 counties that are currently contributing more than their proportional share of IHSS costs would reduce the amount those counties collectively pay by $17 million in the first year, although it would take several years without the application of an inflation factor for them to reach parity.

The Four Counties We Reviewed Complied With Administrative Funding Use and Training Requirements

The four counties we reviewed—Butte, Kern, San Diego, and Stanislaus—used their IHSS administrative funding for allowable purposes. According to Social Services, the State evaluates which county administrative expenses are allowable using federal regulations, state law, and California's federally approved county cost allocation plan (plan). The plan lists specific types of allowable expenses, such as those related to operating costs and staff, including social workers. The plan also lists categories

of unallowable costs, such as fines, penalties, and entertainment expenses. For the counties we reviewed, staff salaries and benefits accounted for between 76 percent and 87 percent of county administrative expenses. Other county administrative expenses included items such as overhead and support, and services and supplies, as shown in Figure 5. The counties we reviewed contracted with various outside service providers such as online hosting companies to provide their IHSS registry, equipment maintenance providers, and legal services companies, all of which are allowable. Although our review identified minor accounting issues, such as a single small payment charged to an incorrect account at one county, we did not identify unallowable expenditures of administrative funds.

Figure 5
County IHSS Administrative Costs in Four Counties From Fiscal Years 2014–15 Through 2018–19 Primarily Supported Staff Salaries and Benefits



Source: County IHSS accounting records.

Further, administrative expenditure amounts at the four counties we reviewed appear reasonable, although all four counties are at or above the statewide average for the percentage of costs spent on administration. As Table 7 shows, each of the counties we reviewed had administrative expenses for their IHSS program that ranged from 7 percent to 10 percent of their total IHSS program costs during the five-year period of our review, fiscal years 2014–15 through 2018–19. Overall, 46 counties spent more than the statewide average on administration as a percentage of their total program costs including the four counties that we reviewed. When we followed up with our selected counties on their administrative expenditures, they were able to adequately explain their higher administrative expenditures. For example, while Kern County's administrative percentage was the highest of the four counties we reviewed, its number of IHSS recipients also increased by the largest percentage—over 100 percent—from 2014 to 2019. According to the administrative services officer at Kern, the county increased its administrative spending in fiscal year 2012–13 in anticipation of this program growth. By 2019 the county's administrative spending was close to the statewide average. According to the IHSS program accountant at Stanislaus County, the IHSS program and Public Authority moved into new offices in 2016, which increased the county's IHSS administrative costs.

Table 7
Administrative Costs Represented 7 Percent to 10 Percent of Program Costs From Fiscal Years 2014–15 Through 2018–19 in the Counties We Reviewed (Dollars in Millions)

COUNTY	COUNTY IHSS COSTS *(Care and Administration)*	COUNTY ADMINISTRATIVE COSTS *(County and Public Authority)*	ADMINISTRATIVE PERCENTAGE OF IHSS PROGRAM COSTS
Butte	$290	$21	7%
Kern*	320	33	10
San Diego	1,820	143	8
Stanislaus	380	36	9
STATEWIDE	$38,810	$2,768	7%

Source: County IHSS accounting records, Social Services' IHSS program and County Expense Claim system data.

* Kern County's IHSS program doubled in size from 2014 to 2019. Kern's administrative costs were 7 percent of program costs in fiscal year 2018–19.

The counties we reviewed also generally spent what they budgeted. We examined the IHSS administrative budgets and expenses for the county welfare department and public authority at each of the four counties we reviewed. Because Social Services does not inform counties of their state administrative allocations until midway through the fiscal year, the budgets that counties create are estimates and can vary from the approved allocation. Nevertheless, the four counties we reviewed spent about 94

percent of the amounts they budgeted for IHSS administration. The individual amounts the four counties spent ranged from 90 percent to 98 percent of their budgeted amounts for their welfare departments, and from 73 percent to 102 percent for their public authorities, as we show in Table 8. When we followed up on variances between budgets and spending, the rationales the counties provided were reasonable. For example, when we asked Butte County why its public authority expenses were less than the amount it budgeted in 2017, county staff explained that before 2018 the public authority's small staff had been contract employees likely with fewer benefits than county employees, which made filling vacancies and absences difficult. However, since 2018 Butte County has reclassified its public authority staff as county employees. At Stanislaus County, according to the IHSS program accountant, because the county does not receive its allocation letters from the State until November or later, it is sometimes hard for the county to fully use the allocation. However, the accountant stated that the county has added additional staff to support workload growth, and we observed that the Stanislaus public authority's administrative salary expenses have recently increased.

Table 8
Counties We Reviewed Generally Had IHSS Administrative Expenses That Were Close to Their Budgets From Fiscal Years 2014–15 Through 2018–19

COUNTY	PERCENT OF IHSS ADMINISTRATIVE BUDGETS EXPENDED	
	COUNTY WELFARE DEPARTMENT	COUNTY IHSS PUBLIC AUTHORITY
Butte	91%	73%
Kern*	98	102
San Diego	96	93
Stanislaus	90	79

Source: County budget documents.

* Kern County public authority expenses greater than 100 percent were primarily due to professional services expenses, including IHSS fraud investigations conducted by the Kern County district attorney.

Finally, each of the counties we reviewed provided state-mandated caregiver training. State law requires that caregivers be provided training through a public authority or nonprofit. This law does not generally specify the nature or frequency of this training; however, starting in 2009, another law has required prospective caregivers to complete a caregiver orientation developed by Social Services at the time of enrollment. This orientation must include, among other things, a description of the IHSS program and rules and provider-related processes and procedures, such as properly completing timesheets. All four of the counties we reviewed provided the required training by regularly conducting new caregiver orientations using state-mandated materials.

Furthermore, San Diego also requires its registry caregivers—those who are available to care for IHSS recipients who do not come to the program with a caregiver such as a family member—to complete a three-hour county training and offers all its caregivers a voluntary 18-hour advanced training course. Similarly, Stanislaus recently signed a memorandum of understanding with its local caregiver union and will provide funding to deliver optional supplemental training classes to caregivers. Butte and Kern counties do not generally provide any caregiver training outside of the state-mandated orientations.

Recommendation

The Legislature

To provide for more equitable financial participation by counties, the Legislature should revise the State's IHSS funding formula to include annual updates based on current program growth and costs and a review of specific funds available to counties. To the extent that some counties' revenues dedicated to IHSS are insufficient to cover their IHSS contributions, the Legislature should provide counties with assistance as it deems appropriate or designate additional funding sources in state law.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

ELAINE M. HOWLE, CPA
California State Auditor

February 25, 2021

Appendix A

SURVEY OF COUNTIES REGARDING IHSS

We surveyed directors of county IHSS programs to obtain additional information on how the IHSS program is performing statewide. We received 51 responses, and seven counties did not respond: Fresno, Lassen, Modoc, Placer, San Mateo, Sierra, and Solano. Table A provides a selection of questions and summarizes county answers.

Table A
Selected Answers From the Survey of Counties

Please note that where answers are not Yes/No, respondents were allowed to select more than one answer.

Does your county have a sufficient number of IHSS caregivers to provide all approved services to each IHSS recipient?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
Yes	19	37%
No	32	63

If no, what hurdles exist that prevent your county from having enough caregivers for each recipient to receive all approved services?

The percentages shown here are out of total "No" respondents, above, 32.

	NUMBER	PERCENT
Insufficient pay rates to attract caregivers.	14	44%
Difficulty matching caregivers with recipients in isolated geographic areas.	26	81
Recipients with specific or challenging needs that few caregivers can or will satisfy.	30	94
Recipients are reluctant to hire nonfamily members as caregivers.	10	31
Caregivers do not have enough time to provide services to all recipients.	16	50
Other*	18	56

If no, other than maintaining the mandated registry of caregivers, what activities has the county undertaken to ensure each recipient has a provider?

The percentages shown here are out of total "No" respondents, above, 32.

	NUMBER	PERCENT
When recipients indicate short-term or specific needs, notify them of caregivers who can deliver services as needed.	26	81%
Assist recipients in interviewing caregivers.	25	78
We have taken no additional steps.	1	3
Other†	23	72

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Has your county performed any analysis to identify how many caregivers it needs currently and in the future?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
Yes	2	4%
No	49	96

Does your county actively recruit caregivers?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
Yes	45	88%
No	6	12

What obstacles, if any, do recipients in your county typically face in hiring caregivers?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
Insufficient pay rates to draw applicants.	22	43%
Potential caregivers may not have knowledge of the program.	14	27
Potential caregivers do not pass background checks.	11	22
Potential caregivers do not have transportation.	29	57
Potential caregivers are unwilling to provide care in certain geographic areas.	45	88
Potential caregivers are unwilling to provide certain types of care.	42	82
Other‡	20	39

Has your county created a plan to account for future growth in the number of recipients in your county?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
Yes	4	8%
No	47	92

Has your county performed any analysis to identify its future budgetary needs for the IHSS program?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
Yes	14	27%
No	37	73

What concerns, if any, does your county have with its county contribution payments to the State?

The percentages shown here are out of total respondents, 51.

	NUMBER	PERCENT
None, there are no concerns with the county contribution.	14	27%
The county contribution penalizes the county for negotiated increases in wages.	15	29
The county contribution inflation rate is arbitrary and does not reflect realities in the county.	27	53
The county contribution does not reflect actual program costs.	26	51
Other§	24	47

Source: Auditor analysis of county survey responses.

* Counties listed several additional hurdles that prevent them from having enough caregivers, including the COVID pandemic and the caregiver's inability to complete their background check.

† Counties reported several other steps they took to ensure that each recipient has a caregiver, including that the public authority contacts recipients to better understand their hiring needs and providing caregiver recommendations to recipients.

‡ Counties reported several other obstacles that recipients face when hiring caregivers, including that some caregivers are unwilling or unable to pay for a background check.

§ Counties reported several other concerns with the county contribution, including its unpredictable nature, that it does not correlate to the realignment base, and that state allocations are insufficient.

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Appendix B

COUNTY IHSS POPULATIONS AND PERFORMANCE METRICS

The Audit Committee asked us to provide a variety of information related to IHSS populations and performance metrics. The following tables summarize additional or more detailed results of our review of data related to the IHSS populations and performance metrics.

Table B.1
The Overall Number of Authorized Hours Not Provided Increased Between 2015 and 2019

	2015				2019			
COUNTY	AUTHORIZED HOURS	PROVIDED HOURS	DIFFERENCE	PERCENTAGE OF AUTHORIZED HOURS NOT PROVIDED	AUTHORIZED HOURS	PROVIDED HOURS	DIFFERENCE	PERCENTAGE OF AUTHORIZED HOURS NOT PROVIDED
Alameda	27,699,069	26,239,186	1,459,883	5%	34,542,303	32,307,236	2,235,067	6%
Alpine	28,670	27,747	923	3	28,546	27,574	972	3
Amador	254,536	241,095	13,441	5	397,265	371,670	25,595	6
Butte	5,179,122	4,958,298	220,824	4	5,364,090	5,063,563	300,527	6
Calaveras	440,439	416,704	23,735	5	589,614	559,765	29,849	5
Colusa	139,063	119,626	19,437	14	340,838	318,370	22,468	7
Contra Costa	9,460,235	9,015,226	445,009	5	14,232,654	13,167,108	1,065,546	7
Del Norte	524,385	501,878	22,507	4	606,537	582,042	24,495	4
El Dorado	1,564,393	1,511,045	53,348	3	2,416,545	2,332,701	83,844	3
Fresno	19,312,101	18,782,620	529,481	3	28,608,173	27,708,588	899,585	3
Glenn	634,768	602,205	32,563	5	769,898	723,391	46,507	6
Humboldt	1,919,902	1,764,651	155,251	8	2,793,535	2,559,540	233,995	8
Imperial	4,857,191	4,755,612	101,579	2	6,606,213	6,468,131	138,082	2
Inyo	163,464	147,506	15,958	10	203,995	182,369	21,626	11
Kern	4,134,188	3,973,487	160,701	4	9,416,063	8,748,498	667,565	7
Kings	2,096,066	2,012,112	83,954	4	3,441,272	3,297,510	143,762	4
Lake	2,754,551	2,631,031	123,520	4	2,968,445	2,812,899	155,546	5
Lassen	179,323	172,317	7,006	4	231,430	217,263	14,167	6
Los Angeles	226,780,272	219,182,471	7,597,801	3	291,929,309	283,021,908	8,907,401	3
Madera	1,946,516	1,860,971	85,545	4	2,758,274	2,645,947	112,327	4
Marin	2,237,161	2,132,082	105,079	5	2,497,071	2,344,087	152,984	6
Mariposa	213,764	209,244	4,520	2	354,342	331,896	22,446	6
Mendocino	2,159,003	2,010,563	148,440	7	2,296,328	2,130,115	166,213	7
Merced	3,131,631	3,009,596	122,035	4	3,799,322	3,648,242	151,080	4

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	2015				2019			
COUNTY	AUTHORIZED HOURS	PROVIDED HOURS	DIFFERENCE	PERCENTAGE OF AUTHORIZED HOURS NOT PROVIDED	AUTHORIZED HOURS	PROVIDED HOURS	DIFFERENCE	PERCENTAGE OF AUTHORIZED HOURS NOT PROVIDED
Modoc	85,172	78,135	7,037	8%	193,411	183,343	10,068	5%
Mono	50,665	48,851	1,814	4	52,507	50,304	2,203	4
Monterey	4,392,101	4,249,592	142,509	3	6,303,741	6,115,148	188,593	3
Napa	1,482,768	1,434,300	48,468	3	1,764,120	1,660,626	103,494	6
Nevada	886,464	847,246	39,218	4	844,071	802,553	41,518	5
Orange	26,801,852	25,016,981	1,784,871	7	41,315,549	39,082,983	2,232,566	5
Placer	4,106,491	3,978,314	128,177	3	6,364,662	6,102,582	262,080	4
Plumas	322,901	302,592	20,309	6	399,286	368,843	30,443	8
Riverside	30,153,378	28,942,908	1,210,470	4	50,218,411	48,385,172	1,833,239	4
Sacramento	29,941,130	29,049,376	891,754	3	41,537,689	40,238,254	1,299,435	3
San Benito	760,831	735,011	25,820	3	826,475	789,029	37,446	5
San Bernardino	31,254,378	30,229,611	1,024,767	3	44,444,956	42,866,454	1,578,502	4
San Diego	28,979,647	27,947,145	1,032,502	4	39,463,190	37,948,092	1,515,098	4
San Francisco	24,763,481	23,458,848	1,304,633	5	28,233,554	26,884,997	1,348,557	5
San Joaquin	6,080,578	5,840,280	240,298	4	7,952,765	7,581,942	370,823	5
San Luis Obispo	2,203,212	2,091,462	111,750	5	2,742,328	2,624,372	117,956	4
San Mateo	5,821,686	5,514,749	306,937	5	7,637,085	7,304,711	332,374	4
Santa Barbara	3,572,189	3,405,447	166,742	5	4,382,499	4,125,687	256,812	6
Santa Clara	23,506,657	22,519,972	986,685	4	35,652,022	34,102,657	1,549,365	4
Santa Cruz	3,137,991	2,979,588	158,403	5	3,429,624	3,153,759	275,865	8
Shasta	3,505,889	3,362,997	142,892	4	4,278,714	4,041,440	237,274	6
Sierra	39,601	36,912	2,689	7	53,443	49,496	3,947	7
Siskiyou	532,175	492,243	39,932	8	639,753	595,706	44,047	7
Solano	5,708,046	5,501,307	206,739	4	7,185,453	6,875,431	310,022	4
Sonoma	6,731,314	6,454,524	276,790	4	8,612,697	8,167,172	445,525	5
Stanislaus	6,001,204	5,764,981	236,223	4	8,325,044	7,887,891	437,153	5
Sutter	1,166,519	1,124,526	41,993	4	1,462,948	1,381,572	81,376	6
Tehama	1,105,774	1,053,656	52,118	5	1,570,273	1,470,632	99,641	6
Trinity	202,813	187,877	14,936	7	245,641	226,504	19,137	8
Tulare	2,762,742	2,595,488	167,254	6	6,006,782	5,649,047	357,735	6
Tuolumne	372,870	340,587	32,283	9	572,579	513,943	58,636	10
Ventura	5,919,667	5,647,497	272,170	5	9,438,129	8,992,967	445,162	5
Yolo	2,935,329	2,805,649	129,680	4	3,874,233	3,674,987	199,246	5
Yuba	775,185	746,553	28,632	4	1,075,896	1,000,476	75,420	7
STATEWIDE	583,872,513	561,062,478	22,810,035	4	794,291,592	762,469,185	31,822,407	4

Source: Auditor's analysis of Social Services' CMIPS II data.

Table B.2
Varying Numbers of Recipients in All Counties Experienced Gaps in Care

	2015		2019	
COUNTY	MONTHLY AVERAGE RECIPIENTS	MONTHLY AVERAGE RECIPIENTS WITHOUT IHSS CARE	MONTHLY AVERAGE RECIPIENTS	MONTHLY AVERAGE RECIPIENTS WITHOUT IHSS CARE
Alameda	21,553	1,560	25,388	2,382
Alpine	27	2	24	2
Amador	233	26	330	41
Butte	3,766	378	4,015	406
Calaveras	385	35	445	42
Colusa	164	35	269	35
Contra Costa	8,812	664	11,419	1,268
Del Norte	346	27	381	34
El Dorado	1,022	80	1,392	116
Fresno	16,132	731	21,414	1,148
Glenn	471	40	539	50
Humboldt	1,748	286	2,149	343
Imperial	5,658	219	6,540	217
Inyo	141	29	151	26
Kern	4,382	296	8,319	923
Kings	1,982	163	2,699	205
Lake	2,100	170	2,285	188
Lassen	183	19	216	29
Los Angeles	210,093	9,668	236,443	10,179
Madera	1,884	117	2,281	149
Marin	1,840	168	2,028	222
Mariposa	163	7	247	30
Mendocino	1,802	217	1,845	241
Merced	3,171	235	3,518	239
Modoc	93	15	140	12
Mono	31	4	31	3
Monterey	4,464	278	5,242	273
Napa	1,104	66	1,246	121
Nevada	713	65	708	62
Orange	26,989	2,773	34,509	3,010
Placer	2,632	171	3,627	316
Plumas	319	43	352	51
Riverside	27,392	1,820	37,980	2,513
Sacramento	24,041	1,312	29,955	1,645

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COUNTY	2015 MONTHLY AVERAGE RECIPIENTS	2015 MONTHLY AVERAGE RECIPIENTS WITHOUT IHSS CARE	2019 MONTHLY AVERAGE RECIPIENTS	2019 MONTHLY AVERAGE RECIPIENTS WITHOUT IHSS CARE
San Benito	603	33	654	54
San Bernardino	26,884	1,490	34,200	2,066
San Diego	27,171	1,811	31,797	2,194
San Francisco	23,072	1,721	23,251	1,726
San Joaquin	6,255	471	7,176	553
San Luis Obispo	1,848	197	1,971	185
San Mateo	4,690	389	5,623	426
Santa Barbara	3,272	304	3,704	396
Santa Clara	21,580	1,338	26,114	1,681
Santa Cruz	2,573	272	2,901	444
Shasta	3,052	260	3,439	385
Sierra	32	5	44	8
Siskiyou	570	83	618	86
Solano	4,251	289	5,209	387
Sonoma	5,701	445	6,401	612
Stanislaus	6,507	436	7,687	679
Sutter	1,084	91	1,317	130
Tehama	983	105	1,203	153
Trinity	183	26	236	33
Tulare	3,157	366	4,981	530
Tuolumne	364	63	463	81
Ventura	5,031	414	7,196	583
Yolo	2,471	213	2,816	271
Yuba	720	48	946	106
STATEWIDE	527,890	32,589	628,074	40,290

Source: Auditor analysis of Social Services' CMIPS II data.

Table B.3
Counties Did Not Meet the 30-Day Deadline for Approving Applications for New Recipients

	2015		2019	
COUNTY	NUMBER OF NEW RECIPIENTS	AVERAGE DAYS FROM APPLICATION TO APPROVAL	NUMBER OF NEW RECIPIENTS	AVERAGE DAYS FROM APPLICATION TO APPROVAL
Alameda	3,184	82	3,208	61
Alpine	2	12	4	45
Amador	55	47	52	43
Butte	702	51	513	55
Calaveras	84	43	96	54
Colusa	47	43	68	60
Contra Costa	1,216	104	1,763	144
Del Norte	47	41	66	51
El Dorado	221	64	253	73
Fresno	3,010	78	3,427	73
Glenn	84	42	74	44
Humboldt	416	49	370	46
Imperial	697	148	950	123
Inyo	18	44	32	32
Kern	972	69	2,245	83
Kings	346	68	464	84
Lake	401	46	323	53
Lassen	41	55	52	65
Los Angeles	25,329	90	27,480	66
Madera	270	125	373	89
Marin	247	62	261	78
Mariposa	21	36	53	51
Mendocino	302	63	293	66
Merced	551	68	533	74
Modoc	22	35	24	52
Mono	11	62	4	60
Monterey	680	77	863	55
Napa	165	56	171	56
Nevada	148	63	125	58
Orange	4,320	80	4,645	66
Placer	463	75	553	71
Plumas	69	45	69	53
Riverside	5,149	68	6,533	56

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	2015		2019	
COUNTY	NUMBER OF NEW RECIPIENTS	AVERAGE DAYS FROM APPLICATION TO APPROVAL	NUMBER OF NEW RECIPIENTS	AVERAGE DAYS FROM APPLICATION TO APPROVAL
Sacramento	3,580	97	4,778	63
San Benito	84	81	110	83
San Bernardino	4,281	72	5,445	85
San Diego	3,784	70	5,387	60
San Francisco	2,031	49	2,221	61
San Joaquin	964	117	1,084	156
San Luis Obispo	305	95	326	62
San Mateo	934	50	1,012	54
Santa Barbara	487	56	670	64
Santa Clara	3,116	109	3,585	83
Santa Cruz	352	82	391	81
Shasta	508	49	652	39
Sierra	11	42	8	42
Siskiyou	118	48	121	49
Solano	725	96	721	87
Sonoma	897	84	869	83
Stanislaus	855	115	1,087	117
Sutter	173	50	234	94
Tehama	174	56	218	65
Trinity	31	58	47	85
Tulare	704	79	1,073	131
Tuolumne	47	69	87	65
Ventura	945	54	1,102	55
Yolo	331	78	400	74
Yuba	119	38	143	135
STATEWIDE	74,846	82	87,711	72

Source: Auditor analysis of Social Services' CMIPS II data.

Table B.4
Counties Did Not Meet the 15-Day Deadline for Ensuring Prompt Care for New Recipients Who Did Not Receive Services Until After They Entered the Program

	2015		2019	
COUNTY	NUMBER OF NEW RECIPIENTS*	AVERAGE DAYS FROM APPROVAL TO FIRST SERVICE	NUMBER OF NEW RECIPIENTS*	AVERAGE DAYS FROM APPROVAL TO FIRST SERVICE†
Alameda	598	132	602	56
Alpine	0	N/A	1	334
Amador	27	64	11	46
Butte	175	68	121	55
Calaveras	20	59	24	49
Colusa	12	191	18	55
Contra Costa	227	123	224	67
Del Norte	20	29	18	60
El Dorado	51	101	45	59
Fresno	278	89	249	46
Glenn	20	94	25	49
Humboldt	126	157	107	51
Imperial	105	33	90	27
Inyo	12	130	14	50
Kern	159	77	322	58
Kings	57	80	46	54
Lake	88	103	63	48
Lassen	13	44	14	40
Los Angeles	2,366	120	2,369	57
Madera	19	82	32	76
Marin	78	57	61	49
Mariposa	5	67	17	67
Mendocino	80	69	54	63
Merced	95	96	69	36
Modoc	16	47	11	43
Mono	5	31	0	N/A
Monterey	75	48	117	41
Napa	36	54	51	49
Nevada	42	52	34	66
Orange	719	153	695	48
Placer	74	80	96	49
Plumas	22	34	17	53
Riverside	664	67	801	51

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COUNTY	2015 NUMBER OF NEW RECIPIENTS*	2015 AVERAGE DAYS FROM APPROVAL TO FIRST SERVICE	2019 NUMBER OF NEW RECIPIENTS*	2019 AVERAGE DAYS FROM APPROVAL TO FIRST SERVICE†
Sacramento	503	87	505	45
San Benito	14	127	15	35
San Bernardino	483	75	609	55
San Diego	752	73	991	50
San Francisco	416	70	459	39
San Joaquin	112	97	113	54
San Luis Obispo	68	72	69	60
San Mateo	203	123	206	42
Santa Barbara	128	76	135	48
Santa Clara	449	111	394	57
Santa Cruz	79	108	86	70
Shasta	143	45	194	34
Sierra	8	25	1	6
Siskiyou	38	48	42	35
Solano	133	114	84	61
Sonoma	204	78	147	58
Stanislaus	125	125	125	52
Sutter	71	44	45	60
Tehama	58	68	52	50
Trinity	7	76	7	56
Tulare	169	96	152	50
Tuolumne	14	52	16	110
Ventura	192	97	159	50
Yolo	76	69	72	50
Yuba	59	44	47	52
STATEWIDE	10,788	98	11,143	52

Source: Auditor analysis of Social Services' CMIPS II data.

* This table only includes new recipients who started receiving services after being approved for IHSS services.

† While not shown in the above tables, counties approved more than 12,700 recipients in 2019 who had not yet received services when we reviewed the CMIPS II data in June 2020. Thus the 2019 averages will increase once these recipients receive services.

Table B.5
Most Counties Have Experienced Significant Growth In Their IHSS Programs Since 2015

COUNTY	GROUP	2015	2019	PERCENTAGE INCREASE FROM 2015 TO 2019
Alameda	Caregivers	23,548	26,754	14%
Alameda	Recipients	24,489	28,618	17
Alpine	Caregivers	36	27	-25
Alpine	Recipients	32	28	-13
Amador	Caregivers	231	320	39
Amador	Recipients	295	389	32
Butte	Caregivers	4,491	4,583	2
Butte	Recipients	4,507	4,829	7
Calaveras	Caregivers	453	492	9
Calaveras	Recipients	470	531	13
Colusa	Caregivers	148	285	93
Colusa	Recipients	209	350	67
Contra Costa	Caregivers	9,910	12,001	21
Contra Costa	Recipients	10,108	13,016	29
Del Norte	Caregivers	420	473	13
Del Norte	Recipients	406	451	11
El Dorado	Caregivers	1,255	1,682	34
El Dorado	Recipients	1,224	1,651	35
Fresno	Caregivers	17,967	22,923	28
Fresno	Recipients	18,536	24,114	30
Glenn	Caregivers	545	609	12
Glenn	Recipients	562	614	9
Humboldt	Caregivers	1,867	2,350	26
Humboldt	Recipients	2,147	2,591	21
Imperial	Caregivers	5,513	6,393	16
Imperial	Recipients	6,320	7,337	16
Inyo	Caregivers	131	146	11
Inyo	Recipients	178	178	0
Kern	Caregivers	5,050	8,468	68
Kern	Recipients	5,374	10,106	88
Kings	Caregivers	2,163	2,953	37
Kings	Recipients	2,337	3,107	33
Lake	Caregivers	2,504	2,505	0
Lake	Recipients	2,510	2,637	5
Lassen	Caregivers	197	233	18
Lassen	Recipients	234	278	19

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COUNTY	GROUP	2015	2019	PERCENTAGE INCREASE FROM 2015 TO 2019
Los Angeles	Caregivers	191,913	222,529	16%
Los Angeles	Recipients	233,346	260,971	12
Madera	Caregivers	2,005	2,540	27
Madera	Recipients	2,170	2,635	21
Marin	Caregivers	1,992	2,052	3
Marin	Recipients	2,131	2,313	9
Mariposa	Caregivers	215	279	30
Mariposa	Recipients	193	293	52
Mendocino	Caregivers	1,964	1,962	0
Mendocino	Recipients	2,111	2,128	1
Merced	Caregivers	3,329	3,839	15
Merced	Recipients	3,791	4,126	9
Modoc	Caregivers	87	170	95
Modoc	Recipients	118	171	45
Mono	Caregivers	37	40	8
Mono	Recipients	42	40	-5
Monterey	Caregivers	4,729	5,560	18
Monterey	Recipients	5,192	6,029	16
Napa	Caregivers	1,436	1,515	6
Napa	Recipients	1,276	1,415	11
Nevada	Caregivers	912	838	-8
Nevada	Recipients	867	839	-3
Orange	Caregivers	25,734	32,847	28
Orange	Recipients	30,784	38,870	26
Placer	Caregivers	3,340	4,152	24
Placer	Recipients	3,151	4,203	33
Plumas	Caregivers	342	367	7
Plumas	Recipients	396	419	6
Riverside	Caregivers	29,057	39,266	35
Riverside	Recipients	32,480	43,929	35
Sacramento	Caregivers	26,951	34,019	26
Sacramento	Recipients	27,380	34,111	25
San Benito	Caregivers	703	766	9
San Benito	Recipients	688	757	10
San Bernardino	Caregivers	28,457	35,805	26
San Bernardino	Recipients	31,446	39,384	25
San Diego	Caregivers	27,898	32,946	18
San Diego	Recipients	31,103	36,417	17

COUNTY	GROUP	2015	2019	PERCENTAGE INCREASE FROM 2015 TO 2019
San Francisco	Caregivers	23,915	25,520	7%
San Francisco	Recipients	25,581	25,538	0
San Joaquin	Caregivers	6,785	7,760	14
San Joaquin	Recipients	7,422	8,369	13
San Luis Obispo	Caregivers	1,979	2,169	10
San Luis Obispo	Recipients	2,138	2,307	8
San Mateo	Caregivers	5,666	6,900	22
San Mateo	Recipients	5,591	6,597	18
Santa Barbara	Caregivers	3,466	3,764	9
Santa Barbara	Recipients	3,833	4,309	12
Santa Clara	Caregivers	23,714	29,528	25
Santa Clara	Recipients	24,374	29,169	20
Santa Cruz	Caregivers	2,899	2,951	2
Santa Cruz	Recipients	2,981	3,311	11
Shasta	Caregivers	3,483	3,894	12
Shasta	Recipients	3,651	4,112	13
Sierra	Caregivers	37	52	41
Sierra	Recipients	44	54	23
Siskiyou	Caregivers	556	609	10
Siskiyou	Recipients	703	757	8
Solano	Caregivers	5,106	6,050	18
Solano	Recipients	5,075	5,971	18
Sonoma	Caregivers	6,298	6,660	6
Sonoma	Recipients	6,602	7,174	9
Stanislaus	Caregivers	6,564	7,573	15
Stanislaus	Recipients	7,498	8,700	16
Sutter	Caregivers	1,244	1,441	16
Sutter	Recipients	1,280	1,595	25
Tehama	Caregivers	1,131	1,408	24
Tehama	Recipients	1,166	1,455	25
Trinity	Caregivers	187	231	24
Trinity	Recipients	216	296	37
Tulare	Caregivers	3,211	5,113	59
Tulare	Recipients	3,800	5,875	55
Tuolumne	Caregivers	398	485	22
Tuolumne	Recipients	444	554	25
Ventura	Caregivers	5,376	7,646	42
Ventura	Recipients	5,943	8,263	39

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COUNTY	GROUP	2015	2019	PERCENTAGE INCREASE FROM 2015 TO 2019
Yolo	Caregivers	2,864	3,291	15%
Yolo	Recipients	2,861	3,222	13
Yuba	Caregivers	834	1,026	23
Yuba	Recipients	867	1,140	31
STATEWIDE	Caregivers	525,166	628,281	20
STATEWIDE	Recipients	594,848	701,548	18

Source: Auditor analysis of Social Services' CMIPS II data.

Note: Statewide totals do not equal the county totals because recipients may move between counties and caregivers may provide services to multiple recipients in different counties.

Appendix C

COMPARISON OF LIVING WAGE TO ACTUAL CAREGIVER WAGES IN CALIFORNIA COUNTIES

The Audit Committee asked us to provide information related to caregiver wages. Table C indicates the actual caregiver wages and living wage in all 58 counties as of 2019. Our selected counties Butte, Kern, San Diego and Stanislaus, are indicated in blue shading.

Table C
Counties Did Not Pay IHSS Caregivers a Living Wage In 2019

COUNTY	IHSS CAREGIVER WAGE	COUNTY LIVING WAGE*	AMOUNT BY WHICH LIVING WAGE EXCEEDS CAREGIVER WAGE	CAREGIVER WAGE AS A PERCENTAGE OF LIVING WAGE
Alameda	$12.50	$25.38	$12.88	49%
Alpine	$12.00	$18.99	$6.99	63%
Amador	$12.00	$19.55	$7.55	61%
Butte	$12.00	$20.04	$8.04	60%
Calaveras	$12.00	$19.42	$7.42	62%
Colusa	$12.00	$19.00	$7.00	63%
Contra Costa	$12.25	$25.38	$13.13	48%
Del Norte	$12.00	$19.09	$7.09	63%
El Dorado	$12.00	$20.53	$8.53	58%
Fresno	$12.00	$19.22	$7.22	62%
Glenn	$12.00	$18.32	$6.32	66%
Humboldt	$12.00	$19.19	$7.19	63%
Imperial	$12.00	$18.98	$6.98	63%
Inyo	$12.00	$19.26	$7.26	62%
Kern	$12.00	$18.84	$6.84	64%
Kings	$12.00	$19.49	$7.49	62%
Lake	$12.00	$18.99	$6.99	63%
Lassen	$12.00	$18.38	$6.38	65%
Los Angeles	$12.60	$23.26	$10.66	54%
Madera	$12.00	$19.23	$7.23	62%
Marin	$14.20	$31.00	$16.80	46%
Mariposa	$12.00	$19.00	$7.00	63%
Mendocino	$12.00	$19.52	$7.52	61%
Merced	$12.00	$18.63	$6.63	64%
Modoc	$12.00	$17.64	$5.64	68%
Mono	$12.00	$20.38	$8.38	59%
Monterey	$12.50	$22.31	$9.81	56%

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COUNTY	IHSS CAREGIVER WAGE	COUNTY LIVING WAGE*	AMOUNT BY WHICH LIVING WAGE EXCEEDS CAREGIVER WAGE	CAREGIVER WAGE AS A PERCENTAGE OF LIVING WAGE
Napa	$12.10	$22.64	$10.54	53%
Nevada	$12.00	$20.18	$8.18	59%
Orange	$12.00	$24.89	$12.89	48%
Placer	$12.00	$20.53	$8.53	58%
Plumas	$12.00	$19.05	$7.05	63%
Riverside	$12.00	$20.64	$8.64	58%
Sacramento	$13.00	$20.53	$7.53	63%
San Benito	$12.00	$22.86	$10.86	52%
San Bernardino	$12.00	$20.64	$8.64	58%
San Diego	$12.50	$24.62	$12.12	51%
San Francisco	$15.00	$31.00	$16.00	48%
San Joaquin	$12.00	$19.59	$7.59	61%
San Luis Obispo	$13.00	$22.03	$9.03	59%
San Mateo	$13.90	$31.00	$17.10	45%
Santa Barbara	$12.10	$25.12	$13.02	48%
Santa Clara	$13.00	$29.39	$16.39	44%
Santa Cruz	$12.46	$26.29	$13.83	47%
Shasta	$12.60	$19.15	$6.55	66%
Sierra	$12.00	$20.63	$8.63	58%
Siskiyou	$12.00	$18.34	$6.34	65%
Solano	$12.50	$21.95	$9.45	57%
Sonoma	$13.00	$23.68	$10.68	55%
Stanislaus	$12.00	$19.44	$7.44	62%
Sutter	$12.00	$18.59	$6.59	65%
Tehama	$12.00	$18.32	$6.32	66%
Trinity	$12.50	$18.36	$5.86	68%
Tulare	$12.00	$18.76	$6.76	64%
Tuolumne	$12.50	$19.40	$6.90	64%
Ventura	$12.78	$23.12	$10.34	55%
Yolo	$12.00	$20.84	$8.84	58%
Yuba	$12.00	$18.59	$6.59	65%
Statewide	**$12.29**	**$21.19**	**$8.90**	**58%**

Source: Auditor analysis of Social Services' data and the MIT living wage data.

* The living wage framework was created by MIT to identify the minimum employment earnings necessary to meet a family's basic needs; it uses geographically specific expenditures related to likely minimum food, childcare, health insurance, housing, and other basic costs.

Appendix D

EFFECT OF REDUCING THE INFLATION FACTOR ON CERTAIN COUNTIES

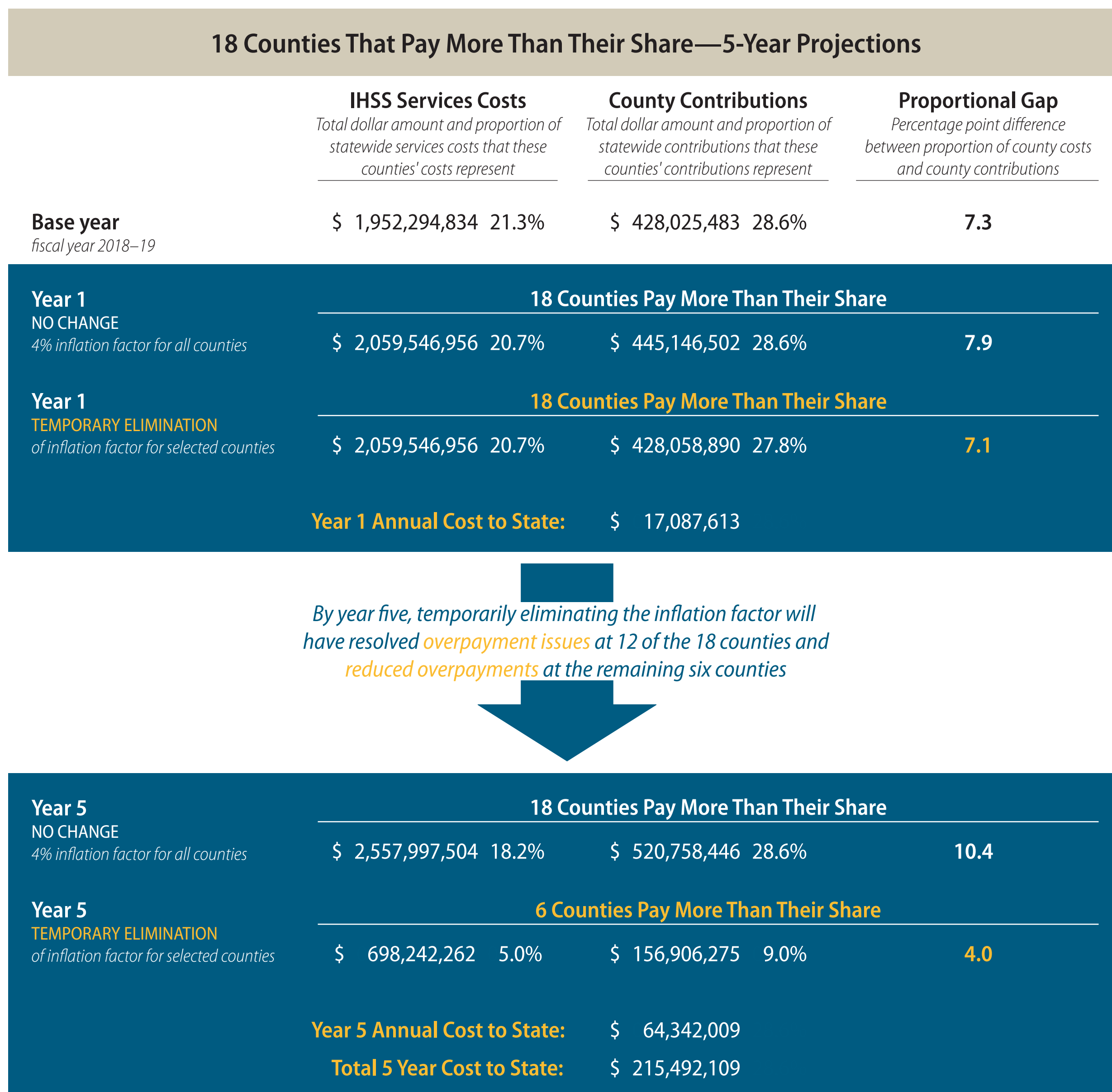
As we note in the main report, since 2012, the State's method of calculating county contributions for IHSS funding has created significant disparities in the individual proportions of funding that counties provide to the IHSS program. Statewide IHSS costs have increased because of changes such as implementation of the Affordable Care Act and the State's expansion of Medi-Cal, both of which increased the number of recipients, as well as increases in the number of hours of care recipients receive and increases in caregiver wages. However, although all counties' IHSS costs have increased, growth in costs has not been proportional across counties because of variations in local populations and local caregiver wages. Despite this, since 2012 the State's annual inflation factor has applied a flat percentage increase to the amount each county pays the State, regardless of the extent of the growth of its program costs. Over time, these disparities have resulted in some counties paying significantly more or less than their share of the overall IHSS program costs would suggest.

Although before 2012 each county paid the State a set proportion of about 18 percent of their overall IHSS program costs, by fiscal year 2018–19, counties paid between 6 percent and 29 percent of their costs, depending on how much faster or slower their costs grew compared to the State's annual inflation factor. Returning to the pre-2012 funding system would require some counties to pay over $20 million more annually. As the revenues from sources the Legislature dedicated to counties to support the program have not increased as rapidly as the program itself, it is unlikely that counties would be able to bear the expense of these increases, as Finance has noted. However, without state action, these disparities in the proportions that counties pay will continue to grow.

Immediately eliminating proportional overpayments by counties would require the State to increase its support of the program by $86 million per year, based on fiscal year 2018–19 ratios. However, by adjusting the IHSS inflation factor annually based on the availability of dedicated county funds and annual county program growth, as we recommend on page 34, the State could gradually move to a more equitable funding model. Selectively reducing the inflation factor for counties paying more than their proportional share would allow the State to gradually reduce overpayments. For example, by temporarily eliminating the inflation factor for 18 counties that pay more than their share, by year five overpayments would be eliminated for 12 of the 18 counties, and reduced for the remaining six counties, at a cost to the State of $215 million. Likewise, an annual review of the

availability of dedicated funds may allow the State to increase the percentage of support paid by those counties not currently paying a proportional share. Table D demonstrates the effect a decrease in inflation factors at selected counties would have on the counties and the associated costs to the State.

Table D
Eliminating the Inflation Factor for Counties Paying More Than Their Share Would Gradually Reduce Overpayments



18 Counties That Pay More Than Their Share—5-Year Projections

	IHSS Services Costs *Total dollar amount and proportion of statewide services costs that these counties' costs represent*		County Contributions *Total dollar amount and proportion of statewide contributions that these counties' contributions represent*		Proportional Gap *Percentage point difference between proportion of county costs and county contributions*
Base year *fiscal year 2018–19*	$ 1,952,294,834	21.3%	$ 428,025,483	28.6%	**7.3**
	18 Counties Pay More Than Their Share				
Year 1 NO CHANGE *4% inflation factor for all counties*	$ 2,059,546,956	20.7%	$ 445,146,502	28.6%	**7.9**
	18 Counties Pay More Than Their Share				
Year 1 TEMPORARY ELIMINATION *of inflation factor for selected counties*	$ 2,059,546,956	20.7%	$ 428,058,890	27.8%	**7.1**
	Year 1 Annual Cost to State:		$ 17,087,613		
	18 Counties Pay More Than Their Share				
Year 5 NO CHANGE *4% inflation factor for all counties*	$ 2,557,997,504	18.2%	$ 520,758,446	28.6%	**10.4**
	6 Counties Pay More Than Their Share				
Year 5 TEMPORARY ELIMINATION *of inflation factor for selected counties*	$ 698,242,262	5.0%	$ 156,906,275	9.0%	**4.0**
	Year 5 Annual Cost to State:		$ 64,342,009		
	Total 5 Year Cost to State:		$ 215,492,109		

By year five, temporarily eliminating the inflation factor will have resolved overpayment issues at 12 of the 18 counties and reduced overpayments at the remaining six counties

Source: Social Services' communications with counties and IHSS program data.

Note: This example is based on fiscal year 2018–19 county IHSS costs and contributions. We project future county costs based on historical growth rates, and use the State's current 4 percent annual inflation factor, which we reduce to 0 percent for counties that pay proportionally more than their share.

Appendix E

Scope and Methodology

The Audit Committee directed the State Auditor to examine the expenditure of state funds for the IHSS program at four counties selected by the State Auditor. Table E below lists the objectives that the Audit Committee approved and the methods we used to address them.

Table E
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Identified and reviewed relevant federal and state laws, rules, and regulations related to the IHSS program.
2	Analyze the counties' expenditures of IHSS funding, including the counties' costs to administer IHSS and the amount of funds paid for providers' wages and benefits. Also, determine whether counties are spending all IHSS funding each year.	• Interviewed relevant staff at each of the selected counties, IHSS public authorities, and Social Services. • Reviewed financial documentation at the selected counties and public authorities. Reviewed Social Services' IHSS data for the most recent five fiscal years. Determined the following: the percent of budgeted expenditures spent, expenditures on IHSS provider salary and benefits, administrative expenditures, and the costs related to the public authorities. • Reviewed Social Services' county expense claim system data to compare selected county administrative expenses to statewide averages.
3	Determine whether each county uses IHSS funding for anything other than provider wages, benefits, and county administrative costs. If so, assess the rationale for other uses.	• Reviewed state law and found that the State funds IHSS caregivers wages and benefits, and that counties do not receive this funding from the State. • Interviewed relevant staff at each of the selected counties and public authorities. • Reviewed county financial documentation to identify any usage of IHSS funds for purposes not directly related to IHSS administration or benefits during the past five fiscal years. • Reviewed a minimum of 95 percent of the dollar amount of each selected county's IHSS administrative expenses to determine if the expenses were within allowable categories for IHSS under the State's claiming rules. Compared counties financial documentation with expenditures they reported to Social Services.

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	AUDIT OBJECTIVE	METHOD
4	Identify trends in the number of IHSS providers and recipients within each county. Assess whether each county has a shortage of providers given the IHSS hours authorized for recipients.	• Interviewed relevant staff at Social Services and their contracted data experts as we developed our methodology and performed our analysis. • Used data acquired from Social Services' CMIPS II system as of June 2020 to determine the number of providers, recipients, approved hours, and hours provided at our selected counties for the past five calendar years. Also determined trends for providers, recipients, approved hours, and hour usage. To account for delays in providers submitting timesheets, we included all timesheet data through June 2020 but limited our analysis to services rendered through December 2019. • Interviewed county staff to determine the rationale for differences in budgeted versus actual expenditures and care hours and for any shortages of providers. • Conducted analysis to determine the extent of provider availability and associated trends. • Conducted data reliability assessment testing of CMIPS II data using data from our selected counties and internal dataset verification. • Surveyed counties throughout the State to determine whether gaps in care exist and the extent of current planning efforts, as well as to gain perspective related to their administration, hours utilization, recruitment, retention, and potential best practices.
5	Determine the average minimum wage of each county and compare it to the average wage rate for providers in each county. To the extent possible, determine the cost of living within each county and compare that to the average provider wage rate in that county.	• Determined minimum wages in all counties for the most recent five calendar years. Used Social Services' data to determine average provider wages in all counties over the past five fiscal years. • Reviewed publicly available living wage analysis, including analysis previously conducted at universities. Conducted analysis comparing current wage data and living wage data by county for all counties. Further, compared current wage data to other data sets such as federal per diem, and federal poverty threshold.
6	Identify and assess the biggest challenges to increasing IHSS provider wages within each county.	• Interviewed the provider union for our selected counties to determine challenges to IHSS provider wage increases. • Utilized our survey of counties throughout the State to gain perspective on the extent of current planning to increase provider wages at all counties, and on the challenges to increasing IHSS wages. • Reviewed the State's IHSS funding mechanisms to determine whether they discourage counties from increasing provider wages.
7	Determine the costs incurred by each county to recruit and provide training to new IHSS providers.	• Interviewed relevant staff, and to the extent it was available reviewed financial documentation related to recruiting and training efforts at each of the selected counties. • Reviewed available county financial documentation. Determined that counties we reviewed perform minimal recruitment and do not track recruitment expenses. • Determined that training costs in Butte and Kern counties were minimal. Found that Stanislaus has a memorandum of understanding with its caregiver union for the union to provide health and safety training for costs not to exceed $40,000 per year. Found that the San Diego County Public Authority has staff and other resources dedicated for training, but we were unable to determine their costs based on the financial documents the county provided. • Used our survey of counties throughout the state to gain perspective and unaudited data related to recruitment and training issues and expenses.

	AUDIT OBJECTIVE	METHOD
8	To the extent possible, determine what challenges exist for IHSS recipients including, but not limited, to those without family support—when hiring and retaining providers. Specifically, assess the effect of wages on hiring and retention.	• Used data obtained from Social Services' CMIPS II data system to determine the average time between selected milestones including from application to initial home visit, home visit to approval for services, and approval until the provision of initial services. Conducted interviews at our selected counties and Social Services to determine the cause of delays. • Used data obtained from Social Services' CMIPS II data system to determine retention rate of providers at each counties in the State. To the extent possible, filtered data for recipients to determine turnover rate for those utilizing family support. We found that the providers who were family members had similar retention rates to providers who were not family members. • Identified and interviewed a selection of nonrelated IHSS caregivers who left the program while their associated care recipient remained and determined the reason for their departure. • Analyzed county complaint policies and processes. Requested plans from the four selected counties related to resolving issues with recruiting and retaining providers, including potential increases to wages. Surveyed counties about lack of available planning. • Requested planning documents at our selected counties related to pending increases in recipients. Surveyed counties about lack of planning. • Surveyed counties throughout the State to determine any potential challenges IHSS recipients experienced when hiring and retaining providers. Further, surveyed counties on potential challenges related to collective bargaining agreements. • Analyzed gaps between IHSS provider wages and the living wage. Compared gaps against the retention rates of counties. Reviewed outside analysis related to IHSS worker availability. Our review did not identify a causal link, likely due to the disparity between existing wages and the living wage at all counties. However, we did note that counties with a smaller gap between the living wage and provider wage in some cases had greater retention for paid providers in the later years of our review.
9	Determine how long it takes for new providers, on average, to receive their first timesheet. To the extent possible, assess the impact that this timeline has on hiring and recruiting new non-family IHSS providers.	• Interviewed relevant staff at Social Services and their contracted data experts as we developed our methodology and performed our analysis. • Used data from Social Services' CMIPS II system to determine average time from initial hire until the issuance of timesheets for providers in our selected counties. Reviewed the length of time from initial eligibility to first timesheet, and calculated the average number of hours worked by providers within the selected counties. To the extent possible, filtered Social Services' data to determine whether providers were non-family providers. • Used data from Social Services' CMIPS II system to determine the number of approved providers in the selected counties who never received a time card and those that only worked for a limited period. • Reviewed selected county and public authority onboarding materials and related policies and procedures to determine their compliance with state law. • Analyzed the amount of time it took new IHSS caregivers to receive their first timesheets. Interviewed former non-family IHSS caregivers to determine their reasons for leaving the program. No information identified to establish a causal link between potential timesheet delays and caregiver hiring and retention.

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	AUDIT OBJECTIVE	METHOD
10	Review and assess any other issues that are significant to the audit.	• Reviewed the State's IHSS funding mechanisms to determine whether incentives exist for counties to limit IHSS services. • Reviewed the State's IHSS funding mechanisms to determine whether they were equitable and provide for stable county IHSS funding.

Source: Audit Committee's audit request number 2020-109, planning documents, and information identified in the table column titled Method.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on IHSS program eligibility and timesheet data from Social Services' CMIPS II system to calculate various program statistics and to evaluate trends about providers and recipients in the program. To evaluate these data, we reviewed existing information about the data, interviewed staff knowledgeable about the data, performed electronic testing of the data, and conducted accuracy testing on a selection of key data elements. We found that these data were of undetermined reliability. Although this determination may affect the precision of the numbers we present, sufficient evidence exists in total to support our audit finds, conclusions, and recommendations.

In addition, we obtained electronic expenditure data from each of the four counties we reviewed. We performed data validation and verification through logic testing of key elements. We determined that those data were reliable for the purposes of this audit.

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

KIM JOHNSON
DIRECTOR

GAVIN NEWSOM
GOVERNOR

February 3, 2021

Ms. Elaine M. Howle, CPA*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

SUBJECT: CDSS RESPONSE TO CALIFORNIA STATE AUDITOR'S REPORT

Dear Ms. Howle:

Below you will find the California Department of Social Services (CDSS) response to the recommendations for CDSS in the California State Auditor's (CSA) Report on the In-Home Supportive Services (IHSS) Program.

CSA Recommendations for CDSS:

To help ensure that all recipients throughout the State receive prompt approval for services and receive all approved services, by August 2021 and annually thereafter, Social Services should require counties to submit required annual plans. These plans should include, at a minimum, a description of how each county will ensure that services are promptly approved and that recipients promptly receive the approved services.

To help counties prepare to meet future needs for IHSS services, Social Services should revise its regulations to require counties to include long-range projections and strategies in their annual plans. For example: (1)

To help ensure that recipients receive timely care, Social Services should by August 2021 begin monitoring counties' compliance with the following:

- Approval of IHSS applications within 30 days, unless an extension for obtaining a medical certification applies. Prompt approval of IHSS applications for which the 45-day extension for a medical certification applies.
- Provision of services within 15 days of application approval. For counties that struggle to comply with its regulations regarding providing timely services, Social Services should require—and regularly follow up on—corrective action plans from these counties.

* California State Auditor's comments begin on page 69.

Ms. Elaine M. Howle
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CDSS Response:

CDSS agrees with the goal of ensuring that all recipients throughout the State receive ② prompt approval for services and receive all approved services. CDSS plans to repeal the regulation that requires counties to submit annual county plans. The requirement for ③ county plans is an outdated regulation from when services were primarily provided by county homemakers that are employed and directed by the county. As the program evolved to a self-directed model, and recipients became responsible for the hiring and ④ directing of the care provider, county plans were no longer meaningful as the county does not control the service provision of the program.

⑤ CDSS plans to also repeal the regulation regarding 15 days from application to provision of services. As a self-directed program, IHSS recipients are responsible for managing their own care. Recipients sign an SOC 332 (IHSS Recipient/Employer Responsibility Checklist) at their assessment that states it is the recipient's responsibility to hire and manage their own provider and direct how and when they receive their services. Counties have no authority to hire a provider for a recipient. The county ensures recipients are assessed and authorized for services; it then becomes the recipient's responsibility to hire a provider.

⑥ Regarding the requirement to approve IHSS applications in 30 days, CDSS is in the process of revising regulations to include the new statutory requirements for an IHSS applicant to complete a Medi-Cal eligibility determination and health care certification prior to authorization of IHSS. Both requirements allow 45 days for the applicant to complete and run concurrently.

⑦ Lastly, CDSS has established Quality Assurance and Monitoring Units and a Program Integrity Unit (PIU) which is responsible for monitoring counties in the areas which they are responsible for (application processing, assessing recipients and authorizing hours correctly, conducting reassessments timely, etc.) and will continue to do so.

Additional Clarifications

The additional responses below provide clarification on the IHSS Program.

The following topics are addressed:

1) IHSS Public Authorities
2) IHSS recipients not receiving services;
3) Data referenced;
4) IHSS Maintenance of Effort;
5) Preparation for the future; and
6) IHSS Program Background.

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IHSS PUBLIC AUTHORITIES

Report:

Page 9, “Most counties have established public authorities – entities separate from the counties that are deemed the employer of IHSS caregivers to perform various functions related to caregivers.”

CDSS Response:

Public Authorities (PA) are the employer of record only for purpose of collective bargaining. They are not the employer for any other purpose, the recipient is. Counties and PAs provide supports to assist recipients in their role as employer, such as maintaining a provider registry (operated by the county IHSS PA) to assist recipients in finding a provider if necessary, provider and recipient training, etc.; but counties are not providers’ employer for the purpose of ensuring the provision of services. ⑧

IHSS RECIPIENTS NOT RECEIVING SERVICES

Report:

Page 3, “From January 2015 through December 2019, the number of recipients statewide who lacked care grew from 33,000 to more than 40,000 on average each month…County administrators provided several reasons why a recipient would not receive services, including extended hospitalizations, the inability to hire a provider, and recipients moving to a new location and requiring a new provider.” ⑧

Page 3, “The number of recipients already exceeds the number of caregivers, and as that gap widens, it will likely increase the number of recipients who go without services.”

CDSS Response:

Calculating the number of recipients who did not receive needed in-home care each month by comparing paid hours versus authorized hours is not an accurate methodology for determining this. Recipients and providers are usually made eligible retroactively. Hours not claimed in a particular month can be claimed in a later month. Furthermore, there are providers who save their timesheets and claim all of their hours in December, causing paid hours to be over 100% of authorized hours in that month. Just because a timesheet was not submitted on time does not mean that a recipient didn't receive care. ⑨

CDSS would like to supply additional information regarding the reasons provided in the Report for why a recipient would not receive services for clarification. When an IHSS recipient is hospitalized, IHSS services are paused because it would be a duplication of services as the individual is not needing care in the home during that time period. Not receiving services through the IHSS program while a recipient is in the hospital does not mean that the individual wasn’t receiving needed services. It is the recipient’s ⑩

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responsibility as the employer to hire an IHSS provider. Hours can be claimed at a later date, so when hours are not claimed, it does not necessarily mean services were not received.

(11) Many providers that work for multiple recipients. The number of providers has always been lower than recipients. The total number of IHSS providers being lower than the total number of IHSS recipients does not indicate that recipients are going without services.

DATA REFERENCED

Report:

Data tables provided in appendices. Throughout the report, it refers to data derived from these tables.

CDSS Response & Questions:

(12) The source listed for Tables B.1, B.2, B.3, B.4, B.5 is, "Auditor analysis of Social Services' CMIPS II data." The columns in the data tables aren't defined and the source of the data used (fields and tables within CMIPS) is not clearly stated.

(12) It is unclear how CSA derived the following:

- The 18% of recipients who did not have familial status providers
- Number of "new recipients" in each table (it seems to differ)
- The calculation of "Average Days from Application to Approval"
- The calculation of "Average Days from Approval to First Day of Service"
- The Total number of recipients and providers in Table B5

The following issues have been identified with the data:

- (9) (13) It is unclear if the totals are averages or aggregates in the tables. This is problematic and doesn't provide a complete picture, particularly with authorized versus paid data, considering there are certain months of the year where providers submit timesheets they save. To truly get a picture of what is happening with recipients, and whether or not they are receiving their services, takes much more than authorized versus paid data.
- (14) The number of "new" recipients differs in Tables B.3 and B.4. To measure how long it takes for "new recipients" to get from application to authorization, and also measure how long it take them to get services, then averages are needed for the entire population. The number of "new recipients" in Table B.4 is different than the number of "new recipients" in Table B.3. There is nothing in the report that states Table B.4 is a subset of the data included in Table B.3.
- (14) In Table B.3 the 2019 Total Number of "new recipients" is 87,711. In Table B.4 is states the 2019 number is 11,143, with a footnote that states there was no data

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for 12,700. This leaves a discrepancy of 63,868 if the Total line is meant to be a total in Table B.4 and not an average. ⑮

- In Table B.5 the report states that in 2019 there was 701,548 recipients and 628,281 providers. These numbers are higher than the data CDSS has on both a monthly and yearly basis.
- If Table B.4 is an average, it is does not align with the average when the 2015 and 2019 data are compared. ⑯
- The total lines in each table do not seem to align. At first glance it seems as though the auditor is using a total in B.3 and B.5, and average in B.4, but the numbers are not correct. ⑰

CDSS compared the data provided in the tables for Alpine and Sierra counties to the number of applicants in CMIPS. The following was found:

- The number of applicants match the numbers included in Table B.3 for Alpine. However, when the data for each of the 4 cases were reviewed in the payroll system, all 4 cases authorized in 2019 have hours paid to the first date when services were authorized. Table B.4 states that there was 1 “new recipient” in Alpine in 2019 and it took 334 days to receive their first service. CDSS could find no recipient where that was the case. When paid hours were reviewed for all 4 cases, there was no recipient who didn’t have timesheet activity dating all the way back to the first pay period they were authorized services. Therefore, the data in Table B.4 is incorrect. ⑱
- In Table B.3 the report states there were 8 “new recipients” for Sierra. When CDSS reviewed the monthly data in CMIPS, there were 14 applicants in 2019 and of those 10 became eligible for services. Table B.4 states that there was only 1 “new recipient” and it took them 6 days to receive their first services. All cases had timesheet activity back to the first pay period their cases were authorized. Therefore, the data in Table B.4 is incorrect. ⑲
- Based on the data for just these two counties, it would seem the auditor’s premise that there is a delay between the time a recipient is approved and the day they receive their first services is false and that there is most likely more data issues. The data does not support that there was any delay in services a recipient received when there are timesheet records that claim time back to the first authorized pay period. The timesheet is the proof that the services were provided. It is also important to note that a recipient does not necessarily need to receive services from Day 1 of their authorization. Their services could have started on a Monday, but they scheduled their provider to start on Wednesday. This does not mean that a recipient didn’t receive the services that they needed on Monday and Tuesday; it could be that they didn’t need services those days. ⑳

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IHSS MAINTENANCE OF EFFORT (PROGRAM FUNDING, INCENTIVE TO NEGOTIATE WAGE INCREASES)

Report:

Page 27, "The State's decision in fiscal year 2012-13 to adjust the contribution each county pays toward the IHSS program by a set percentage—or inflation factor—each year rather than updating each county's contribution based on its proportion of the IHSS program's costs has resulted in some counties paying significantly more than their proportional share while others pay less. This approach has effectively increased the State's share of program costs and penalized counties whose programs did not expand as rapidly as others did."

Page 21, "The State's Funding Structure and Recent Shortfalls in County Funding Sources Create a Disincentive to Increase Caregiver Pay."

Maintenance of Effort (MOE) Background:

The 2012 funding structure was a part of the Coordinated Care Initiative (CCI) which contained a trigger that would end it if Department of Finance (DOF) determined that it was not at least cost neutral to the state. In January 2017, DOF made this determination and CCI ended. That legislation included language that if CCI ended the IHSS funding structure would return to the previous sharing ratios. When the trigger was pulled this would have shifted $600 million back to the counties based on the previous sharing methodology. At the time DOF made the decision, they also committed to working with the counties to mitigate this impact. Subsequent discussions between DOF and county representatives resulted in a continued MOE structure that began in FY 2017-18.

Under the 2017 County IHSS MOE, the counties' share of IHSS costs was reset to reflect the counties' share of estimated 2017-18 IHSS costs based on historical county cost-sharing levels. The 2017 County IHSS MOE increased annually by: (1) counties' share of costs from locally established wage, health benefit, or non-health benefit increases; and, (2) an annual inflation factor of zero to 7 percent based on 1991 Realignment revenues.

In January 2019, the Department of Finance (DOF) found that 1991 Realignment could no longer support county costs of IHSS in its Senate Bill 90: 1991 Realignment Report. As a result, Welfare and Institutions Code (WIC) sections 12306.1 and 12301.16 (SB 80, Chapter 27, Statutes of 2019) were enacted and the new County IHSS MOE became effective on July 1, 2019.

Changes to the County IHSS MOE included:

- Reduction of the County IHSS MOE base from $2.06 billion to $1.56 billion;

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- Allocation of state General Funds (GF) for IHSS County and PA administration with no county share up to the allocation amount and 100 percent county cost for the non-federal share of any expenditures above the allocation amount;
- Annual inflation factor of 4 percent beginning July 1, 2020 and annually thereafter;
- The non-federal sharing ratio will change for any locally established increase in wages or benefits on or after the state minimum wage reaches $15.00 per hour from 65 percent state and 35 percent county to 35 percent state and 65 percent county and the state participation cap is eliminated.

Incentives for Counties to Negotiate include:

- Wage Supplements - If a county negotiates a wage supplement, the County IHSS MOE shall include a one-time adjustment for the county share. Subsequent application of the wage supplement to the new state minimum wage will not adjust the County IHSS MOE.
- 10% option - For a county that is at or above the current state participation cap in combined wages and health benefits, the county may negotiate a contract for combined wages and benefits, and the state shall participate, splitting the cost of the non-federal share 65 percent state and 35 percent county, in a cumulative total of up to 10 percent of the sum of the combined total of changes in wages, health benefits, or both within a three-year period and upon request by the county.
- State Participation Cap - The state shall participate in a total of individual provider wages and health benefits up to one dollar and ten cents ($1.10) per hour above the state minimum wage until the state minimum wage reaches $15.00. Once the state minimum wage reaches $15.00, there will be no cap on state participation for approved locally negotiated increases in provider wages and individual health benefits

CDSS Response:

The MOE does not penalize certain counties or disincentivize counties to negotiate wage increases for IHSS providers. (21)

The 2019-20 base MOE is based on each county's expenditures. The annual inflation factor is to cover caseload growth (caseload growth exceeds the inflation factor, so the state picks up the difference). (22) Some counties are not paying significantly more than their proportional share due to the annual inflation factor because the MOE is based on each county's expenditures. (22) The items that would potentially create disparities among the counties is the way the offsets, 991 realignment funds and county and PA administration allocations were distributed. (22) The distribution for each of these items was negotiated by the California State Association of Counties (CSAC) and the DOF. CSAC negotiates, on behalf of the counties, how funding for the IHSS program should be

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(23) distributed; therefore, essentially, the counties have determined how the funding is split between themselves for MOE off-sets, realignment funding and IHSS County and PA admin.

Counties have always had a share in the costs of the program. Prior to the MOE, counties paid a percent of all program costs. With the implementation of the MOE, the only adjustments to the amount they pay is the annual inflation factor and a share of any locally bargained increase to wages and benefits. No counties were penalized. Most counties have paid less than they previously would have because the state has covered (24) minimum wage increases and has an increased share of cost via the 10% and wage supplement options. Counties negotiated above minimum wage in prior years because there was no legislation in place for the minimum wage increases that is in place now. Due to this, many counties have utilized the supplemental wage referenced above to continue to pay above the minimum wage with no additional cost to the county.

PREPARATION FOR THE FUTURE

Report:

Page 12, "Providing timely IHSS care may become more difficult, as the number of recipients is expected to increase dramatically over the next 10 years. Despite the pending increase, the counties and the State have not planned for this influx of older Californians needing care."

CDSS Response:

(25) The State is constantly planning and preparing for the future to ensure Californians receive needed services. Most recently the IHSS program and its future has been a primary topic of the Master Plan for Aging stakeholder committee that was established by executive order of the Governor. These conversations will continue as a part of ongoing planning.

PROGRAM BACKGROUND

Report & CDSS Response:

Page 7, "IHSS provides services based upon the needs of each recipient, which may include bathing, bowel and bladder care, feeding, and accompaniment to health-related appointments."

(26) Domestic and related services should be mentioned here as the majority of IHSS recipients receive those services.

Page 7, "State law allows up to 195 hours per month of care, or 283 hours of services each month for severely impaired individuals."

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The statutory maximum is 283 hours. The statutory maximum is 283 hours. However, the maximum number of hours a recipient can receive varies depending on whether they are severely impaired of non-severely impaired, and which Medi-Cal program funds their services. (See WIC §§12303.4, 14132.95, 14132.952 and 14132.956.)

RESPONSE FOLLOW UP

Questions or requests for clarification regarding the information in this letter should be directed to Debbie Richardson, Chief, Office of Audit Services at Debbie.Richardson@dss.ca.gov.

Sincerely,

KIM JOHNSON
Director

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

To provide clarity and perspective, we are commenting on the response to our audit report from the California Department of Social Services (Social Services). The numbers below correspond with the numbers we have placed in the margin of its response.

① The "For example:" in Social Services' response appears to be an error. Our recommendation does not include an example.

② Social Services cannot simply repeal its regulations and thereby eliminate counties' and its responsibilities related to annual plans. State law requires counties to submit annual plans. Specifically, Welfare and Institutions code §12302 states that each county is obliged to ensure that services are provided to all eligible recipients during each month of the year in accordance with the county plan. Moreover, state law requires Social Services to review such plans for compliance with certain other requirements.

③ Although Social Services has failed for decades to comply with state law intended to ensure that counties conduct appropriate planning for people dependent on the IHSS program, the need for such planning is not outdated. As we note on page 12, as of 2019, more than 40,000 recipients on average did not receive in home care each month. Further, as indicated on page 12, 32 of the 51 counties responding to our survey stated that they lacked a sufficient number of caregivers to provide all approved services to each IHSS recipient. Additionally, other county level planning to ensure IHSS care is provided to all recipients is not occurring. For example, of the counties we surveyed only two indicated that they performed any analysis to identify the number of caregivers needed currently or in the future. Similarly, only four counties indicated that they had created a plan to account for future growth in the number of IHSS recipients. Clearly, the need for planning persists.

④ Social Services is using recipients' responsibilities under the IHSS program as an excuse for it to not hold counties accountable for their responsibilities. In particular, although state law allows recipients to hire their caregivers, as we note on page 16, it also requires counties to conduct planning necessary to ensure care is provided. Further, counties can take a variety of measures to ensure that recipients receive care. For example, three of the four counties we reviewed indicated that they would arrange short-term care for recipients through contracted local providers when necessary.

⑤ Social Services decision to repeal its longstanding regulation requiring counties to ensure IHSS recipients receive care within 15 days of approval is concerning. As we discuss beginning on page 15, the majority of recipients enter the IHSS program with a caregiver. However, during the period we reviewed nearly 58,000 did not. On average these recipients wait over 100 days after their approval to receive services. Delays of this magnitude put Californians who qualify for in home care at risk.

⑥ Social Services decision to change its 30-day IHSS application processing requirement to longer than that timeframe is disappointing, particularly given that in 2019 no counties in California met the current requirement, instead taking 72 days on average. We believe Social Services' decision to increase the processing time requirement does not demonstrate appropriate urgency in providing care for Californians.

⑦ Although Social Services has established quality assurance and program integrity units, they have failed to monitor compliance with state law related to county planning, application processing, and the legal requirement that counties ensure care is provided to recipients within 15 days of approval. Similarly, on page 16 we note that Social Services advised us that it does not track compliance with its regulations related to the time between approval and care for recipients.

⑧ We informed Social Services prior to it submitting its response to our draft report that we had already clarified text on page 6 regarding this point.

⑨ We accounted for the timing of timesheet submission by care providers in our analysis. We understand that providers may delay submitting timesheets which show when authorized services were provided; thus we included all timesheet data that providers submitted to Social Services for payment through June 2020. However, we limited our analysis to the services which would have been rendered through December 2019. Thus, providers had at least six months to submit their timesheets before we received the data for analysis. We believe this is a reasonable time period to expect that the majority of providers would submit their timesheets for payment, particularly since Social Services' data experts asserted that around 90 percent of all timesheets are completed within 10 days of the timesheet period.

⑩ Social Services' response is misleading. On page 12 we note that more than 40,000 IHSS recipients, on average, per month in 2019 did not receive monthly IHSS care. As we indicate on page 12, County administrators detailed several reasons a recipient might not receive monthly care. Some are troubling, such as the inability

to hire a caregiver, or delays in obtaining a new caregiver after moving. Others such as hospitalizations may be unavoidable. As such we simply note that gaps in care can represent periods of increased risk of injury or other hardships for IHSS's elderly and disabled beneficiaries. We note that Social Services did not dispute that gaps in care can result in increased risks to recipients generally.

⑪ Social Services is correct to point out that many caregivers serve multiple recipients. However, its response fails to acknowledge two critical points. As we note on page 16, expected rapid growth in the number of recipients will likely place increased strain on the IHSS program in the near future. Further, as we note on page 17, this period of rapid growth, which we estimate could result in a 52 percent increase in recipients, coincides with a period where family members will be less available to provide care due to changing demographics. Further, 32 counties responding to our survey have already indicated they lack a sufficient number of caregivers to provide all approved services to each IHSS recipient.

⑫ It is not our practice to include the detailed steps we take in performing our analysis in the report. However, we worked with Social Services to understand the available data. Social Services referred us to its contracted data experts when we had specific questions related to the system and specific data elements. We worked closely with the contractor and Social Services throughout the audit as we developed our methodology and performed our analysis. Additionally, we shared the results of our analysis with the four counties we reviewed and they did not question the validity of the results.

⑬ We stand by our analysis. To address this issue and provide additional clarity on our methodology, we included further context for the totals of the tables in Appendix B, beginning on page 39.

⑭ As we state in the title and footnote for Table B.4 on page 45, the table only includes recipients who began receiving IHSS services after the county approved their case. Further as the title indicates, Table B.3 relates to all new recipients.

⑮ Social Services did not explain how it calculated the numbers in its response. Our analysis on Table B.5 on page 47 contains the number of caregivers and recipients who either provided or received IHSS care at any point in calendar years 2015 and 2019. We worked closely with Social Services and their contracted data experts throughout the audit as we developed our methodology and performed our analysis.

⑯ Social Services' concern is unclear. Each table in Appendix B stands on its own and covers the information presented in the title.

(17) The totals in all the tables in Appendix B are correct. However, to provide additional clarity, we included further context for the totals of the tables in Appendix B beginning on page 39.

(18) We worked with Social Services to investigate the Alpine case. The research that Social Services conducted in February 2021 showed that the recipient's providers turned in their timesheets after we obtained the data. As discussed in the Scope and Methodology, Social Services furnished us with a copy of its program data in June 2020. It is reasonable that current data may differ from the June 2020 copy of the data we received and analyzed.

(19) The data that Social Services used to draw its conclusions were more current than what we analyzed. Additionally, while these timing issues may affect a limited number of cases, we stand by our analysis and it is unreasonable to discount an entire table that shows more than 11,000 individuals who were approved for care during 2019 but had not received care by June 2020.

(20) We stand by our analysis. While there may be a limited number of issues with the timing of when services were reported to Social Services, there is sufficient evidence in total to support our conclusion that there is a delay in providing services for a large number of new recipients.

(21) Any county that negotiated a caregiver wage increase before the wage supplement law went into effect in 2017, or which could not take advantage of that law after 2017, is paying an ongoing increase to their county contribution. Such counties will continue to pay more for those wage increases even after the state minimum wage catches up. We provide an example of the fiscal impact of this state law on page 22.

(22) Social Services is incorrect. According to the methodology developed by the California State Association of Counties, the fiscal year 2019–20 county contribution amounts are based on the prior fiscal year's contribution, with adjustments for any locally negotiated wage increases, and a 2 percent reduction per county. As of January 2021 Social Services had not yet published the final fiscal year 2019–20 county contribution amounts. Further, as we indicate on pages 8 and 27, county contributions are based largely on fiscal year 2011–12 county costs, as adjusted for locally negotiated wage increases, and an inflation factor. This does not result in county contributions based on their actual expenditures. Instead, some counties pay more than their proportional share because their IHSS costs grew more slowly than the inflation factor, while others pay less than their share because their costs grew more quickly than the inflation factor.

In 2017 the offsets and adjustments which Social Services describes amounted to less than $200 million of the $1.4 billion in county contributions for fiscal year 2017–18. The remaining $1.2 billion was based on the State's prior methodology.

(23)

Social Services provides no evidence for its assertion that counties negotiated wages higher than the state minimum in prior years because of a lack of legislation for increases to the minimum wage. If a county's IHSS caregiver wages are above minimum wage, it was because that county and its IHSS caregivers agreed during collective bargaining that the caregivers should be paid a wage that was above the minimum wage. Moreover, if Social Services assertion was correct, we would not have expected to see the reduced number of counties paying above minimum wage as shown in Figure 4 on page 24.

(24)

Our remarks, which we have clarified, referenced failures by the counties and Social Services to complete mandatory IHSS county plans for decades. However, our review of The Master Plan for Aging, signed by the Governor and issued in January 2021, indicates that the State acknowledges the need to explore options to increase the stability of IHSS beneficiaries through backup provider systems and registries. Such planning is in line with our recommendations to Social Services on page 25, which includes requiring counties to complete and expand their mandatory planning to include items such as long-range projections and strategies.

(25)

The examples provided are intended to give readers an understanding of the services provided by the IHSS program and are not meant to be exhaustive.

(26)

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Employment and Social Services

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February 2, 2021

Ms. Elaine Howle
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for your review and recommendations to improve the In-Home Supportive Services (IHSS) Program in Butte County. The *In-Home Supportive Services Program: It is not providing needed services to all Californians approved for the program, is unprepared for future challenges, and offers low pay to caregivers* (Audit 2020-109) audit report takes a constructive look at the IHSS program which helps individuals remain in their homes and prevent more costly institutionalization.

The Department of Employment and Social Services (DESS) is proud to be a partner in the service of its IHSS recipients and providers with our State oversight agency, the California Department of Social Services (CDSS), our County oversight body, the Butte County Board of Supervisors, and the California State Auditor. We strive to provide the highest caliber of services along with other County departments and community partners.

DESS generally agrees with the finding and recommendation of the audit report. Our comments on the specific item are enclosed. We appreciate the collaborative manner in which your staff conducted the work leading to this report. We welcome the opportunity to examine our practices and implement the change as prescribed by the California State Auditor. If you have any additional questions, I can be reached at (530) 538-7891.

Sincerely,

Shelby Boston, MSW
Director

Chapter 1

State law requires that each county develop an annual county plan that specifies the means by which it will provide IHSS services and submit that plan to Social Services for review and, when appropriate, approval. (Page 12)

RECOMMENDATION

To help ensure that recipients at each county receive prompt approval for services and receive all approved services. Butte should by August 2021 and annually thereafter, complete required plans that include, at minimum, specific provisions for how [the] county will ensure prompt approval of services and that recipients promptly receive the approved services.

The California Department of Social Services (CDSS) is the oversite agency for Butte County Department of Employment and Social Services. CDSS issues All County letters (ACLs) and All County Information Notices (ACINs) to inform counties of the implementation requirements of regulations and policies. DESS is not in receipt of any directives from CDSS in the form of an ACL or ACIN that requires county IHSS programs to provide an annual county plan.

When or if these directives are received, Butte County will comply with any and all directives from CDSS including but not limited to a County plan.

Lito Morillo – Director
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(661) 868-1000; (661) 868-1001 FAX

February 1, 2021

Elaine Howle, CPA
California State Auditor
621 Capitol Mall Ste. 1200
Sacramento, CA 95814

Dear Ms. Howle:

We appreciate you and your team's effort in evaluating the In Home Supportive Services (IHSS) program in its entirety. Kern County Aging and Adult Services Department (KCAASD) has reviewed the draft report on its IHSS program and this letter serves as our written response to the draft report.

In reviewing the report, KCAASD agrees that the IHSS program will continue to grow in number of IHSS recipients as well as care providers. The report outlines California seniors will increase from 6 million in 2019 to 8.5 million by 2030. For Kern, this growth began prior to 2019. This growth is reflected in the increase in Kern's IHSS caseload which the report states increased over 100% over the last five years.

The report identifies that the number of recipients who lacked services increased from 296 to 923. As the report states, there are varying reasons as to why recipients do not receive services ranging from hospitalization to not finding a care provider they like. We have recently put a measure in place that will follow up with IHSS clients not using the services to ensure that they maximize the services that were approved and authorized for them.

As it relates to new applications, the report states it took Kern an average of 83 days to approve applications. Although Kern is unsure how the 83 days was arrived at, we will continue to evaluate our intake process to determine inefficiencies. Kern will also continue to look at staffing ratios, reallocation of staff, and operational work flow to streamline the number of days to approve applications.

Using a Massachusetts Institute of Technology (MIT) living wage model, the report states that Kern's living wage is $18.84, and IHSS caregivers earn minimum wage. The gap between the living wage and minimum wage is a disparity that exist in each county, and will continue to be an issue depending on the fiscal challenges each county faces. Unfortunately, this issue is prevalent in other occupations and industries throughout the state.

We continuously work with IHSS care providers in collaboration with the United Domestic Workers (UDW) union. In 2015-2016, Kern offered and provided classroom training to IHSS care providers, but without additional fiscal incentive, IHSS care provider participation in those classes were very low. As an alternative resource for training, KCAASD's website has various videos on caregiving classes, as well as resources for other classes offered in the community that are designed to support and assist a caregiver. Recently, we have partnered with the UDW in the distribution of Personal Protective Equipment (PPEs). Kern understands and agrees with the need to recruit additional non family care providers and will work towards additional outreach and other opportunities to increase available care providers in general. This includes evaluating other county's best practices in this area for potential implementation in Kern.

The report states that Kern received a proportionally greater state subsidy. Kern's county contribution, as stated in the report, has increased every year from $7.46 million in 2012 to $11.16 million in 2019. It is also important to emphasize the growth of Kern's IHSS program, as stated earlier, has dramatically increased by over 100% which impacts the overall cost. While the growth and cost of the program increased, Kern's administrative costs remained at 7% of the program cost in FY 18-19.

Kern's IHSS program is audited and evaluated annually by the California Department of Social Services (CDSS). Although there have been no significant findings, we continually look for opportunities to improve the program and services to our clients and care providers. This includes looking for efficiencies within our operations to provide services in a more efficient and effective manner. As the program continues to grow, Kern will strive to enhance and improve its operations for IHSS clients and care providers and report our plans and outcomes to CDSS. Thank you for the opportunity to allow us to respond. If you have any questions, please contact me at (661) 868-1052.

Sincerely,

Lito Morillo
Director

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

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DEAN ARABATZIS
CHIEF OPERATIONS OFFICER

February 2, 2021

Elaine M. Howle
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Re: California State Audit No. 20-109

Dear Ms. Howle:

The County of San Diego ("County") has reviewed a draft of California State Audit No. 20-109. We are pleased that the California State Auditor highlighted some of the many services provided by the County to enhance the In-Home Supportive Services ("IHSS") program. Specifically we appreciate your recognition of: the County's program to render care when a recipient's regular caregiver is ill or temporarily unavailable; the County's building better health plan to improve the health of our elderly population; the County's self-imposed goal to complete IHSS assessments within 45 days; and the County's voluntary 18-hour advanced training course for IHSS caregivers.

The County values the importance of the IHSS program to our community and welcomes the opportunity to further improve our program whenever possible.

Enclosed please find the response to the sole recommendation directed towards San Diego County.

Sincerely,

DEAN ARABATZIS
Acting Agency Director

CALIFORNIA STATE AUDIT NO. 20-109
SAN DIEGO COUNTY RESPONSE

RECOMMENDATION:
"San Diego … should, by August 2021 and annually thereafter, complete required plans that include, at minimum, specific provisions for how [the] county will ensure prompt approval of services and that recipients promptly receive the approved services."

RESPONSE:
The California Department of Social Services (CDSS) has communicated a performance standard of approving applications within 90 days.[1] This year, the County of San Diego ("County") has processed 99.2% of applications within this timeframe—exceeding the statewide average of 92.2%. San Diego's approval process includes the following efficiencies:

- Assign applications to a social worker within one business day of receipt.
- Assign applications with a pending Medi-Cal determination to a specialized social worker to track and monitor for Medi-Cal approval; and once approved by Medi-Cal, complete the initial assessment.
- To further reduce wait times, social workers schedule and complete initial assessments promptly and do not wait for a completed SOC 873 *Health Care Certification* from the applicant's physician. If the applicant's physician is not timely in sending the SOC 823, the social worker will communicate directly with the physician to resolve the delay and will utilize a Public Health Nurse if needed to assist with complex medical situations.
- Social workers will evaluate for the need exception to a SOC 873 to further reduce wait times.
- Provide supervisors with monthly and cumulative reports on pending applications to track efficiency.
- If overflow exists for a particular office, implement mitigation plans that may include the reassignment of assessments to other regional offices to expedite pending applications.

The County believes that just meeting, or even exceeding these standards, is not enough—we must always look for ways to improve.

Although this audit discusses a required annual county plan, our understanding is that CDSS does not currently require county plans.[2] However, the County understands the intent of this recommendation. The County will collaborate with CDSS to ensure that they have all necessary documentation regarding the specific actions the County takes to ensure prompt approval, and receipt, of services.

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[1] We note that the CDSS Manual of Policies and Procedures still reflects the decades old standard of 30 days, which was not formally changed following the imposition of additional legal requirements for applications.

[2] See *In-Home Supportive Services: Past, Present, and Future*, California Welfare Directors Association, January 2003, ("Consistent with all public entitlement programs, IHSS provides applicants certain rights - timely decision of eligibility, timely notice of change in eligibility or service, and an appeals process to dispute eligibility decisions. California Welfare and Institutions Code Section 12302 states, 'Each county is obligated to ensure that services are provided to all eligible consumers during each month of the year in accordance with the county plan...' <u>While the state no longer requires counties to submit an annual plan, the obligations remain</u>."(Emphasis added.))

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February 1, 2021

Elaine Howle
C/O Nick Phelps, Team Leader
CALIFORNIA STATE AUDITOR
621 Capitol Mall, Ste 1200
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Re: State Auditors' Draft Report and Certificate of Compliance

Dear Elaine Howle,

I am in receipt of the draft report titled, "In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers" which you provided to me via email on January 27, 2021, at 1:37 p.m. Our authorized recipients have reviewed the contents and note that there is only one recommendation in the Draft addressed to the County of Stanislaus. We have no objection to the single recommendation and have no other comment on the remainder of the document. If you have any questions you may contact me at the number above.

There will be an attachment, I think titled, "Certification of Compliance With Government Code sections 8545 and 8545.l(b)(2)".

Sincerely,

Thomas E. Boze
County Counsel

TEB/jw
Attachment

STRIVING TOGETHER TO BE THE BEST!