



California Association of
Public Authorities for IHSS



January 21, 2015

Anastasia Dodson,
California Department of Health Care Services
Via Email: WaiverRenewal@dhcs.ca.gov

**RE: Section 1115 Medicaid Waiver Renewal – Workforce Development
In-Home Supportive Services**

Dear Anastasia:

California's current Section 1115 Medicaid Demonstration Waiver – which funds hospitals and indigent care – expires on October 31, 2015. It is our understanding that the waiver renewal request must be submitted to the Centers for Medicare and Medicaid Services (CMS) at least 6 months before the end of the current waiver and that DHCS intends to submit the waiver request within the next few weeks. One of the stakeholder groups has been working on Workforce Development and it recently came to our attention that DHCS is considering use of Medi-Cal 1115 waiver funds to incentivize targeted training of in-home supportive services (IHSS) workers. Specific options include:

- Training programs for IHSS workers to improve clinical skills, communication and coordination of patient care;
- Financial incentives for IHSS workers to obtain training.

The IHSS program provides personal care and chore services to certain individuals to help them remain safely in their own homes and communities. Recipients, who must be low-income and aged, blind, or disabled, are eligible to receive up to 283 hours per month of assistance with tasks such as bathing, dressing, housework, and meal preparation. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider—oftentimes a family member or relative. In 2013-14, it is estimated that about 450,000 individuals will receive IHSS and approximately 390,000 individuals will work as IHSS providers. IHSS does not provide 24-hour skilled nursing care in a home setting. It can only supplement the provision of those services by other agencies, as one piece of the long-term care system.

The concept paper describes the objective of using 1115 waiver funds for IHSS training as follows:

“Training programs could improve IHSS providers’ ability to ensure that their clients are empowered to communicate their care needs and direct their care; enhance protections of clients from abuse and restraints; ensure client safety and reduce risk of falls and injuries; identify worsening health status and facilitating timely intervention; and preventing occupational injury. Because IHSS providers’ services are directed by the recipients they serve, it is important that recipients have discretion regarding whether they want their IHSS provider to coordinate care with their primary care provider and other medical providers.”

This description undermines the key role that consumers have in training their IHSS provider and directing their own care. The cornerstone of IHSS is the consumer directed foundation of the program; consumers are experts on their own lives; they are the ones who are best able to direct the services they receive. IHSS has helped make it possible for people with disabilities and seniors to live productive lives in the community without being forced into institutions. The program was designed based on this independent living concept and is one of the reasons why IHSS has been so successful in reducing institutionalization: consumers are the most informed about what help they need.

If empowerment of consumers is the goal why not empower them rather than surrogates (e.g. their IHSS providers)? IHSS and the independent living movement were born and thrived as a direct response to the long history of others speaking for and about people with disabilities, so the idea that public funds would be used to return to that model is disgusting. This training concept ignores that the consumer is the employer, that half or more of the providers are never going to work for anybody else so they don't need training unrelated to the current consumer for whom they work, that there is no evidence that random training leads to better outcomes for consumers, and that not only do IHSS workers not have a clear obligation to coordinate care, they have no right to coordinate care.

The recent federal court action to invalidate the Fair Labor Standards Act has created new questions about whether IHSS providers can be paid by IHSS to participate in care coordination teams under the Coordinated Care Initiative. The FLSA regulations required IHSS providers to be paid when they were engaged in medical accompaniment tasks. The federal court vacated the FLSA regulations and our state has decided to halt implementation of compensation for overtime, travel time and medical wait time. The IHSS program only pays its providers for the specific tasks authorized by the county social worker. Care coordination is not one of the authorized tasks. Hence, it begs the question about why IHSS providers should receive clinical training to participate in care coordination teams when the IHSS program will not compensate those workers for that time.

We disagree with the premise that IHSS providers need to improve their “clinical skills” – although IHSS is not a clinical program, the IHSS consumers are not the patients of the workers, and their homes are not clinical settings.

One of the core mandates of Public Authorities is to provide access to training to both IHSS consumers and providers. Some public authority training programs are set up in cooperation with local education entities and are providing quality training to providers and recipients. We endorse efforts to improve the quality of IHSS services, which might include training, career ladders and expanded pathways to citizenship for all workers. We also are strong supporters of the independent living movement as well as disability rights and disability justice movements. We see consumers and providers in a complimentary relationship and support worker as well as consumer protections. CAPA strongly supports voluntary training for IHSS workers. Any worker who wants training should be able to receive it; indeed, training is currently available through many sources.

CAPA is concerned that inclusion of IHSS providers in the 1115 waiver workforce development component could lead to mandatory training for IHSS providers. We are concerned that this aims to place service expertise in the hands of the provider as opposed to the consumer and will erode the social model that has been the basis of the IHSS model historically. Any mandate for standardized medical training that makes no mention of the fundamental concept underpinning the entire IHSS program (the consumer's right to choose), is contradictory to the entire social model of IHSS. Training should be available and readily accessible to those who want it, but it should be the choice of the consumer and the provider.

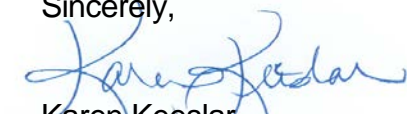
We note that the legislature mandated CDSS to develop a voluntary IHSS provider training curriculum that addresses issues of consistency, accountability, and increased quality of care for IHSS recipients, no later than January 1, 2014. A workgroup was composed of representatives from CDSS; DHCS; counties; Public Authorities; IHSS consumers and providers; advocates; labor unions; and California State University, Sacramento, College of Continuing Education. The workgroup held numerous meetings resulting in a voluntary provider training curriculum that includes 15 topics and a variety of subtopics, which are available on the CDSS website at: <http://www.cdss.ca.gov/agedblinddisabled/PG1788.htm>. The curriculum allows IHSS providers to voluntarily review documents and links to websites that will assist them in providing consistency, accountability, and increased quality of care to IHSS consumers.

In 2011, Washington voters approved Initiative 1163 (I-1163), which expands background check and training requirements for these workers. It also requires them to obtain a home care aide certificate or hold another qualifying certification. The Washington Department of Social and Health Services (DSHS) estimates there were about 60,000 workers in fiscal year 2013. The law requires that the State Auditor's Office conduct a performance audit every two years. The Washington State Auditor recently released the second audit of the training program which revealed that 42% of IHSS providers did not complete the process and did not obtain a home care aide certificate. We are very concerned that any mandate for IHSS provider training would have similar results in California; many consumers would be disconnected from their provider-of-choice if IHSS workers failed to complete any mandated training.

Instituting any standardized medical training for IHSS providers or – worse case --- actually

mandating training for these workers is the wrong direction to take. Public Authorities have a strong imperative to increase access to training for both consumers and providers. To our knowledge, the 1115 Workforce Development stakeholder process has primarily included licensed health practitioners. We believe that the IHSS community, including disability rights advocates, should be included in any discussion about including IHSS training in the 1115 waiver. Given the rapidly approaching deadline for DHCS to submit the 1115 waiver request to CMS, we recommend that DHCS exclude IHSS training from the final waiver package.

Sincerely,


Karen Keeslar,
CAPA Executive Director


Janie Whiteford,
CICA President

cc: CDSS Director Lightbourne
Donna Campbell, Governor's office