

In-Home Supportive Services: *Characteristics, Cost Drivers and Cost Containment Strategies*

A Report Commissioned by:
The Southern Area Consortium of Human Services (SACHS)

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EXECUTIVE SUMMARY

BACKGROUND

The purpose of this study, commissioned by the Southern Area Consortium of Human Services (SACHS), was to research and report on the following In-Home Supportive Services (IHSS) issues identified by SACHS directors at the February 2004 meeting:

- ▶ Program characteristics
- ▶ Assessment process
- ▶ Quality control issues
- ▶ Cost drivers
- ▶ Cost control strategies

METHOD

Methodology included a literature review, interviews and consultation with several key informants, and a survey that was disseminated to all SACHS counties. The survey captured demographic data, IHSS recipient, provider and caseload characteristics, as well as perceived cost drivers.

SUMMARY OF FINDINGS

- ▶ Notable variations were reported across SACHS counties in the following areas:
 - Ethnicity of IHSS recipients (see [Figure 2](#), page 6)
 - Percentage of relative (verses non-relative) caregivers ranged from 29% to 81% (see [Figure 7](#), page 10)
 - Provider wage ranged from \$6.75 to \$8.50 (see [Table 6](#), page 11)
 - Average number of cases per worker ranged from 205 to 355 (see [Table 11](#), page 12)
 - Percent caseload growth from 2000 to present ranged from 26% to 85% (see [Figure 8](#), page 13)

“IHSS is widely perceived as a cost-effective and a model program.” (per several key informants)

- Average monthly paid hours per case ranged from 67 to 87 (see [Figure 10](#), page 15)
 - Average monthly cost per case ranged from \$542 to \$776 (see [Figure 11](#), page 15)
 - Hours of IHSS eligibility and regulations training ranged from 8 to 60 (see [Table 13](#), page 17)
- ▶ Major cost drivers are: entitlement status and caseload growth; consumer-driven; mode of service delivery; increased wages and benefits; and variations in assessments;
 - ▶ Cost control strategies include elimination of contract mode; simplification of assessment tool; utilization of “hours predictor;” provision of consistent training; and moving eligible recipients to Personal Care Services Program (PCSP) program.
 - ▶ Promising practices include increased use of assistive devices; piloting new assessment forms; utilizing nurses to assist with assessment; cash and counseling programs; waivers to limit per diem costs; providers undergo criminal background investigations.

NEXT STEPS

SACHS staff will review report findings and facilitate discussion on the below topics with directors and designated Adult Services staff at the May 2004 SACHS meeting on:

- ▶ Long-term cost-containment planning;
- ▶ Uniform assessment training;
- ▶ Use of nurses during assessment process;
- ▶ Increased use of assistive technology devices;
- ▶ Joint MediCal/IHSS fraud investigations;
- ▶ Criminal background checks for providers; and
- ▶ Prioritizing services for the “nursing home” eligible population.

Special thanks to SACHS Directors, Adult Services Directors, IHSS Program Managers, and key informants for their input and consultation.

A full copy of this report can be downloaded at:
http://pcwta.sdsu.edu/sachs_research.html

I. PROJECT AIMS

In-Home Supportive Services (IHSS) caseload growth has been a “hot topic” for Southern Area Consortium of Human Services (SACHS) directors and is the featured discussion item at the May 2004 meeting. In March 2003, SACHS staff presented a descriptive report entitled “Factors Contributing to IHSS Caseload Growth: Perspectives from SACHS Counties.” At the February 2004 meeting directors asked SACHS staff to study and report on the following issues at the May meeting:

- ▶ Program characteristics
- ▶ Assessment process
- ▶ Quality control issues
- ▶ Cost drivers
- ▶ Cost control strategies

In addition, staff were asked to conduct a literature review and survey SACHS counties to identify number of hours assessed, caseload and provider data as well as relevant demographic information. Finally, directors asked staff to identify a speaker who would address IHSS issues at the May 2004 SACHS meeting. This report will present findings, common themes and recommendations.

II. BACKGROUND

Over the past ten years the IHSS program has experienced numerous changes such as implementation of Public Authority/registry; increased labor union involvement; split between personal care services and homemaker services; and various lawsuits. Additionally, caseload growth has increased dramatically. According to a recent California State Association of Counties (CSAC) article, “as caseload growth in realigned programs and realignment dollars fail to keep pace, counties have less money to fund the mandated entitlement programs.” (CSAC, 2002) Counties are increasingly concerned that IHSS program costs are consuming dollars meant for other realignment programs.

Governor's Budget Proposal

The Governor's budget proposes to: (Note: this may change with May Revise)

- ▶ Reduce total funding by \$495 million;
- ▶ Eliminate Residual Program (supportive services provided by spouse or parent to "domestic service only," protective supervision and advance pay cases);
- ▶ Reduce state participation in wages to the minimum wage beginning October 1, 2004;
- ▶ Remove mandates for IHSS Advisory Committee, Public Authorities and County Employer of Record; and
- ▶ Eliminate provision of domestic services if recipients live with family members and the service is shared in common. (CDSS, January 2004)

UPDATES:

- ▶ The state has applied for a federal Medicaid waiver for the Residual Program to be called "IHSS Plus." CWDA has written a letter of support. The assumption is that the Feds have indicated they are willing to approve it.
- ▶ On April 28 the Assembly Budget Subcommittee rejected the proposed reductions of state participation in wages, and making employer of record and advisory committee optional (and has restored funding). (Personal Communication, I. Harita, April 30, 2004)

The following presents an estimate of the impact of the proposed Residual Program elimination. This is based on an analysis of current Residual recipients who are not eligible for federal reimbursement through Medicaid: (Legislative Analyst's Office, February 2004)

Type of Case	Estimated Caseload ^a 2004-05	Percent of Total	
		Cases ^b	Expenditures
Receives advance pay	837	1.1%	3.8%
No personal care services (domestic services only)	29,175	38.9	20.4
Responsible relative provider (spouse or parent)	18,042	24.1	25.5
Protective supervision	14,516	19.4	23.4
Unknown	12,424	16.6	27.0
Totals	74,995	100.0%	100.0%

^a Based on percentages from September 2001 Department of Social Services (DSS) data applied to the caseload for 2004-05.

^b Based on DSS September 2001 special data report.

The LAO notes that the budget assumes that the “approximately 18,000 recipients would choose a non-relative provider and retain eligibility. The remaining 57,000 cases will become ineligible for IHSS.” (Legislative Analyst’s Office, February 2004)

Eliminating the IHSS Residual Program affects children with the most severe disabilities who are risk of institutionalization and spouses who need personal care and are at risk of institutionalization. Virtually all would qualify for MediCal funded long-term care. (Protection & Advocacy, Inc., December 2003) County costs could soar if recipients are forced into institutions as costs associated with institutionalization are estimated to be three to five times higher than costs associated with IHSS (Wormeli & Yamada, 2004). If the Residual Program is eliminated, some recipients may be able to shift to the Personal Care Services Program (PCSP), however they may be unable to locate providers due to the general shortage, possible drop in wages, and loss of registry. (Harrington & Newcomer, 2004).

Many politicians and program administrators in other states strongly oppose the policy option of paying family members to provide services because they believe that the traditional ethic of “family responsibility” requires family members to provide these services free of charge. (Doty, Benjamin, Matthias, & Franke, April 1999). However, advocacy groups for the aged, children and the disabled note the discomfort associated with possible disruption in services and having someone other than a parent/spouse assisting with intimate needs (Protection & Advocacy, Inc., December 2003).

III. METHOD

Literature Review. Staff reviewed approximately 50 sources using key words such as In-Home Supportive Services, In-Home Care, Homemaker Services, Personal Care Services, Home Health Care, etc. While there is a paucity of academic literature on In-Home Supportive Services, there were many governmental studies and anecdotal reports. Most of the studies support a “consumer-directed” model rather than a “medical” or “professional management” model for service provision. The literature provided some insights into controlling costs (see section IV below and bibliography in Appendix A).

Key Informant Interviews. Staff interviewed the following persons:

- ▶ Carole Barnes, Ph.D., Director, Institute for Social Research, California State University, Sacramento
- ▶ Joan Boomer, Section Manager, IHSS, San Francisco Human Services Agency
- ▶ Pamela Doty, Ph.D., Senior Policy Analyst, Office of Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services
- ▶ Susan Era, Adult Services Deputy Director, Mendocino County Department of Social Services
- ▶ Eldon Luce, IHSS Manager and Public Authority Manager, Placer County Health & Human Services Department.
- ▶ Ingrid Harita, Director of Adult Services and Assistance Programs, Orange County Social Services Agency
- ▶ Ellen Schmeding, IHSS Chief, San Diego County Health and Human Services Agency

Survey. Staff surveyed SACHS county IHSS program staff to collect information on the characteristics of IHSS recipients, and providers, and caseloads, as well as perceived cost drivers. (See Appendix B)

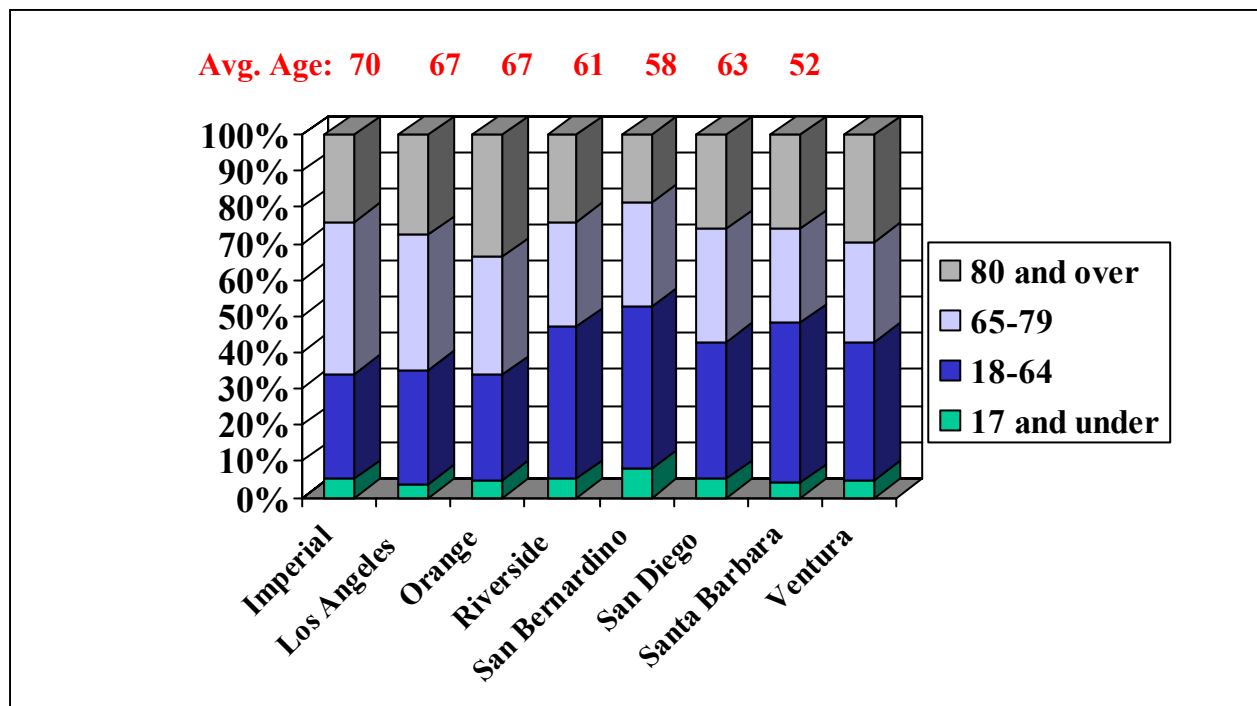
IV. FINDINGS

SURVEY RESULTS

Recipient Characteristics

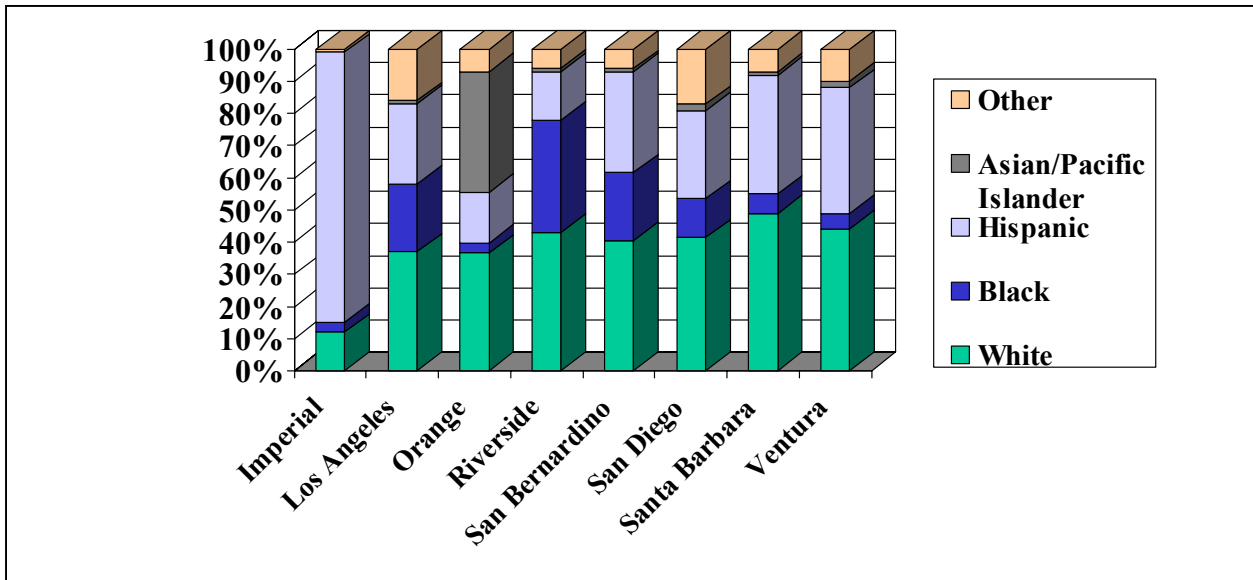
► Age

Figure 1.
Age of IHSS Recipients



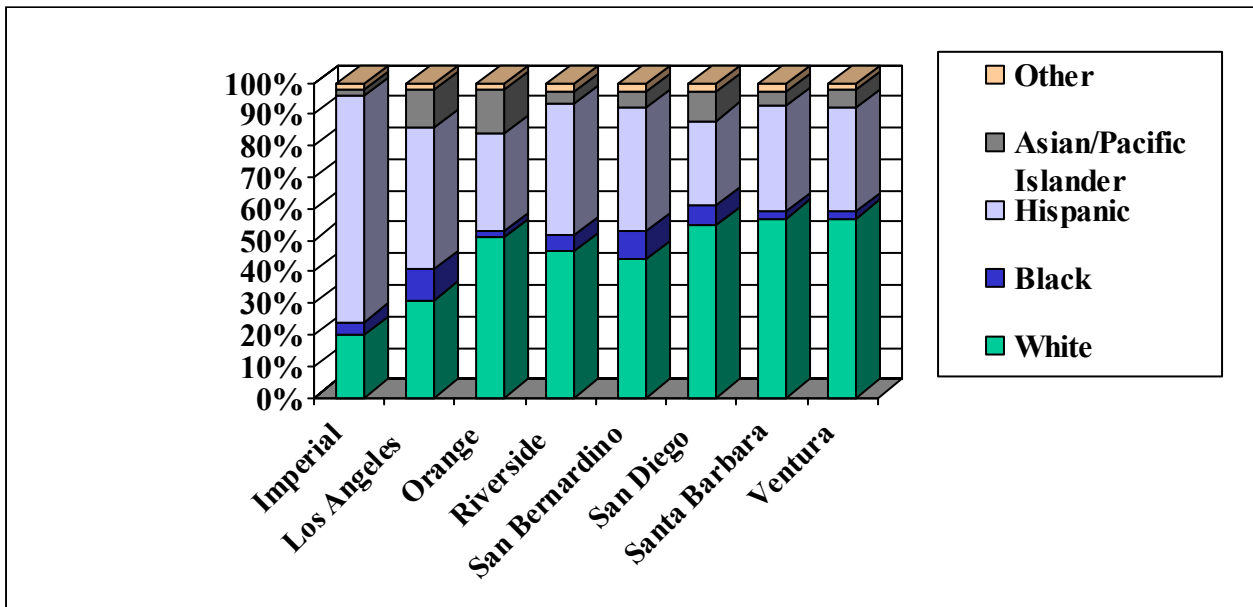
► Ethnicity

Figure 2.
Ethnicity of IHSS Recipients



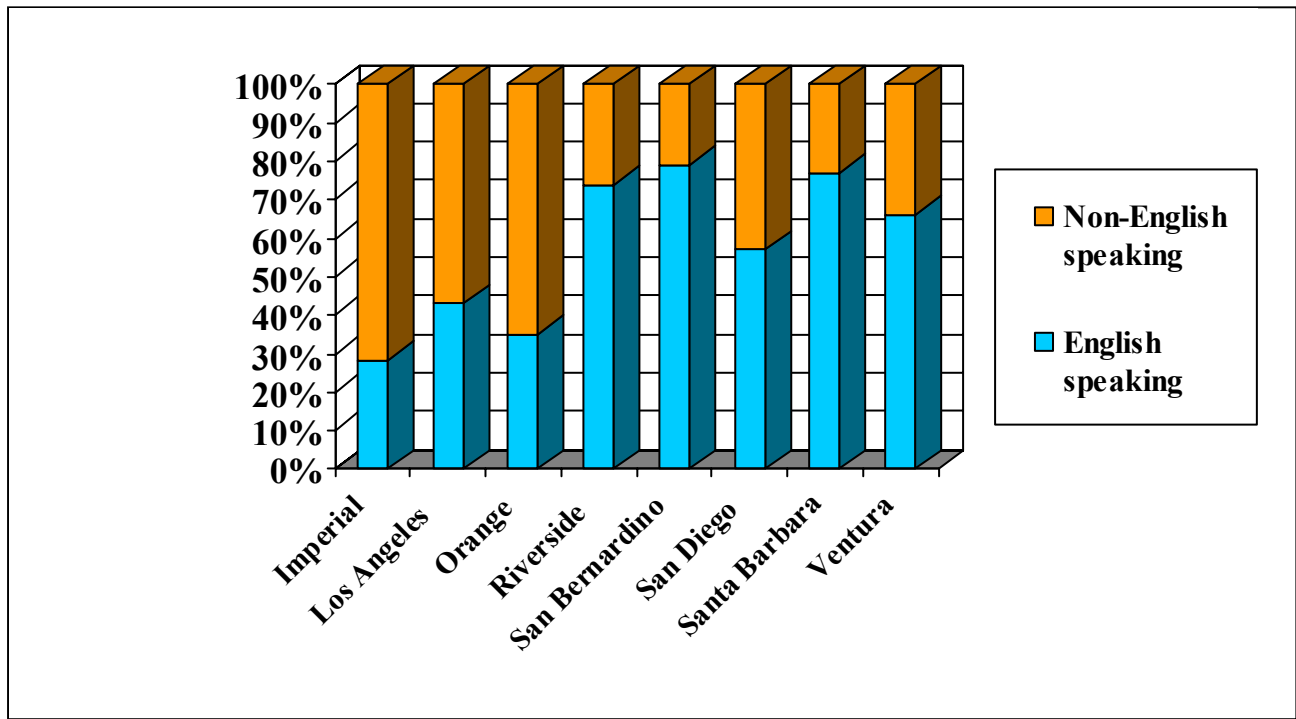
For comparison purposes, the following figure presents ethnicity breakdowns for the county populations for SACHS Counties.

Figure 3.
Ethnicity of Entire County Population



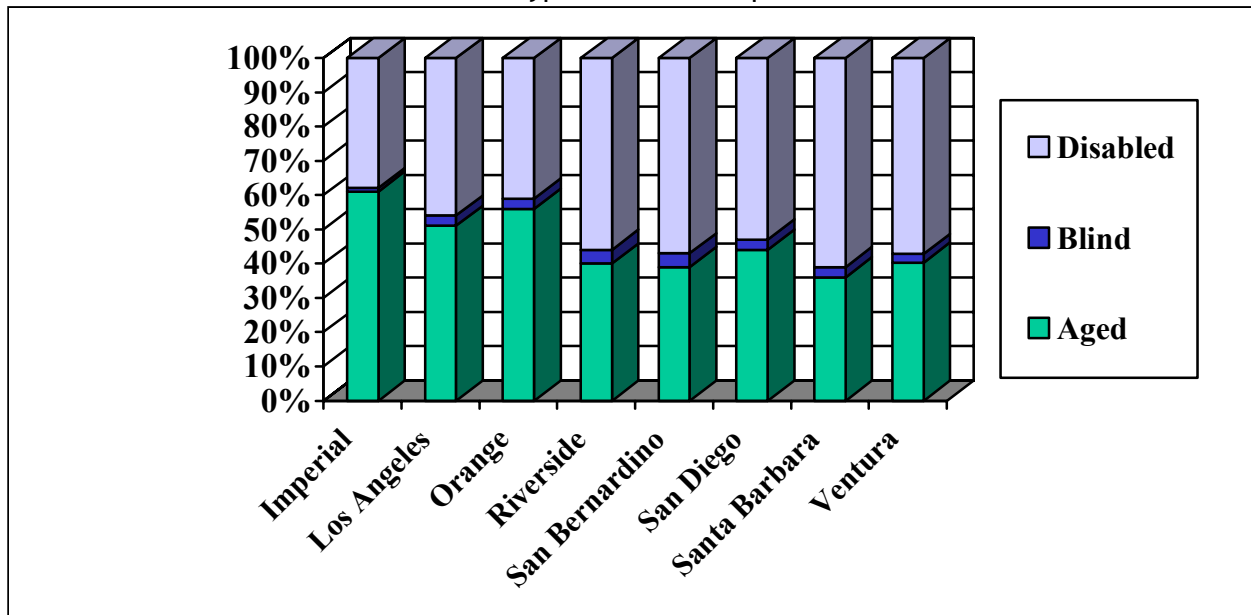
► *Language Spoken*

Figure 4.
Language Spoken by IHSS Recipients



► *Aid Type*

Figure 5.
Aid Type for IHSS Recipients



► *Impairment*

Table 2.
Impairment Type for IHSS Recipients

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Severely Impaired	20%	19%	15%	29%	24%	19%	21%	26%
Non-Severely Impaired	80%	81%	85%	71%	76%	81%	79%	74%
Total	100%	100%	100%	100%	100%	100%	100%	100%

► *Share of Cost*

Table 3.
Share of Cost for IHSS Recipients

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Share of Cost	3%	6%	1%	10%	4%	15%	12%	3%
No Share of Cost	97%	94%	99%	90%	97%	85%	88%	97%
Total	100%	100%	100%	100%	101%*	100%	100%	100%

*Figure exceeds 100% due to rounding error

► *IHSS Recipients on MediCal who are SSI*

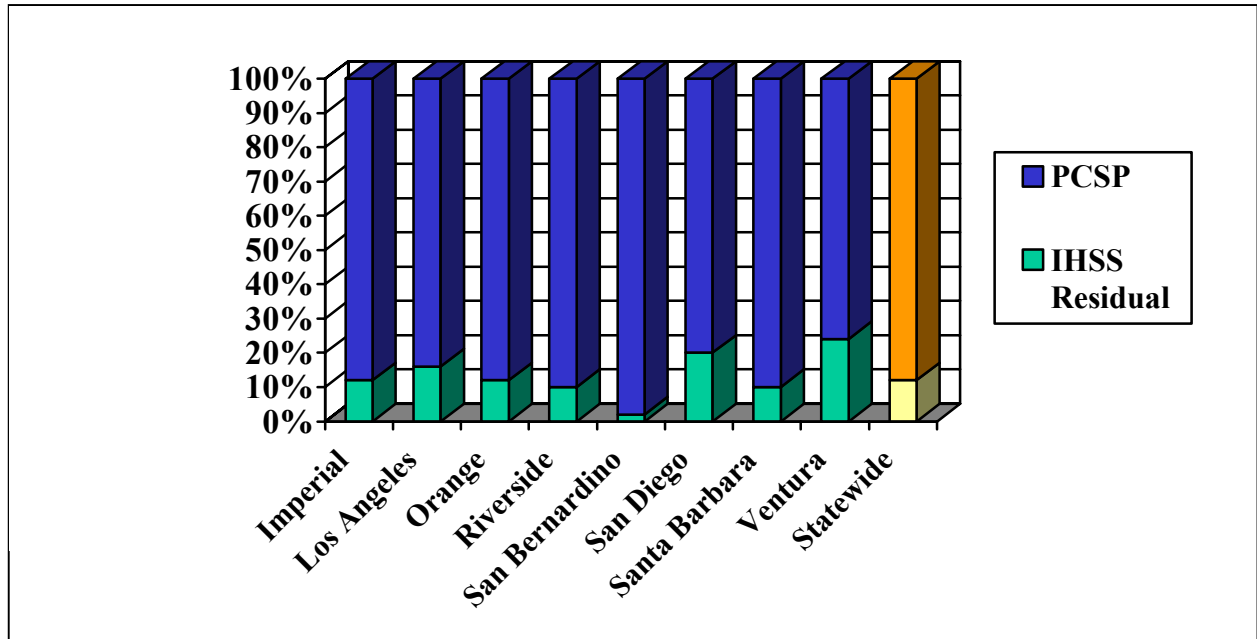
Table 4.
IHSS Recipients on MediCal who are SSI

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
On MediCal who are SSI	81%	90%	91%	78%	80%	92%	78%	78%

► Authorized Cases by Personal Care Services Program (PCSP) or Residual Program

Figure 6.

Authorized Cases by PCSP or Residual Program



Provider Characteristics

► Provider Mode

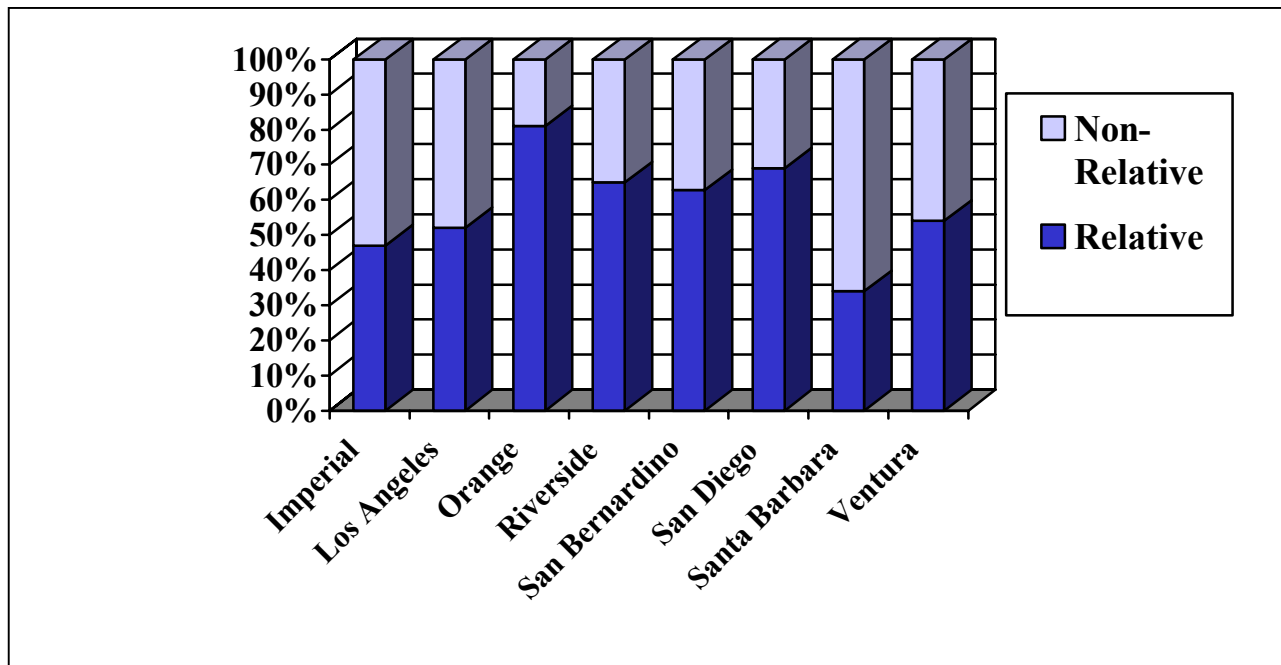
Table 5.
Provider Mode

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Individual Provider	100%	100%	100%	82%	100%	88%	80%	100%
Contract Provider	--	--	--	18%	--	12%	20%	--
Total	100%	100%	100%	100%	100%	100%	100%	100%

► Individual Providers by Relative/Non-Relative Status

Figure 7.

Individual Providers by Relative/Non-Relative Status



► *Provider Wage*

Table 6.
Provider Wage

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Provider Wage (per hour)	\$6.75	\$7.50	\$8.00	\$8.00 \$8.50 effective 7/1/04	\$8.50	\$8.50	\$8.00	\$7.11

State average is \$8.10 per hour.

► *Provider Health Care Benefits*

Table 7.
Provider Health Care Benefits

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Yes (63%)		X	X	X		X	X	
No (37%)	X				X			X
When		4/02	1/04	3/04			FY04/05	

► *Public Authority*

Table 8.
Implementation of Public Authority

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Yes (100%)	X	X	X	X	X	X	X	X
When	1/03	10/97	2/03	7/02	1/02	7/01	1/03	12/02

Caseload Characteristics

► *Number of IHSS Recipients*

Table 9.
Number of IHSS Recipients

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Number of Recipients	3,897	136,001	10,336	11,748	14,762	19,611	2,270	2,679

► *Number of Monthly IHSS Applications*

Table 10.
Number of Monthly IHSS Applications

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
# of Monthly Applications	150	4,036	604	424	911	833	138	123

► *Average Number of Cases per Worker*

Table 11.
Average Number of Cases per Worker

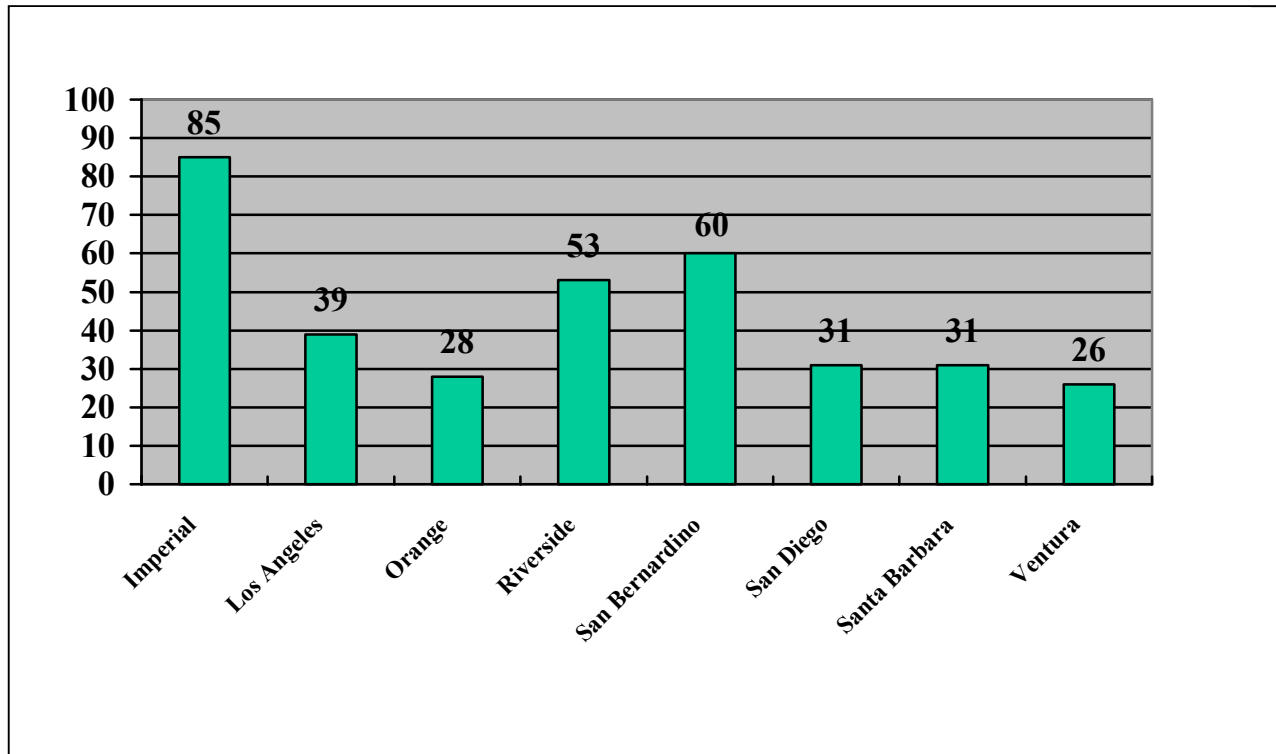
	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
Average # of Cases per Worker	355	306	271	287	250	248	241	205

Caseload Growth

- ▶ *Percentage of IHSS Caseload Growth from 2000 to present*

Figure 8.

Percentage of IHSS Caseload Growth from 2000 to present

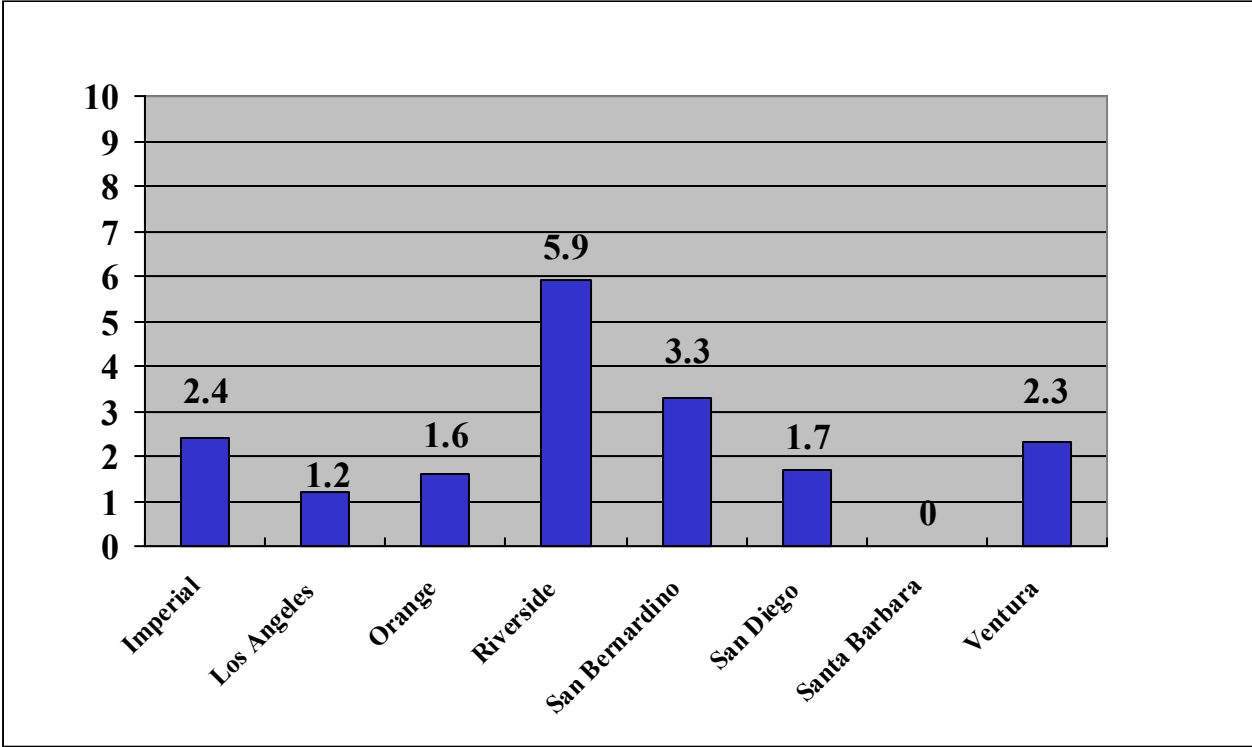


The following figure presents percentage of overall county population growth from 2000 to 2001. As overall county population growth percentages represent growth for only a one-year period, those percentages will need to be multiplied by four (to estimate population growth from 2000 to 2004) in order for growth comparisons to be comparable.

► *Percentage of Overall County Population Growth from 2000 to 2001*

Figure 9.

Percentage of Overall County Population Growth from 2000 to 2001 (most recent data).

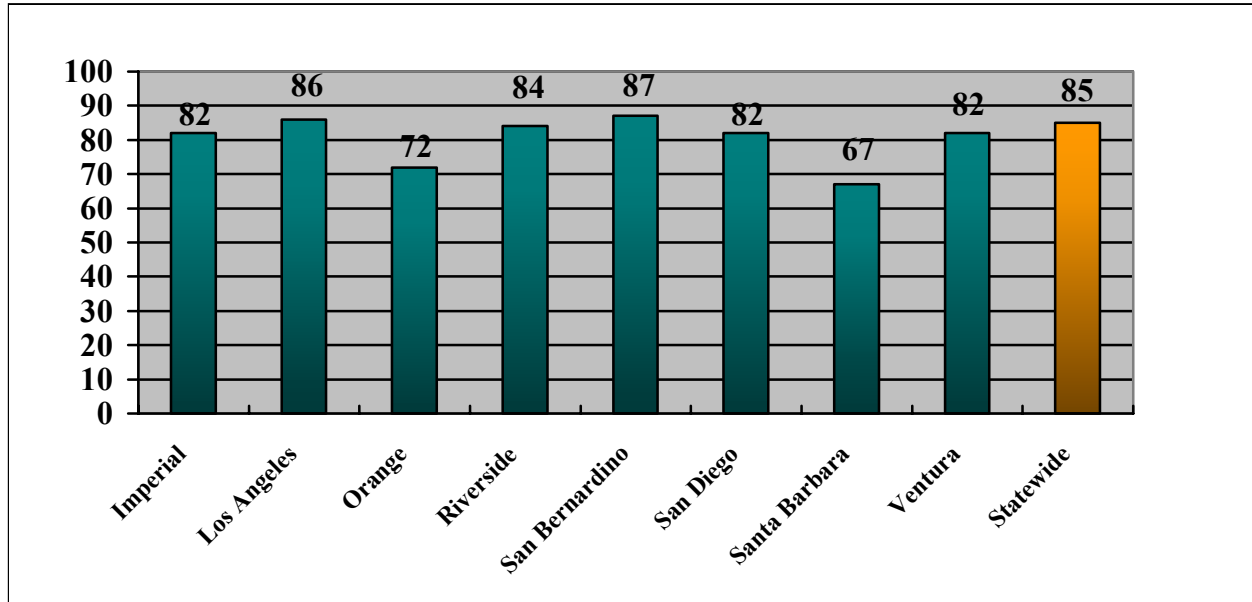


Caseload Costs

► Average Monthly Paid Hours per Case

Figure 10.

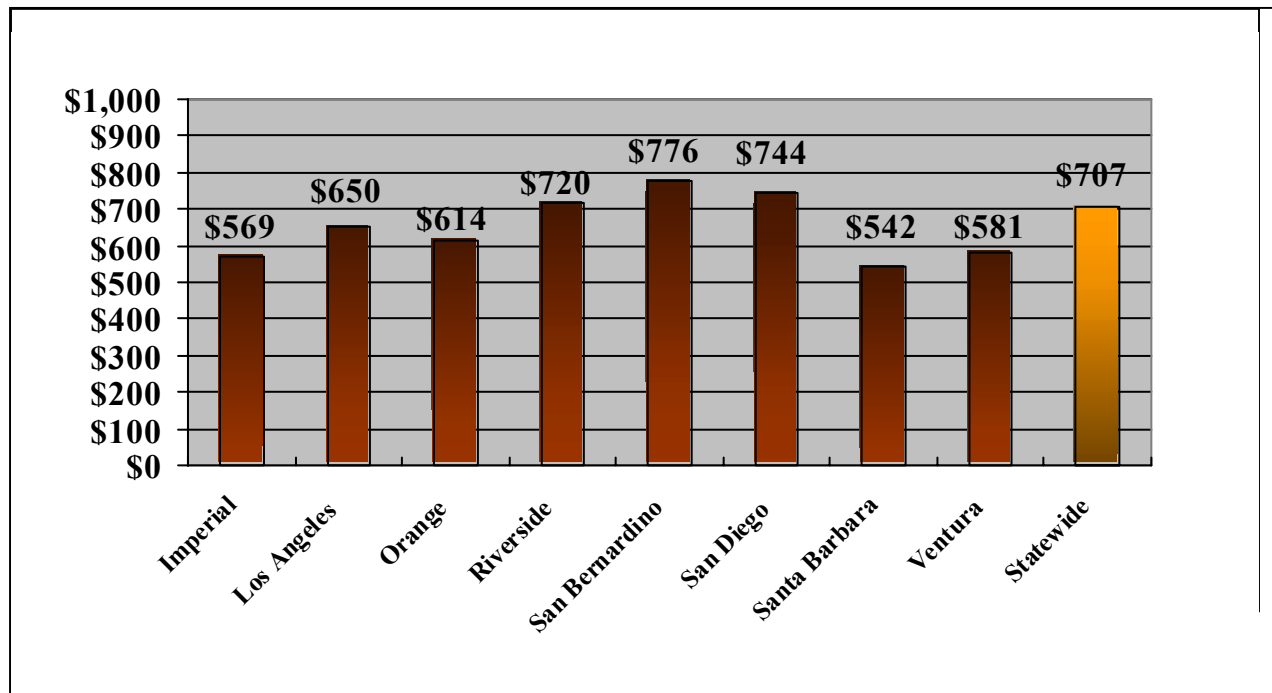
Average Monthly Paid Hours per Case



► Average Monthly Cost per Case

Figure 11.

Average Monthly Cost per Case



Perceived Cost Drivers

Table 12.
Perceived Cost Drivers*

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura	Total % Mentioned
Caseload growth	X	X	X	X	X	X	X	X	100%
General population growth	X	X	X	X	X	X	X	X	100%
Provider wage increases		X	X	X	X	X	X		75%
Addition of Provider benefits		X	X	X		X	X		63%
Increased community outreach		X				X	X	X	50%
Increase in number of children eligible for IHSS		X	X					X	38%
Lack of uniform assessment process			X				X		25%
Increase in APS cases referred to IHSS				X		X			25%
Lack of alternative resources								X	13%
Deinstitutionalization of Long Term Care clients									0%

*As reported by SACHS Counties' IHSS Staff.

General Information

► Status of Union Negotiations

Imperial: Currently in negotiations that began 6/03

Los Angeles: Negotiations with the union have produced a tentative agreement pending ratification by members

Orange: MOU in effect through September 04

Riverside: Contract was negotiated as of 1/04, will be in place 1/04-6/05

San Bernardino: A MOU is in place for the time period 4/1/04 through 3/31/05. No change in hourly wage from previous MOU. County will contribute a total of \$550,000 local cost toward health benefits.

San Diego: Currently in negotiations

Santa Barbara: Currently in final stages

Ventura: Proceeding with negotiations, but slowly

► Social Worker Training

Table 13.

Number of Hours of Social Worker Training

	Imperial	Los Angeles	Orange	Riverside	San Bernardino	San Diego	Santa Barbara	Ventura
IHSS eligibility and regulations	20	60	40	40	40	14	20	8
IHSS uniform assessment process	20	8	40	8	8	3	4	4
Other	32		4		3	5	24	24
	UC Davis Trainings		Cultural Diversity		Appeals	Safety in the Field; Elder Abuse	UC Davis Professional Development Presentations	Leadership Academy

Program Characteristics

According to many key informants interviewed for this study, California's IHSS program is considered a model program. The program is characterized by the following strengths:

- ▶ Flexible consumer-directed services
- ▶ Family members may be hired to provide care, consistent with Medicaid regulations
- ▶ Almost all California counties have chosen to deliver IHSS through Public Authorities (PAs) and Non-Profit Consortia (NPCs). PAs and NPCs provide registries, help recipients find providers and provide training resources to consumers and providers to improve accessibility and quality of service. (Home and Community Based Services, 2003)
- ▶ The cost of IHSS services is approximately 1/5 the cost of institutional care. (Harrington & Newcomer, 2004)

Cost Increases

IHSS is an entitlement program and there is currently no cap on program increases. Additionally it is consumer-driven and recipients determine how/when they are served according to Social Worker's functional assessment (social vs medical model assessment). (CWDA, January 2003)

CSAC (2002) notes that between 1998-99 and 2002-03, the county share of the IHSS program doubled (\$287 million to \$562 million). According to LAO's Analysis in 2002-2003, IHSS has been the fastest growing social services program in terms of State General Fund spending. From 1993-94 through 2001-02, general Fund expenditures increased almost four-fold, rising from \$232 million in 1993-94 to an estimated \$903 million in 2001-02. This represents an average annual growth rate of about 19 percent. (Legislative Analyst's Office, 2002)

It is uncertain how many IHSS recipients would enter out-of-home care if their IHSS services were eliminated or reduced. Costs for out-of-home care, such as nursing facilities, are significantly higher than costs for IHSS services. The average monthly cost of an IHSS Residual case is approximately \$650 (state pays 65% of costs), compared to about \$3500 per month for a skilled nursing facility, or about \$4400 per month for intermediate care facility (state pays about 50% of costs). (California Budget Project, February 2004) Recent analysis by the

California Center for Long-Term Care Integration examined MediCal eligibility and nursing home utilization. Findings show that since the 1990's there was a 25% increase in the number of MediCal eligibles over age 65, while average use of nursing homes decreased from nearly 44 days in 1991 to just over 36 days in 2001 (stats are for MediCal eligibles aged 65 and older). One may extrapolate that reductions to IHSS may lead to an increased use of out-of-home care with associated higher costs. (CWDA, 2004)

Finally, the 2004 CWDA report also notes that while the IHSS caseload has grown rapidly across categories, the proportion of disabled consumers has grown at a faster rate. In essence, IHSS is serving an increasing population of relatively young, disabled consumers who need more hours of service to live safely at home for a longer time period.

Realignment

The original funding structure of Realignment was intended to accommodate IHSS caseload growth and COLA. Unfortunately, the creators of realignment did not anticipate the scope of IHSS and the policy changes of the 1990's. (CSAC, 2002)

- ▶ Realignment increased the county share of non-federal IHSS costs from 3% to 35% (in the 10 years since realignment).
- ▶ Many counties have had to use the transfer provisions under the realignment law to cover IHSS costs.
- ▶ "It's conceivable that in the future, IHSS costs could consume the funding for other realigned programs." (CSAC, 2002)

The above factors emphasize the need to reexamine how realignment funding is allocated across programs.

Cost Drivers

Costs in the IHSS program are mainly driven by three factors: caseloads, hours of service per case, and the hourly cost of providing services (directly linked to provider wage). (California Budget Project, February 2004)

Caseload Growth

- ▶ Olmstead Decision (1999) - court order that challenged federal, state, and local governments to develop more opportunities for the disabled through integrated cost-effective community services. It also had the effect of moving people from institutions to homes (thereby increasing IHSS program costs)
- ▶ Caseload growth expected due to growing aging population and elderly and severely disabled living longer. (CWDA, 2003)
- ▶ Caseload growth in the IHSS program is exceeding growth in the general population by over 300%. (CSAC, 2002)
- ▶ Between 1996 and 1999 the IHSS disabled caseload grew by 21.1% due to a significant increase in IHSS recipients leaving institutions and returning to the community. (CWDA, 2003) It would be interesting to examine corresponding changes in institutional care populations during this same time period.
- ▶ County budget reductions may impact caseloads and staffing, thereby reducing their ability to promptly reassess clients' needs for services.

Hours of Service Per Case

- ▶ Total spending growth from 1993-94 through 2001-02 was about \$670 million, mostly attributable to caseload growth, increases in the hours of service per client, and higher wages for providers. Specifically, caseload and service hour growth, in combination with inflation, account for about \$220 million of the increase. (Legislative Analyst's Office, 2002)
- ▶ As depicted in [Figure 10](#) (page 15), the average number of monthly paid hours per case varies across counties. The number of monthly paid hours per case ranges from 67 to 87 among SACHS counties.

Hourly Cost of Providing Services

- ▶ Assembly Bill 1682 - Employer of Record (1999) - requires county to act as employer of record for IHSS, which affected provider wages via collective bargaining.
- ▶ County welfare departments believe that increased wages are leading to increased program utilization. (CSAC, 2002)

Income Eligible Shift to PCSP

- ▶ In 1999, the income level was raised for the Aged and Disabled Poverty limit. This resulted in a decrease in the number of cases that pay a share of cost. The current limit is \$1,026 for an individual or \$1,371 for a couple. (World Institute on Disability, 2003)

Cost Control Strategies

Key informants who were interviewed by SACHS staff identified the following strategies:

- ▶ Decrease community outreach/marketing of IHSS services
- ▶ Cap provider wage
- ▶ Eliminate contract mode (given administrative costs, hourly rate is substantially higher for contract mode providers).
- ▶ Change screening and assessment process to tighten up initial screening. (This requires that staff is properly trained and supported, have reasonable caseloads so that they have more time to thoroughly assess clients' needs, and that alternative community resources are available to IHSS recipients.)
- ▶ Provide training on making uniform assessments to provide a direct relationship between need and number of authorized hours
- ▶ Move all eligible recipients to PCSP mode of service
- ▶ More frequent reassessments might prove useful in identifying health improvements and the reduced need for services sooner among individuals recently released from hospitalization or nursing homes or those who may have suffered a temporary health episode that required an increase in service hours.

Assessment Process

CDSS introduced the IHSS Uniform Assessment process in 1988. Barnes, Sutherland & Johnson (1996) explored the IHSS assessment process to examine the feasibility of setting standards for assigning equivalent hours to persons with comparable functional index scores. The key tasks and overall goal include:

- Task 1: Determine whether there was reliable application of the assessment tool.
- Task 2: Examine whether hours were authorized in a consistent manner within counties and on a statewide basis.
- Goal: To establish an “Hours Predictor” that would provide standardized statewide assessment and service to comparable clients.

Findings from the Barnes study indicate that the CDSS IHSS Functional Index is a highly reliable tool when used by independent investigators. County assessments were much higher than the investigator team and also varied considerably for the same client population. Barnes, et. al. note that perhaps there are diverse policies and training protocols in the sample counties, with inconsistent training producing varying assessments. The greatest variations were seen in the following sample counties: Los Angeles and San Francisco.

Key informants interviewed by SACHS staff made the following recommendations regarding the assessment process:

- ▶ Closely examine high hour cases, especially those needing protective supervision
- ▶ Ensure uniform assessments.
- ▶ Utilize nursing skills in assessment process (in selected cases) to ensure accuracy

Please see recommendation section below for additional suggestions.

Quality Control

According to the Governor’s budget, up to 25% of authorized service hours “may be unnecessary or not actually provided.” The Legislative Analyst’s Office’s assessment (2004) underscores the importance of investing in “quality assurance.” They recommend that the administration report at budget hearings on the costs and benefits of an IHSS Quality Assurance program.

The LAO specifically recommends funding for:

- Technical assistance to better train county social workers who make IHSS assessments to ensure consistency;
- Additional Social Worker positions so that caseloads may be reduced to allow time to be more thorough and consistently assign service hours.

CWDA's 2003 proposal recommends the creation of an IHSS fraud investigation unit as well as improved security measures within the payrolling system. These changes, in addition to reducing the social worker to consumer ratio, will help insure program integrity.

At the February 2004 SACHS meeting, during a phone conference with Stan Rosenstein, Deputy Director, Medical Care Services, California Department of Health Services, SACHS Directors requested that Rosenstein facilitate a meeting to include Kim Belshé, Secretary of California Department of Health and Human Services and Donna Mandelstam, Deputy Director of Disability and Adult Programs, CDSS). The purpose of this meeting would be to explore coordination efforts between MediCal and IHSS fraud.

Fraud Prevention Efforts

The following fraud prevention efforts were highlighted in document recently compiled by CWDA (CWDA, November 2003):

- ▶ Sacramento: Has fraud investigators trained and assigned to IHSS.
- ▶ Fresno: Has implemented IHSS oversight implementation plan with Fraud detection, prevention and reporting.
- ▶ Riverside: Has a full-time fraud investigator assigned to their department.
- ▶ Ventura: Nurses are becoming more involved in assessing cases. They have a fraud unit.
- ▶ San Diego: Has dedicated a three person quality control unit to do unannounced home calls; Has a MOA with the District Attorney to investigate and prosecute.
- ▶ Imperial: Has an IHSS fraud investigator.

Promising Practices and Pilot Projects

Managed Care Demonstration Project

In the early 1990's, Tulare County implemented a "managed care" demonstration project in an attempt to analyze and control IHSS program costs. An evaluation of this program was conducted to assess whether IHSS recipients could be fully, competently, and efficiently served by a contract provider at the FY 1992/93 allocation levels. (Barnes, Sutherland & Johnson, 1995) Findings include:

- ▶ Managed care led to a sharp decline in caseload in Tulare, an unprecedented increase in terminations as well as drastic reduction in approvals;
- ▶ Caseload shifted to less needy recipients;
- ▶ There was an increase in donated services from family, household and community;
- ▶ Clients were served less efficiently (increased administrative cost per case) and less appropriately (when compared with service in comparable counties); and
- ▶ Provider training and supervision had no effect on quality of care.

San Mateo County Home Care Assessment Pilot Project

This five year pilot project authorizes San Mateo County to adopt the Minimum Data Set-Home Care Assessment Form, a uniform assessment instrument that shares a common language for nursing facilities and home health agencies. The instrument is oriented to obtaining specific information about the client's functional abilities and needs. This pilot is being evaluated by an external evaluator, with results to be reported to the Legislature and the Long-Term Care Council on or before May 2009. (AB 786 "San Mateo County: Home Care Assessment Pilot Project, 2003; For more information, contact Marcia Fong, San Mateo IHSS, 650-573-2701)

The goals of the pilot are as follows:

- ▶ Test the efficacy of the uniform, automated screening and eligibility assessment tool.
- ▶ Ensure the use of an assessment tool to facilitate communication among multiple agencies so that assessment and subsequent care planning are person-centered, effective, coordinated (eliminating duplication).
- ▶ Evaluate the potential adoption of the assessment tool statewide to improve planning, funding and service delivery.

Telephone Check-In System

Santa Barbara County will be piloting a “telephone” check-in system developed by GovConnect where IHSS providers check in by phone when they arrive and leave a client’s home. This system will link to CMIPS system.

Assistive Technology

Results of a recent study suggest that human assistance only may be an outdated approach to personal care. Researchers note that empowering the consumer to find their own workers and to supplement them with purchases of assistive technology devices, to assist with activities of daily living, may be superior alternatives to spending more money on personal care. An assistive technology device (AD) as defined by the Technology-Related Assistance for Individuals With Disabilities Act of 1988, is “any item, piece of equipment or product system, whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain or improve the functional capabilities of individuals with disabilities. Equipment, goods and services can complement and sometimes substitute for human assistance. Examples include wheelchairs, walkers, ramps, chairlifts, grab bars, large button phones, jar/can openers, microwaves, blenders, etc. (Meiners, Loughlin, Sadler, & Mahoney, March 2004)

Cash and Counseling Programs

Cash & Counseling is a national program co-sponsored by The Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation in the United States Department of Health and Human Services and the Administration on Aging. With the cooperation of the aforementioned agencies and the National Program Office located at the Boston College Graduate School of Social Work, a three state Cash & Counseling Demonstration (Arkansas, Florida and New Jersey) was implemented to compare the Cash & Counseling consumer-directed model with the traditional agency-directed approach to delivering personal assistance services. (Cash & Counseling, 2004)

The Cash and Counseling program provides self-directed, individualized budgets to recipients of Medicaid personal care services or home and community-based services. Each person’s allocation is comparable to the value of services that he or she would have received through a traditional agency. Program participants use the allocation to purchase their own care - with the option of hiring friends, family members, or others - instead of receiving it from an

agency. They can also use their budgets to modify their homes or vehicles or to purchase a range of items - from chair lifts to touch lamps - that will help them live independently. Consulting and bookkeeping services are available to help participants weigh their options and keep up with required paperwork. (Cash & Counseling, 2004)

Preliminary evaluation results (of Arkansas) indicate that beneficiaries who had the opportunity to direct their personal assistance services received better care than a control group. They reported higher satisfaction, better quality of life, fewer unmet care needs, better access to service, and less nursing home usage - all without compromising health or safety or significantly increasing Medicaid costs. Additionally, no major instances of fraud or abuse were found. (Doty, Benjamin, Matthias, & Franke, April 1999). As a result of this early success, the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation, and Administration on Aging have authorized an expansion of the Cash & Counseling program that will provide grants and comprehensive technical assistance to additional states (closing date was 3/3/04).

Other State Models

The following are examples of models and strategies used by other states to provide consumer-directed in-home services, similar to California.

Michigan (Tilly &Kasten, February 2001)

- ▶ Controls nursing home spending through reimbursement rates and supply controls.
- ▶ Uses independent provider versus contract mode
- ▶ Got waiver to limit per diem costs and implemented a high cost exceptions process. They cap payments, but have process for those clients with complex medical needs to obtain those services

Washington (Wiener & Lutzky, June 2001)

- ▶ Limits the costs per person. They put a dollar cap on the cost of services. Recipients in their Community Options Program Entry System (COPES) can receive services that cost up to 90 percent of monthly nursing home costs. Although they are authorized to spend this amount on their services, recipients typically purchase services that are much less costly than nursing home services, with the average monthly cost for COPES services being approximately one-third the cost of nursing home care. Further, the dollar cap

encourages the use of independent providers as clients can obtain almost twice as many hours for the same expenditure level as if they were using contract providers.

- ▶ Implemented “nurse delegation,” which saves money by allowing people who provide personal care or homemaker services to provide certain nursing functions, such as injecting medication or changing dressings on wounds.
- ▶ They make heavy use of low cost independent providers rather than contract agencies.
- ▶ Providers undergo criminal background investigations.
- ▶ Providers participate in training (with consumer input).
- ▶ Has a fraud investigation unit.

V. RECOMMENDATIONS

CWDA Recommendations

In the *In-Home Supportive Services: Past, Present and Future* report, CWDA suggests policy and program recommendations in the following four areas:

- ▶ Funding (allocation formula, cost control strategies, written instructions)
- ▶ Quality of Care/Program Integrity (training program to standardize assessments, create a best practice model for IHSS caregiver training, create IHSS fraud investigation unit)
- ▶ Coordination of Services (MOU between CDHS and CDSS, Developmental Service, and Aging) to coordinate responsibilities and oversight
- ▶ Data Collection (provide adequate financial and program support for CMIPS/CMIPS II)

Please refer to full report for specific recommendations. (CWDA, January 2003)

Recommendations from Barnes, et. al. (1996):

- ▶ Simplify assessment instrument;
- ▶ Create clear guidelines for consistent assignment of hours;
- ▶ Provide consistent training;
- ▶ Clarify the following tasks to ensure better distinctions when assessing hours: mobility, transfer and toileting;
- ▶ Develop an “hour predictor” to ensure equitable treatment of comparable clients statewide; and
- ▶ Consider omitting select tasks, including but not limited to “respiration,” due to a low correlation between assessed rank and functional index and have task picked up by paramedical services

In a personal contact, the lead investigator noted that it would be important to consider the implications of these recommendations in the current environment.

United Domestic Workers Recommendations

- ▶ Implement a more uniform assessment tool and process statewide.
- ▶ Reassess current Residual Program cases for PCSP eligibility.

(Seaton-Msemaji, Jeffers, & Sutherland, March 2004)

Other recommendations formulated based on findings reported above

- ▶ Examine differences in average hours assessed across regions.
- ▶ Establish linkage between MediCal fraud unit and IHSS special investigations unit (need to facilitate discussion between Belshé and Mandelstam)
- ▶ Ensure counties have statutory authority to investigate and prosecute suspected fraud.
- ▶ CDSS to generate reports to help detect fraud (e.g., crosscheck of vital statistic death information on recipients (to avoid 6 month delay); check for recipients in multiple counties; check to see if recipient and provider are the same person, etc.) (CWDA, November, 2003)

VI. NEXT STEPS

Based on the information gathered from interviews/consultation with key informants, a literature review, and a survey of SACHS counties, potential items for future discussion include:

- Long-term cost-containment planning;
- Uniform assessment training;
- Use of nurses during assessment process;
- Increased use of assistive technology devices;
- Joint MediCal/IHSS fraud investigations;
- Criminal background checks for providers; and
- Prioritizing services for the “nursing home” eligible population.

“Next steps” will be outlined following the May SACHS meeting discussion.

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IHSS Survey of SACHS Counties

County: Imperial LA Orange Riverside San Bernard. San Diego Santa Barb. Ventura
 Respondent: _____ / _____ / _____
Name Title Phone #

DEMOGRAPHICS (Time Period: January 2004)

- IHSS Recipients**
1. Age
 - a. 17 and under _____%
 - b. 18-64 _____%
 - c. 65-79 _____%
 - d. 80 and over _____%
 3. Average Age of IHSS clts _____ years
 4. Gender
 - a. Male _____%
 - b. Female _____%
 6. Ethnicity
 - a. White _____%
 - b. Black _____%
 - c. Hispanic _____%
 - d. Asian/Pac Isl. _____%
 - e. Other _____%
 8. Caseload growth 2000-present: _____%

- County as a Whole**
(we'll download this from Census site)
- ~~2. Age~~
 - ~~a. 17 and under _____%~~
 - ~~b. 18-64 _____%~~
 - ~~c. 65-79 _____%~~
 - ~~d. 80 and over _____%~~
 - ~~5. Gender~~
 - ~~a. Male _____%~~
 - ~~b. Female _____%~~
 - ~~7. Ethnicity~~
 - ~~a. White _____%~~
 - ~~b. Black _____%~~
 - ~~c. Hispanic _____%~~
 - ~~d. Asian/Pac Isl. _____%~~
 - ~~e. Other _____%~~
 - ~~9. Population growth 2000-present: _____%~~

IHSS RECIPIENT CHARACTERISTICS (Time Period: January 2004)

10. English-speaking _____%
 Non-English speaking _____%
11. Aid Type
 - a. Aged _____%
 - b. Blind _____%
 - c. Disabled _____%
12. Impairment
 - a. Severely Impaired _____%
 - b. Non-Severely Imp. _____%

13. Share of Cost _____%
 No Share of Cost _____%
(out of total IHSS caseload)
14. Below Fed. Poverty Level _____%
(Aged and Disabled FPL cases)
15. On MediCal _____%
(PCSP Cases)
16. On MediCal who are SSI _____%
(% of IHSS caseload that are SSI)

IHSS PROVIDER CHARACTERISTICS (Time Period: January 2004)

17. Provider Mode

- a. Indiv. Provider _____% [of IP's: Relative: _____% Non-Relative: _____%]
 b. Contract Provider _____%
 c. Homemaker _____%

18. Provider Wage \$_____/hour

19. Provider Health Care Benefits? Yes (When?_____) No20. Has your county implemented a Public Authority? Yes (When?_____) No**IHSS CASELOAD CHARACTERISTICS**

21. Consumers: _____(#)

22. Monthly IHSS applications _____(#)

23. Avg # of cases per worker _____(#)

24. Average monthly paid hrs per case _____(#)

25. Average monthly cost per case \$_____ *Please calculate this using the following formula:*
 Average monthly cost per case = Avg. Monthly Hours per case x (provider hourly wage + benefits)

26. Authorized Cases

- d. IHSS Residual _____%
 e. PCSP _____%

PERCEIVED COST DRIVERS

27. *Please place a check mark next to each of the following cost drivers that are impacting your county:*

- a. General population growth
 b. Caseload growth
 c. Provider wage increases
 d. Addition of provider benefits
 e. Increase in APS cases referred to IHSS
 f. Lack of uniform assessment process
 g. Increase in number of children eligible for IHSS
 h. Increased community outreach
 i. Lack of alternative resources
 j. Deinstitutionalization of Long Term Care clients
 k. Other: _____

Please explain:

GENERAL QUESTIONS RE: IHSS

28. Does your county bank cases? Yes No
29. What is the status of union negotiations in your county?
30. What type of trainings have your IHSS social workers attended?
- IHSS eligibility and regulations: approximately how many hours of training? _____
 - IHSS uniform assessment process: approximately how many hours of training? _____
 - Other: _____: approximately how many hours of training? _____
Please specify:
31. Has your county routinely had to use realignment dollars to supplement IHSS allocation?
 Yes No

Please email or fax completed survey by Friday, April 23rd, 2004
to Carrie Gibson at:
cgibson@projects.sdsu.edu
fax: (619) 594-1118
Thank you for your time!