In-Home Supportive Services Statewide Collective Bargaining

Report to the Legislature

APRIL 2025

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LEGISLATIVE MANDATE

Analysis of Approaches that Transition In-Home Supportive Services to Statewide or Regional Collective Bargaining

Assembly Bill 102

Report to the Legislature

Assembly Bill (AB) 102 (Ting, Chapter 38, Statutes of 2023) amended the Budget Act of 2023, requiring the California Department of Social Services (CDSS) to submit a report to the committees on the state budget of the Assembly and Senate that includes an analysis of the costs and benefits of approaches that transition collective bargaining with In-Home Supportive Services (IHSS) providers from the current county model to a statewide and/or regional model, no later than January 1, 2025.

Per AB 102, the report shall include, but is not limited to, a review of how much statewide or regional bargaining would cost for each dollar increase in wages or benefits and its potential impact on workforce recruitment and retention, potential implications on the current county-state realignment structure, how any increases would interact with the statewide minimum wage increases, and what fund sources, including realignment, would be available to implement statewide or regional collective bargaining.

To prepare the analysis, the Department shall complete the following:

A. Consult with representatives from the California Department of Human Resources (CalHR), the Public Employment Relations Board (PERB), the California Department of Health Care Services (DHCS), and the California Department of Finance (DOF).

B. Engage in a stakeholder process and convene interested parties, including but not limited to, the recognized employee organizations of IHSS providers and representatives from the California State Association of Counties (CSAC), the California Association of Public Authorities (CAPA), and the County Welfare Directors Association of California (CWDA). The Department shall also consult with representatives from IHSS consumer organizations.

C. The Department may hire a consultant for the development of this analysis.

The following report is the Department's analysis of approaches that transition IHSS to statewide or regional collective bargaining and is a direct representation of the discussion of the workgroup. Please note, this report does not represent the opinions and/or recommendations from CDSS. Additional copies of this report can be obtained from:

Office of Legislation
California Department of Social Services
744 P Street, MS 9-3-070
Sacramento, CA 95814
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EXECUTIVE SUMMARY

The In-Home Supportive Services (IHSS) program provides domestic and personal care services to children and adults with disabilities, and older adults to keep them safely in their own homes and communities and avoid institutionalization. IHSS is the largest home and community-based services program in the country, with over 820,000 authorized recipients being served by over 720,000 providers. The California Department of Social Services (CDSS) is responsible for overseeing the IHSS program, which is administered by the counties, where county social workers are largely responsible for case management activities.

Assembly Bill (AB) 1682 (Chapter 90, Statutes of 1999) required each county to act as, or establish, an Employer of Record for IHSS providers by January 1, 2003. Nearly all counties established an IHSS Public Authority (PA) or Non-Profit Consortium (NPC) to act on their behalf, with only two counties[1] opting to perform the mandated activities themselves. All IHSS providers are represented, depending on which county they reside in, by one of two unions, Service Employees International Union (SEIU) or the United Domestic Workers (UDW). Currently, IHSS is collectively bargained at the individual county level between the IHSS Employer of Record and the unions who represent the IHSS providers.

This report represents the final product of the workgroup tasked with exploring the costs and benefits of approaches that transition collective bargaining with IHSS providers from the current county model to a statewide and/or regional model. When discussing the topics, as mandated in AB 102, there were some common themes and takeaways among the workgroup.

1. The workgroup thought that statewide bargaining was more viable than a regional model, which introduced significant additional complexities.
2. Involving IHSS recipients in collective bargaining was a priority for the workgroup members, but there was a lack of consensus on how to include them and solicit participation across the state.
3. If statewide or regional collective bargaining moved forward, there would be a material shift in the responsibilities of the PAs and NPCs. Specifically, that the responsibilities related to collective bargaining and conditions of employment would transition to the entity responsible for collective bargaining in a statewide or regional model, but the other duties related to the provider registry, provider enrollment, training and other related duties would remain with the PAs and NPCs.
4. The workgroup highlighted the need to clearly define the scope of statewide or regional bargaining in statute. However, there were a variety of opinions on how broad or narrow the scope of bargaining should be if collective bargaining moves to a state or regional model.
5. Six other states have Medicaid funded personal care services programs with statewide bargaining. Although there are meaningful differences between those programs and IHSS, this information allowed the workgroup to see the various

[1] Alpine and Tuolumne County

possibilities of statewide collective bargaining in home and community-based services programs.
6. The impact of statewide or regional bargaining on recruitment and retention was discussed, but there was not enough data to understand the direct implications.
7. CDSS provided cost modeling based on point-in-time data and estimates the fiscal impact to the program for each $1 per hour statewide wage increase would be at least an additional $1.3 billion to $1.5 billion per year depending on the growth rate in IHSS cases, with the costs split between federal, state, and county funds.
8. The workgroup had discussions about liability, costs, program growth, and funding sources and identified legislative considerations and highlighted impacts to the county Maintenance of Effort (MOE) and realignment that require further discussion if statewide or regional bargaining moves forward.

As mandated by AB 102, this report outlines the current process for collective bargaining, provides the workgroup definition of statewide and regional bargaining, the potential impact on workforce recruitment and retention, potential implications on the current county-state realignment structure, how any increases would interact with the statewide minimum wage increases, and what fund sources, including realignment would be available to implement statewide or regional collective bargaining. Additionally, this report details the fiscal and statutory impacts, costs and benefits as discussed by workgroup members, as well as additional research conducted by the Labor Center from University of California, Berkeley (UC Berkeley). This report does not include all aspects or impacts to the IHSS program of the collective bargaining or administrative process. Depending on the bargaining process, those impacts could vary, potentially resulting in significant State General Fund costs in the billions of dollars in addition to wage increases.

The CDSS is providing this report pursuant to the requirements of AB 102. It is important to note that the information presented in this report is a direct representation of discussions of the workgroup, as well as analysis by CDSS and UC Berkeley. Additionally, workgroup members were provided this report for review and were invited to submit comment letters, if desired. All submitted letters are included in Appendix A of this report.

Please note, this report does not represent the opinions and/or recommendations from CDSS. Furthermore, this report relies on point-in-time assumptions, different assumptions would result in a change to the cost estimates presented in this report, which could be upwards of billions in additional State General Fund costs. Additionally, the report assumes continued receipt of federal funds for the IHSS program pursuant to current law. The fiscal implications of any changes in federal policy could also be upwards of billions in additional State General Fund costs.

BACKGROUND OF THE STATEWIDE COLLECTIVE BARGAINING PROJECT

AB 102 provided $1.5 million for CDSS to work with stakeholders to analyze the costs and benefits of approaches that transition collective bargaining with IHSS providers from the current county model to a statewide and/or regional model and for the Department to submit a report of the analysis to the Legislature by January 1, 2025. As mandated, CDSS convened a workgroup with key IHSS collective bargaining participants that included the following organizations:

- Provider Union Representatives – SEIU and UDW
- An IHSS Provider
- California State Association of Counties (CSAC)
- California Association of Public Authorities (CAPA)
- County Welfare Directors Association of California (CWDA)
- County Staff
- IHSS recipients
- California IHSS Consumer Alliance (CICA)
- Legal Advocates

Additionally, per AB 102 the following state departments, in addition to CDSS provided information and technical assistance to help facilitate workgroup discussions:

- Department of Health Care Services (DHCS)
- California Department of Human Resources (CalHR)
- California Public Employment Relations Board (PERB)

A list of all workgroup participants and their organizations are available in Appendix B of this report.

The CDSS contracted with two consultants to assist with activities related to organizing the workgroup and developing the analysis. The first consultant, High Road Alliance (HRA), was contracted to assist with the facilitation of the workgroup meetings and to conduct participant interviews before the workgroup launched. The second consultant, UC Berkeley, was contracted to conduct research on collective bargaining and provide their findings and data to the workgroup. The work of both contractors assisted with the workgroup as it explored the current IHSS collective bargaining process and the costs and benefits of approaches that transition to a statewide or regional collective bargaining model.

The HRA facilitated the workgroup meetings, beginning with level-setting meetings in February and March of 2024. The purpose of the level-setting meetings was to provide information to workgroup participants to promote a basic understanding of the IHSS program, the IHSS collective bargaining process, and IHSS funding, including the County Maintenance of Effort (MOE) process. After the level-setting meetings, CDSS convened bi-monthly workgroup meetings beginning in April 2024 and concluding in September 2024. During these meetings, the workgroup discussed several aspects of statewide and regional collective bargaining for IHSS, including defining how the statewide and regional collective bargaining process would work, the roles of each entity in the statewide and regional collective bargaining process, any funding and statutory impacts, and the impact to provider retention and recruitment.

The overall goal of the workgroup was to explore the costs and benefits of approaches that transition collective bargaining with IHSS providers from the current county model to a statewide and/or regional model, not to obtain consensus. The CDSS developed this report from the discussions in these stakeholder workgroups and from additional research from UC Berkeley and the CDSS Fiscal and Estimates team.

OVERVIEW OF THE WORKGROUP PROCESS

To prepare for the commencement of the workgroup, CDSS separated the mandated content in AB 102 into topic areas to be covered after the level-setting meetings were completed. To cover all the content, one 3-hour meeting was scheduled each month beginning in April and concluding in August. The meeting dates and their associated topics were:

- April 9, 2024 - Defining Statewide Collective Bargaining
- May 24, 2024 - Defining Regional Collective Bargaining
- June 21, 2024 - IHSS MOUs and Fiscal Impacts
- July 5, 2024 - Scope of IHSS Bargaining and Legislative Considerations
- August 29, 2024 - Realignment and Provider Retention and Recruitment

After each of the longer meetings, a 1-hour meeting was scheduled approximately 2-3 weeks later to give the workgroup an opportunity to follow-up on any topics presented, ask questions, and provide feedback. These meeting were originally scheduled for May 3, June 6, July 12, August 2, and September 13. The meeting on June 6 was ultimately cancelled as the workgroup agreed collectively that the content discussed in the previous meeting did not require any additional discussion.

The CDSS served as a neutral facilitator and content expert for the workgroup and ensured the workgroup covered the statutorily mandated content and discussions remained within the scope of the AB 102. All information included in this report is intended to document the workgroup discussions. It is important to note, AB 102 required the workgroup to explore both statewide and regional collective bargaining models. However, when discussing both approaches the workgroup decided to focus on the statewide model versus the regional model and that decision is reflected in the content of this report.

The mission of the workgroup was to explore the costs and benefits of approaches that transition collective bargaining with IHSS providers from the current county model to a statewide and/or regional model. The goal of the workgroup was not to reach consensus on any topic or approach, but rather have robust conversations about the various topics mandated by AB 102 to be included in the report to the Legislature.

LEVEL SETTING MEETINGS

The CDSS scheduled three level-setting meetings in February and March 2024 to provide the workgroup members an overview of IHSS and the more complex aspects of the program related to collective bargaining. The level-setting meetings on the dates below covered three topic areas:

- February 20, 2024 - IHSS Program Overview
- March 8, 2024 - IHSS Program Funding and the County MOE
- March 22, 2024 - IHSS Collective Bargaining

The following is a high-level summary of information presented to the workgroup as part of the three level setting meetings.

In-Home Supportive Services Program Overview

The IHSS is the largest home and community-based program in the country and one of the fastest growing social services programs in California. The IHSS program, as a service of Medi-Cal, provides in-home assistance to eligible individuals with disabilities including children, adults, and older adults as an alternative to out-of-home care, thus enabling IHSS recipients to remain safely in their own homes. The CDSS provides oversight, policy guidance, training, and payrolling functions for the IHSS program. The counties administer the program at the local level and provide eligibility determinations, assessments and reassessments, and a first point of contact for IHSS recipients and providers.

The IHSS program is a self-directed program where IHSS recipients manage their own care, including how and when their services are provided in their home. Recipients are considered employers of their IHSS providers, and as such are responsible for all management activities including hiring, training, and managing their own providers and services, as well as approving timesheets. Both CDSS and the counties perform limited employer duties on behalf of IHSS recipients, largely limited to payroll activities, such as tax deductions and reporting, collective bargaining, etc.

To access services an applicant must apply and be found eligible. When a case is approved an IHSS recipient can receive a mix of domestic, personal care, paramedical, protective supervision, medical accompaniment, and other one-time services, such as heavy cleaning and yard hazard abatement (a full list and description of IHSS services can be found here). All authorized services are based on the IHSS recipient's individual needs.

The IHSS recipients are served by providers of their choice. An IHSS provider can be a family member, friend, neighbor, or provider from the PA registry. The IHSS providers must complete the enrollment process, which includes a criminal background check to work in the IHSS program. The IHSS providers are represented by one of two unions, SEIU or UDW, depending on the county they work in. The union serves as the employee representative and collectively bargains with the IHSS Employer of Record in each county to determine the IHSS providers' wages, benefits, and other terms of employment. The IHSS Employer of Record is either a designated PA or NPC within each county or in a few cases, the county itself.

In-Home Supportive Services Caseload and Provider Data

The data in this section represents an updated selection of the demographic data available for IHSS recipients and providers as presented to the workgroup. The original data presented to the workgroup was for the month of December 2023. For the purposes of this report, the data has been updated to represent data available as of December 2024[2]. The source of the caseload and demographic data included in this report is the Case Management, Information and Payrolling System (CMIPS), the system of record for IHSS.

[2] Please note, the data included represents authorized cases and hours, so the numbers may be higher when compared to the paid data that is used by CDSS for budgeting purposes. All the data included in this report can be found on the CDSS website on the IHSS Program Data page.

IHSS Recipient Data – December 2024

- Total Authorized IHSS Recipients: **823,399**
- Total Authorized Hours: **96,577,487**
- Monthly Average Number of Hours per Recipient: **117**
- Figure 1 below represents the overall growth in the IHSS caseload for the last eight years from December 2017 to December 2024.
- IHSS caseload has grown by 35.6 percent over the last eight years.

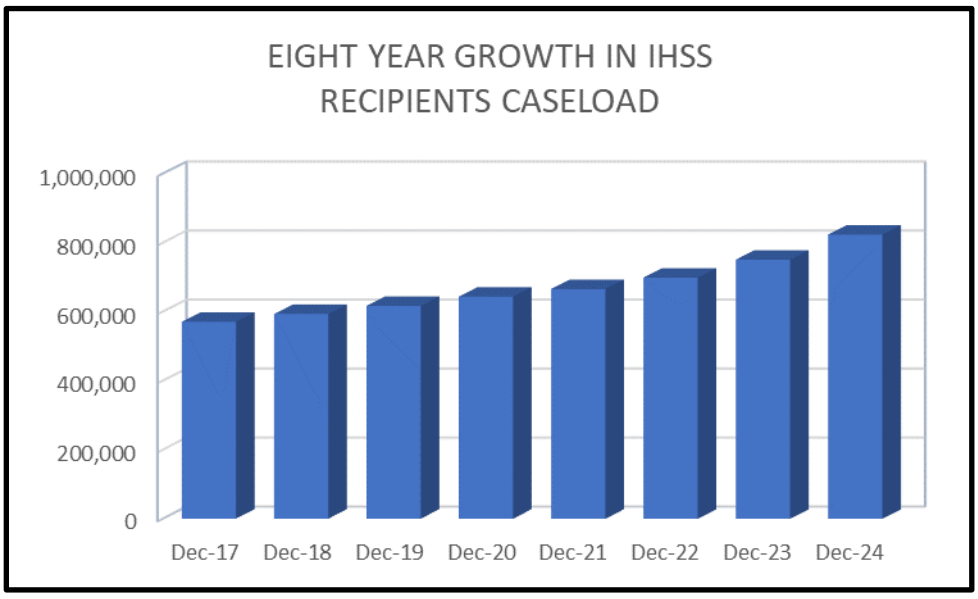

Figure 1: Growth of IHSS Caseload[3]

- Figure 2 displays the breakout of IHSS recipients for the Medi-Cal codes Aged, Blind and Disabled. A Medi-Cal code will remain with an individual as they grow older. While the largest portion of IHSS recipients is identified as Disabled, a majority of IHSS recipients (55.7 percent) across all three Medi-Cal code categories are 65 years old or older.

Category	Recipients	Percentage of Overall Recipients
Total Aged (65 years and over)	**296,681**	**36%**
Total Disabled	**518,001**	**63%**
➢ Disabled (65 years and older)	158,508	19%
➢ Disabled (64 years and younger)	359,493	44%
Total Blind	**8,717**	**1%**
➢ Blind (65 years and older)	3,461	0.4%
➢ Blind (64 years and younger)	5,256	0.6%

Figure 2: Breakout of Medi-Cal Codes for IHSS Recipients

[3] Figure 1 includes the impact of the lower than normal growth in IHSS caseload due to the COVID-19 State of Emergency from March 4, 2020 to February 28, 2023.

- **Ethnicity of IHSS Recipients**[4]: The largest ethnicity reported by IHSS recipients is Hispanic with about a third of all IHSS recipients, followed closely by Caucasian. Figure 3 shows the breakout of the ethnicities for IHSS recipients.

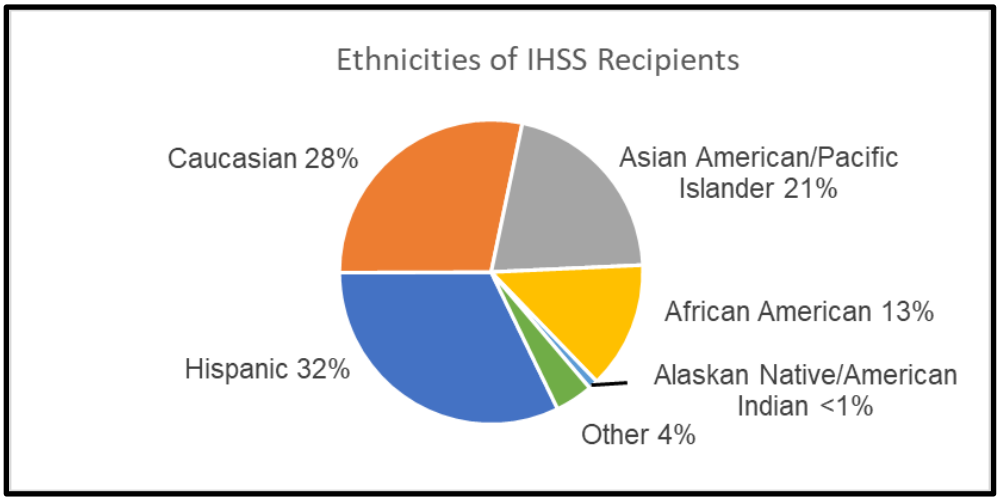

Figure 3: Ethnicities of IHSS Recipients

- **Spoken Language**[5]: Fifty-four percent of IHSS recipients report English as their spoken language. Figure 4 shows the breakout of the top 10 spoken languages for IHSS recipients.

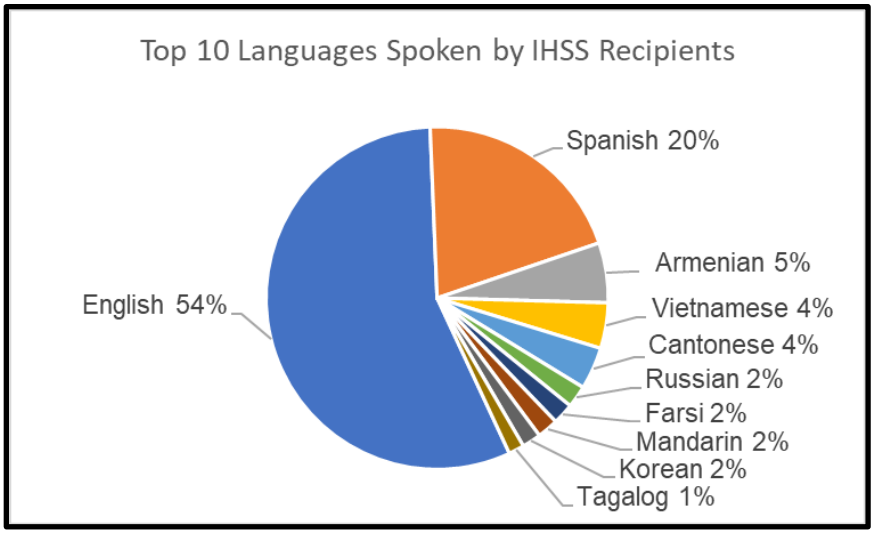

Figure 4: Top Languages Spoken by IHSS Recipients

[4] The data for ethnicities of IHSS recipients represents 98% of the total IHSS population as 2% declined to state or is unknown.

[5] The following data represents the 10 most common languages spoken as reported by IHSS recipients, which represents 95% of the total IHSS population. The remaining 5% is split between 3% of IHSS recipients who selected one of the other 21 languages, 2% who selected "Other-Non-English" and less than 0.1% who declined to state or is unknown.

- Total Enrolled IHSS Providers: **727,787**
- Percentage of Relative Providers: **72 percent**
  - Spouse – 5 percent
  - Parent – 20 percent
  - Other relative – 47 percent
- Percentage of Non-Relative Providers: **27 percent**[6]
- Figure 5 below represents the percentage of live-in providers versus non-live-in providers.

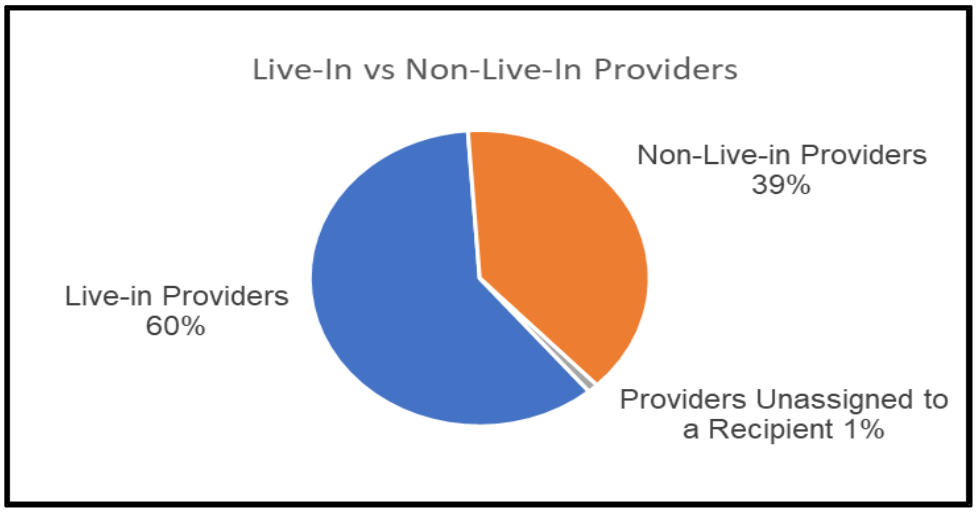

Figure 5: Live-In and Non-Live-In Providers Breakout

- **Provider Spoken Language**[7]: Seventy-one percent of IHSS providers report English as their spoken language. Figure 6 shows the top ten languages spoken by IHSS providers.

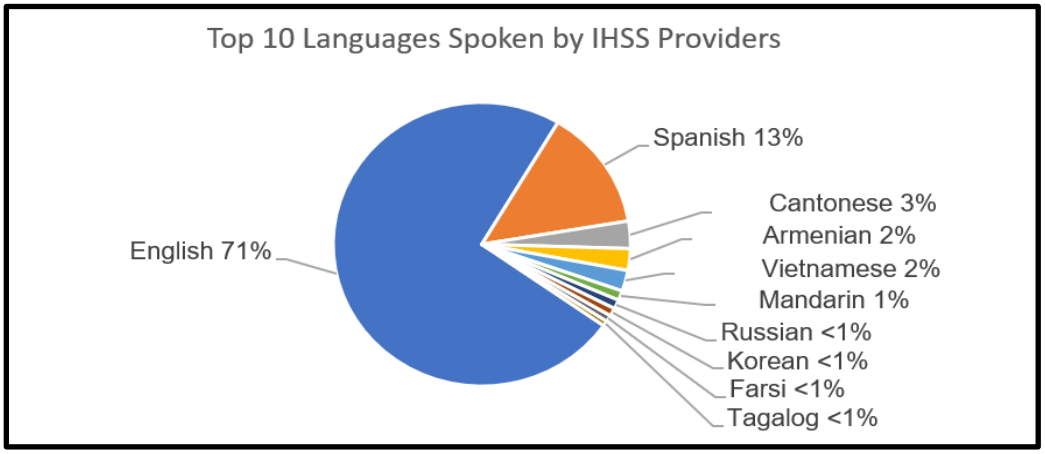

Figure 6: Top Languages Spoken by IHSS Providers

[6] Please note, 1% of providers are unassigned.
[7] The following data represents the top 10 reported languages for IHSS providers. These languages represent 95% of all IHSS providers. The remaining 5% include 2% that speak one of the other 22 languages and 3% of IHSS providers that declined to state their spoken language.

In-Home Supportive Services Program Funding and the Maintenance of Effort

The IHSS program is primarily made up of four separate programs that provide the same IHSS services but have different populations that can be covered. The first three receive federal funding and the last one is a state-funded program:

- Personal Care Services Program (PCSP)
- IHSS Plus Option (IPO)[8]
- Community First Choice Option (CFCO)
- IHSS Residual

Established in 1973, the original IHSS program was originally funded by the State and Counties. In 1993, PCSP was implemented under the Medi-Cal program to cover the same services authorized under IHSS, providing 50 percent federal funding. In August 2004, the IHSS Plus Waiver (IPW) Program became effective, utilizing Medi-Cal funding for services provided by parents and spouses who were not eligible for federal funding in PCSP. The IPW Program was replaced in August 2009 by the IPO Program with no change in program eligibility requirements. In March 2010, the Affordable Care Act (ACA) was enacted allowing for the establishment of a new Medi-Cal state plan option, the CFCO Program. This option enhanced the ability of IHSS to provide community-based personal attendant care services to certain enrollees who would otherwise require institutional care. It also provided a six-percent increase in federal funding for CFCO services and supports that became effective December 1, 2012. California has maintained the original IHSS program as the IHSS Residual Program for IHSS consumers that were ineligible for federal funding and now largely serves individuals who are eligible under a state-only Medi-Cal program.

In-Home Supportive Services Budget

The overall IHSS budget consists of four parts: services, county costs, administration of CMIPS, and state costs. For the budget, the Local Assistance level is broken out into the cost for IHSS services; IHSS administration by the Counties; PAs and NPCs, acting as the IHSS Employer of Record; and the administration of the CMIPS system. State Operations in the budget represents the costs for CDSS' positions and expenses for the IHSS program. The exact amount of federal funding included in each budget item can vary depending on which one of the four IHSS programs is being utilized.

Figure 7 represents a historical view of the IHSS Local Assistance budget, broken out by federal, state, and county shares. All dollar amounts represent billions.

Fiscal Year	Federal	State	County MOE	Total*
FY 2018 – 19	$6.0	$3.8	$1.9	$11.7
FY 2019 – 20	$7.7	$4.3	$1.6	$13.6
FY 2020 – 21	$9.3	$4.4	$1.7	$15.3
FY 2021 – 22	$10.3	$5.1	$1.9	$17.2

[8] Formerly named IHSS Plus Waiver (IPW).

Fiscal Year	Federal	State	County MOE	Total*
FY 2022 – 23	$11.8	$6.1	$1.9	$19.8
FY 2023 – 24	$12.7	$8.0	$2.0	$22.7
FY 2024 – 25[9]	$14.2	$9.5	$2.1	$25.8

* Totals may not add due to rounding.

Figure 7: IHSS Local Assistance Budget

The vast majority of the IHSS budget, specifically 94 percent in FY 2024-25, constitutes IHSS services, which includes wages, health benefits, and non-health benefits paid to IHSS providers. As stated above, the level of federal reimbursement varies based on the program that funds the services. Figure 8 was presented to the workgroup with data from December 2023 to show the breakout of the funding for IHSS services. For the purposes of this report, Figure 8 has been updated to data available as of December 2024:

Program	Federal	State	County	Dec. 2024 Paid Caseload	Percentage of Paid Caseload
ACA[10]	90%	6.5%	3.5%	31,567	4%
CFCO	56%	28.6%	15.4%	380,148	51%
IPO	50%	32.5%	17.5%	22,712	3%
PCSP	50%	32.5%	17.5%	287,660	40%
IHSS Residual	0%	65%	35%	12,638	2%

Figure 8: IHSS Service Costs

The remaining six percent of the IHSS budget constitutes three separate parts: (1) Local Assistance for Counties, PAs and NPCs to administer the IHSS program; (2) Local Assistance for the administration of the CMIPS payrolling system and (3) State Operations cost of IHSS.

In-Home Supportive Services County Maintenance of Effort

Starting after the 1991 Realignment, counties were required to pay 35 percent of the non-federal share of IHSS services costs and 30 percent of the non-federal share of IHSS administrative costs. In 2012, the State implemented the IHSS County Maintenance of Effort (MOE) as part of the Coordinated Care Initiative (CCI). The MOE redefined the statutory required portion of the non-federal share of IHSS to be paid by the counties.

The goal of the MOE was to limit the financial impact to counties when IHSS costs increase due to caseload and hours per case growth. The initial County MOE required counties to pay a set amount of the non-federal share of IHSS costs based on the FY 2011-12 caseload

[9] Local Assistance Budget for FY 2024-25 is based on the 2025-26 Governor's Budget.
[10] ACA cases are part of CFCO, PSCP and IPW but funded by ACA. For this chart ACA cases are separated out to show FMAP funding.

and increased each year by an annual inflation rate of 3.5 percent, as well as any negotiated increases to a county's wages and/or benefits. As part of the 2012 County MOE, any State approved county costs that exceeded the total MOE level were shifted to 100 percent state general fund.

With the ending of CCI in 2017, Governor Brown proposed ending the current MOE and shifting the costs back to the counties, at which point a new County IHSS MOE was negotiated. The new County IHSS MOE included provisions for revenue, collective bargaining provisions, and county administration costs that included:

- An annual MOE amount set in statute at $1,769,443,000.
- An annual inflation rate of 5 percent beginning in FY 2018-19 and 7 percent from FY 2019-20 onward with possible reductions if Realignment revenues grew slowly or decreased.
- Adjustments to the MOE for locally negotiated increases in contract mode and non-health benefits.
- Established FY 2017-18 as the base year for any wage or benefit increases.
- Two new bargaining incentives:
    - Wage supplements which are a specified amount that is in addition to the county provider wage. Wage supplements are included in the calculation of the MOE, thus increases in wage supplements will cause a one-time permanent MOE adjustment. All counties, whose wage rates are at or above minimum wage, or above the state participation cap, can use the wage supplement tool. There is no limit on the amount of the wage supplement; however, the state will only participate up to the state participation cap.
    - 10 Percent Option which allows the counties to secure state participation in the non-federal share of costs of a wage or health benefit increase when the county wage rate is at or above the state participation cap. The limit of state participation for this option is ten percent of the total of the county's wages and health benefits at the time the option is implemented. Counties can utilize the ten percent option in two 3-year periods after minimum wage reached $15 an hour. Currently, 25 counties utilize the ten percent option.

The County IHSS MOE was revised again in 2019 to create a more sustainable fiscal structure for counties to manage IHSS costs after the Department of Finance found that 1991 Realignment could no longer support county costs of IHSS. The new County IHSS MOE included:

- An annual MOE amount set in statute at $1,563,282,000 effective July 1, 2019.
- An annual inflation rate of 4 percent from FY 2020-21 onward.
- Removal of the county administrative costs from the MOE and allocated State General Fund for this purpose.
- Established the base year for any wage or benefit increases as FY 2019-20.
- The two bargaining tools, wage supplement and 10 percent option, described above, continued to be in effect.

State Participation in Wages and Health Benefits

The State participates in the funding of IHSS wages and benefits for providers including wages, overtime pay, health benefits and non-health benefits. For state mandated

changes to wages and/or benefits, such as state minimum wage increases or sick leave pay, the State covers the entire cost of the non-federal share. For increases in locally negotiated wages and/or benefits, the sharing ratio is 65 percent State and 35 percent County for any non-federal share of these costs. Current state statute caps State participation at $1.10 above the State minimum wage. The sum of the hourly wage and health benefits determines if a county is over the State participation cap or the 10 percent option. Counties are solely responsible for the non-federal share of costs for any wages or health benefits over the state participation cap or 10 percent option amount.

In-Home Supportive Services Collective Bargaining Overview

The IHSS providers are represented by one of two unions, SEIU and UDW, depending on which county they reside in. A list of counties and which union represents providers in that county can be found in Appendix C. It is the responsibility of the IHSS Employer of Record in each county to collectively bargain with the union to determine wages and benefits for IHSS providers to reach agreement on a contract, also referred to as a Memorandum of Understanding (MOU). The collective bargaining process may differ slightly from county to county, but in general the process includes the following steps:

- The unions and the IHSS Employer of Record negotiate a new MOU for IHSS providers in a specific county.
- Once the Employer of Record and union agree to a new MOU, the Employer of Record submits the new MOU to the county Board of Supervisors for approval.
- After receiving the Board of Supervisor's approval, the Employer of Record submits the MOU and a rate change packet to CDSS for approval.
- After approving the new rate change packet, CDSS submits the MOU and rate change packet to DHCS for approval for federal funding.
- Once all the approvals are received, CDSS enters any changes to the provider wage and/or benefits rates into CMIPS.

Mediation can be requested by either party if there are disagreements during the bargaining process between the IHSS Employer of Record and a union. If mediation is unsuccessful, either party can refer the negotiations to the PERB factfinding panel review. If there is still no agreement after factfinding and a second mediation, the union can request PERB to reduce a county's realignment funding by ten percent of the county's prior fiscal year's IHSS MOE requirement, as a penalty. This withholding shall continue once per fiscal year, each fiscal year, until the county enters into a collective bargaining agreement with the employee organization[11].

Current Collective Bargaining Statuses

The data in Figure 9 represents updated collective bargaining status for the counties as presented to the workgroup. The original data presented to the workgroup was as of July 2023. For the purposes of this report, the data has been updated to represent all rate

[11] Welfare and Institutions Code Section 12301.61.

changes implemented as of July 1, 2024. For information on an individual county, please see Appendix C.

Collective Bargaining Status	Counties
MOU has not expired	38
Currently Negotiating	13
No Negotiations reported	6
Impasse - Unable to agree	1

Figure 9: Collective Bargaining Status

The one county reporting an impasse is Alpine County. As of May 2024, the union has not requested PERB to reduce the Realignment funding for Alpine County. Only two counties, Lassen and Kern, have been assessed the penalty by PERB and had their Realignment funding withheld. Both counties have subsequently reached agreements and successfully executed contracts.

WORKGROUP DISCUSSION - COLLECTIVE BARGAINING APPROACHES

The formal AB 102 workgroup meetings began in April 2024 and concluded in September 2024. The workgroup was tasked with discussing all topics included in AB 102. As such, the topics were divided as follows:

- April 19, 2024 - Defining Statewide Collective Bargaining
- May 24, 2024 - Defining Regional Collective Bargaining
- June 21, 2024 - IHSS MOUs and Fiscal Impacts
- July 25, 2024 - Scope of IHSS Bargaining and Legislative Considerations
- August 29, 2024 - Realignment and Provider Retention and Recruitment

Prior to the launch of the formal workgroup meetings, workgroup members were asked to participate in interviews conducted by HRA to understand more about how workgroup members viewed the opportunities and challenges of the current county-level approach as well as the costs and benefits of approaches that transition to statewide or regional bargaining. After these interviews, HRA synthesized their major findings and presented the information to the workgroup members at the first meeting on April 19, 2024. There were four categories of opportunities and challenges: overarching, existing county-level approach, possible regional approach, and possible statewide approach.

<u>Overarching opportunities:</u>

- Workgroup members approach this process with an open mind, to see what common ground or workable solutions can be found.
- Workgroup members care about the well-being of consumers as well as providers.
- Workgroup members are excited to explore options related to IHSS collective bargaining.
- Any collective bargaining model will benefit from including consumer voice.

<u>Overarching challenges:</u>

- All providers need to earn a living wage, yet there are funding challenges to achieve this currently or as the program inevitably grows.

- The non-economic issues that are raised in collective bargaining can have economic impacts.

Existing County-Level Opportunities:

- Allows for consideration of local revenue bases and politics, as well as local factors such as cost of living.
- Local relationships can facilitate involvement of consumers, providers, and advisory groups.
- Tools have been developed to help bargaining parties at the local level reach agreements that are financially viable for counties.

Existing County-Level Challenges:

- Ultimate decision-making power lies with the Board of Supervisors, whose priorities may differ from those of IHSS stakeholders.
- County-level collective bargaining has contributed to various wages, benefits, and terms of employment across California's counties.
- Consumer advisory role has been inconsistent across counties.

Possible Regional Approach Opportunities

- Could account for geographic cost-of-living and travel expense differentials.
- Could take into account the potential benefits of both county-level and statewide bargaining.

Possible Regional Approach Challenges

- May be difficult to establish regional boundaries.
- May be difficult to determine what entity has authority to bargain regionally.
- May be difficult to achieve a common voice of the counties in a multi-county region.

Possible Statewide Approach Opportunities

- Greater opportunities in addressing provider recruitment and retention.
- Has the potential to address issues that are not limited to a single county.
- State holds a big picture understanding of the IHSS funding model that can inform negotiations.

Possible Statewide Approach Challenges

- Would have to be very attuned to local funding realities to ensure that resources exist in county-level programs to implement decisions.
- May be difficult to fully consider local issues and nuance.
- Would need to be very clear about what county-level administrative activities cannot be negotiated.

Additionally, as part of the first workgroup meeting before beginning topical discussions and to ensure the discussion stayed in scope, CDSS presented three underlying assumptions related to the IHSS program areas that would not be changed or impacted by statewide collective bargaining as follows:

- IHSS is a self-directed program, regardless of how collective bargaining worked for IHSS providers.
- The counties administer the program at the local level and are responsible for in-home assessments, case management, etc.

- The CDSS is responsible for all payroll activities and maintaining CMIPS.

The workgroup agreed that these three assumptions would not change.

The members then began the task of defining and discussing the concepts of both statewide and regional bargaining. The following section of the report outlines the workgroup's discussions related to define statewide and regional IHSS bargaining. Additionally, the workgroup discussed recruitment and retention, fiscal impacts of collective bargaining, including realignment, potential funding sources, and legislative considerations, which are discussed in other sections of the report below.

Statewide Bargaining

At its first meeting on April 19, 2024, and at the follow-up meeting on May 3, 2024, the workgroup was tasked with discussing how to define statewide bargaining. These meetings included discussions related to who would be bargaining, how consumer voices would be heard, how the statewide bargaining would take regional concerns into consideration, what past or current models could be useful examples, and what would be the scope of bargaining. Please note, that because the issue of scope of bargaining was the subject of significant discussion, it was also discussed separately during the July 25, 2024 meeting and is included as its own section in the report below.

The workgroup generally agreed that the concept of statewide collective bargaining would include transitioning the responsibilities for collective bargaining, currently being executed individually by the 58 counties, to one entity that would act on behalf of the entire state. The state entity would be responsible for all collective bargaining with SEIU and UDW in the development of one master contract for all IHSS providers. The SEIU and UDW would coalition bargain to represent all IHSS providers statewide.

With respect to who would represent at the state, there was discussion about the appropriate entity, including the need to set up a statewide authority. However, it was largely agreed that CalHR would be a strong choice to take primary responsibility for collective bargaining at the statewide level, similar to the role they play with state workers and other bargaining efforts, including childcare bargaining. It was discussed that other entities, such as CDSS and DHCS, would need to have clearly defined, consultative roles in negotiations due to their roles in overseeing implementation, administering the program, and claiming federal funds. The workgroup also expressed that other stakeholders would need to have a voice in the process, including IHSS recipients, PAs, NPCs, counties and their Boards of Supervisors, and other state entities, as appropriate. However, the exact nature of those roles was contingent on several factors. For the counties, for example, there was a correlation between their role in bargaining and how significant their financial obligation would be relative to what the state agreed to in bargaining. Further examples are provided in the workgroup feedback below.

It was envisioned that any negotiated master contract, once accepted by the union members, would be submitted to the Legislature for approval through the budget process and ultimately signed by the Governor once approved.

Workgroup Feedback

In the discussions related to statewide collective bargaining the workgroup provided the following feedback:

- Statewide bargaining could streamline the bargaining process. Instead of having 58 individual counties bargaining separate contracts, there could be one master contract for the entire state.
- In the discussion about who would participate in statewide bargaining, it was suggested that the entities involved in collective bargaining should be determined in part by which entities hold legal responsibilities. Legal responsibilities can be determined by who is responsible for penalties related to bargaining in bad faith, discrimination and/or grievance procedures that are negotiated as part of the contract and may be impacted by how the IHSS Employer of Record is defined.
- There was some interest in using the IHSS Statewide Authority model introduced during the Coordinated Care Initiative as a potential example of how statewide bargaining could be structured.
- There was general agreement that IHSS recipients should be included in any collective bargaining structure, but there was a lack of clarity as to how feedback could be collected from IHSS recipients across the state and how the state would solicit participation.
- Some workgroup members had questions about how statewide bargaining would take into consideration differentials in cost of living, wages, and currently locally bargained benefits, as well as the need for consumer input with a diverse set of perspectives.
- In response to the concerns on local considerations, examples were offered from current state employee bargaining and childcare bargaining that includes regional or local differentials as well as side letters to the master agreement.
- There was substantial discussion on the importance of the involvement of the counties in statewide bargaining, particularly because they administer the program at the local level. It was expressed that the impacts of contracts, whether intentional or unintentional, can go beyond wages and benefits and impact how counties administer the program. It was also expressed that county representatives have deep understanding of local needs and conditions (e.g. specific supplemental wage models, specific uses of realignment funds, specific demands for services) that informs local negotiations and decision-making, and that this nuance will need to be accounted for if bargaining moves to the State.
- Statewide bargaining could potentially result in additional fiscal, administrative/workload, and legal impacts that counties would be unable or unprepared to assume.
- There were concerns raised regarding how locally bargained benefits, such as transit passes, personal protective equipment (PPE), etc., would be identified and preserved in a statewide collective bargaining model.
- The scope of what was included in statewide collective bargaining was discussed in multiple meetings. The workgroup did not have consensus on this issue and options for the scope ranged from narrower, only wages and benefits, to a much broader to include wages, benefits, and all terms and conditions. The workgroup's discussions related to scope of bargaining is documented more in-depth later in this section of the report.

Regional Bargaining

At a subsequent meeting on May 24, 2024, the workgroup was tasked with discussing how to define regional bargaining. This meeting included discussion related to who would be bargaining, how consumer voices would be heard, how the regional bargaining would take county and statewide concerns into consideration, what past or current models could be useful examples, and what would be the scope of bargaining.

The workgroup defined the concept of regional collective bargaining as dividing the state into regions based on a defined criteria and transitioning the responsibilities for collective bargaining to an entity established in each region that would act on behalf of the counties in that region. The regional entity would be responsible for all collective bargaining with SEIU and UDW in the development of one regional contract for IHSS providers. Depending on how the regions were divided, a region could contain counties represented by only one of the unions or both.

The workgroup identified that there could potentially be two different models in regional bargaining that could result in a statewide entity or county entity being responsible for collective bargaining. In one model, a statewide entity would assume the role as IHSS Employer of Record and collectively bargain representing regions across the state. With the second model, the counties and/or Public Authorities would retain the role as the IHSS Employer of Record and would bargain as a coalition representing each pre-determined region. The workgroup as a whole did not think regional bargaining was a viable option for several reasons. These included the complexities of IHSS, including its funding structure, the need for multiple counties to achieve consensus before they could reach an agreement with the union, and the need to establish regions and potentially multiple authorities to bargain for each region.

Workgroup Feedback

In the discussions regarding regional bargaining the workgroup provided the following feedback:

- The workgroup identified numerous issues with regional bargaining and did not think it was a viable option. As such, the workgroup did not discuss this option in as much detail as other issues.
- If regional bargaining was to move forward, the definition of regions would have to be determined based on any number of factors including geography, economics, demographics, etc.
- Concerns were expressed that regional bargaining could be overly complicated because the counties, with very different fiscal situations, political philosophies, and budget limitations, would have to work together and come to agreement.
- While the concept of regional bargaining reduces the overall number of contracts being negotiated across the state, there are still multiple regional contracts that would be difficult to bargain and manage.
- There was a suggested benefit with the concept of regional bargaining that allowed counties and Public Authorities to be more directly involved with collective bargaining than they would be under a statewide model.
- Superior court reporters were identified as an example of how regional bargaining is currently used. California is currently split into four regions for superior court

interpreters and a regional employment relations committee is responsible for bargaining the contract for each region where regions adopt uniform compensation across the region, and other terms and conditions of employment are uniform unless otherwise provided in a written agreement. It was noted, as part of the discussion, that at first look the model seemed comparable, but the funding mechanisms are very different for IHSS where counties and the state share in the costs of the program.

WORKGROUP DISCUSSIONS – OTHER TOPICS

In addition to defining statewide and regional bargaining, the workgroup had robust discussions about other aspects of collective bargaining which are captured in this section.

Stakeholder Involvement

Involving IHSS recipients in collective bargaining was a priority for the workgroup members. The IHSS recipients are often represented in local advisory committees, but their influence and/or involvement is inconsistent and differs from county to county. While all agreed that IHSS recipients should be involved, there was still a lack of consensus on how to include them and solicit participation across the state.

There was discussion about following the same model as the CCI initiative that was legislatively enacted in 2012, when the IHSS Statewide Authority was created to serve as the employer of record of IHSS providers in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties for collective bargaining purposes only. As part of CCI, the IHSS Statewide Authority established a 13-member IHSS Stakeholder Advisory Committee, of which no less than 50 percent of the committee must be individuals who were current or past users of personal assistance services paid for through public or private funds or recipients of IHSS.

The purpose of the IHSS Stakeholder Advisory Committee was to provide ongoing advice and recommendations regarding the IHSS program to the IHSS Statewide Authority. However, there was concern from some workgroup members that a separate advisory committee may not have the ability to substantively contribute or influence bargaining in a meaningful way. As such, while this model was discussed, it was not agreed that the State should replicate it if bargaining moved to a state or regional model.

Based on the feedback from the workgroup, any statewide or regional bargaining model would need to have very clear delineated requirements for including IHSS recipients in the collective bargaining process. It is important to note that there was general agreement about the importance of IHSS recipient input into the bargaining process; however, the workgroup did not reach consensus on how recipients would participate. A range of options was discussed, including recipients serving in an advisory capacity directly to the unions prior to bargaining starting, recipients being appointed to a formal advisory committee by the state, and recipients being at the bargaining table during negotiations.

Employer of Record

In the IHSS program, IHSS recipients are responsible for managing both their services and their provider(s), including approving their provider's timesheet each pay period. Counties administer the program at the local level, providing eligibility determinations, reassessments, and a direct point of contact for recipients. The CDSS is responsible for all payrolling activities executed on behalf of IHSS recipients including, payroll processing, taxes, deductions, and payments. The IHSS Employer of Record is responsible for collective bargaining, provider registry services, managing provider enrollment processes, including provider background checks, providing training for providers and recipients, and providing information/assistance to IHSS providers and recipients necessary for the delivery of IHSS or Waiver Personal Care Services.

The IHSS Employer of Record is defined by statute and is the entity responsible for collective bargaining and other aspects of employment. The AB 1682 (Chapter 90, Statutes of 1999) mandated each county to act as, or establish, an Employer of Record for IHSS providers by January 1, 2003[12].

The CDSS provided an overview of the statutory mandate and the definition of the IHSS Employer of Record to help facilitate workgroup discussions. These discussions provided an opportunity for the workgroup members to ask questions and to discuss the concept of the IHSS Employer of Record, and how the role and/or function would transition to another entity at the state or regional level. Due to their current role as the IHSS Employer of Record, there were concerns raised and questions asked about the implications of statewide or regional bargaining on the PAs and NPCs and the ways in which their current functions might change. In general, the workgroup agreed, for statewide or regional collective bargaining, there would be a material shift in the responsibilities of the PAs and NPCs. Specifically, that the responsibilities related to collective bargaining and conditions of employment would transition to the entity responsible for collective bargaining in a statewide or regional model, but the other duties related to the provider registry, provider enrollment, training and other related duties would remain with the PAs and NPCs.

While at the highest level the workgroup was able to agree that separating these duties between any new entity responsible for collective bargaining at the statewide or regional level and the existing PAs and NPCs was needed, they also highlighted complexities that would potentially need to be addressed with legislation. Also, because CDSS is not involved in the agreements between counties and their PAs/NPCs, the counties would also have to evaluate their current contracts to identify any impacts to the services being provided.

Scope of Bargaining

To prepare for the discussion with the workgroup regarding the potential scope of bargaining for statewide collective bargaining, UC Berkeley reviewed the current MOUs for IHSS providers to identify the range of current benefits, both health and non-health, and

[12] Fifty-six of California's 58 counties established an IHSS Public Authority or Non-Profit Consortium to act on their behalf to fulfill this requirement. Two counties, Alpine and Tuolumne, opted to act as the IHSS Employer of Record and perform the mandated activities themselves.

terms of employment included in the existing contracts for IHSS providers. The benefits offered by county can be found in Appendix D. The following list represents some of the high-level findings presented to the workgroup:

- A subset of MOUs includes negotiated health benefits, with 28 counties having health benefits, 34 counties[13] having dental benefits and 32 counties having vision benefits. Generally, the PA or NPC, as the IHSS Employer of Record in the county, agrees to an employer contribution of a certain health benefits amount per IHSS paid hour, which is then funded with federal, state, and county dollars. Eligibility for these benefits can differ from county to county, with some counties having a limited number of available slots.
- Nine MOUs allocate funding for and develop a training plan for homecare providers and consumers.
- Three MOUs provide incentive payments to IHSS providers for attending programs of education and training. These training incentive payments are separate from the statewide training incentive payments available through the Career Pathways program which is described under the section In-Home Supportive Services Provider Retention and Recruitment.
- Seven MOUs contribute to life insurance program for provider, and dependents in some cases.
- Forty-two MOUs provide PPE or funding for PPE.
- Six MOUs provide transit passes or transportation reimbursement for qualifying providers who travel outside of their home to provide services.
- Forty-three MOUs include payment and payroll procedure language, which includes timesheet and direct deposit procedures, and state that the PA or NPC will assist providers with payroll issues within their purview.

Beyond wages and health benefits, whether additional terms and conditions are collectively bargained varies from county to county. In addition to the list above, MOUs include other clauses including, but not limited to, IHSS recipient and provider rights related to employment, discrimination, union recognition, and other terms of employment.

As the scope of bargaining was discussed with the workgroup, many members discussed the need to clearly define the scope of statewide bargaining in statute. This need was in part in response to confusion under the Coordinated Care Initiative Statewide Authority scope of representation. There were a variety of opinions on how broad or narrow the scope of bargaining should be for statewide or regional collective bargaining models. Broader models would include wages, benefits, and all terms and conditions of employment to help create uniformity and clear designation of responsibilities. Narrower models would be limited to wages and benefits due to the possible unintended impacts on county processes and budgets in statewide collective bargaining, in large part because statewide mandates could impact county administration and may not be able to account for local considerations.

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[13] Included in the 34 counties is Los Angeles County because dental benefits are listed in the MOU. Technically providers in Los Angeles County receive their dental benefits through the union as a union benefit.

Additionally, the workgroup discussed the impact of the IHSS program's unique structure on this question of scope because IHSS services are performed in a recipient's home where neither the State nor the counties have the direct ability to control working conditions. There was also discussion of the impact of statewide or regional collective bargaining on self-direction for IHSS recipients. All workgroup members agreed that self-direction, is a valued core function of the IHSS program and should not be impacted by statewide collective bargaining. Self-direction is defined as the ability for recipients to make their own decisions and manage they own services. IHSS provides a model of service delivery that gives recipients more control over their services. Workgroup members felt that self-direction should not be impacted as self-direction ensured IHSS recipients receive all the necessary services while still allowing a recipient the freedom to choose who serves as their provider and how those services are provided.

During the meetings with the workgroup, there was discussion and consideration of the difference between the impacts of economic (e.g. wages and health benefits) and non-economic factors (i.e. liability for issues in the workplace such as harassment) within the collective bargaining process. There was recognition that the impact of economic factors on county budgets and program administration were more straightforward and easier to quantify, whereas the non-economic factors were more nuanced and could have less evident impacts on county budgets and administrative duties when first discussed but could result in very large changes at the county level. As such, members of the workgroup expressed that any potential statewide collective bargaining process should ensure that counties are given enough time and funding to implement any mandates, including those considered non-economic. These concerns were also highlighted as an example of why counties need to be part of the collective bargaining process.

Other States' Collective Bargaining Strategies

As part of the discussion about the scope of bargaining, representatives from UC Berkeley presented information about how other states approached collective bargaining in other relevant Medicaid-funded, home and community-based programs that utilize self-direction. UC Berkeley conducted interviews with unions and government staff and reviewed collective bargaining agreements, government websites, news articles and statutes for programs in Connecticut, Illinois, Oregon, Massachusetts, Minnesota, and Washington.

Here are some of the key takeaways as presented to the workgroup:

- All six states reviewed by UC Berkeley utilized statewide bargaining but the Employer of Record for bargaining varied from state to state.
- The inclusion of beneficiaries of services in the bargaining process varied by state. In some states, beneficiaries acted in an informal advisory role outside of the bargaining process and in some states, they acted as voting members of the Council deciding the tentative agreement.
- Another key difference is that California's IHSS program is funded by counties in addition to federal and state government and counties play a large role in program administration, while the home care programs in the six other states solely rely on federal and state funding and have a limited local role in program administration.

In the comparison between California and other states with similar programs, it was noted that there are some major differences in both the administration of the various programs, funding, and caseload. In California, IHSS is administered at the local county level, whereas other states managed their programs at the state level. In five of the six states surveyed, the Legislature and Governor determine the budget. In Washington, there is a Consumer-Directed Employer Rate Setting Board which plays a formal role in recommending a vendor rate to the Governor's Office. Once the Governor's Office has assessed the financial viability and approved the proposed rate, it is included in the Governor's budget as a recommendation and then voted on by the Legislature. No other state surveyed shared costs with counties. The size and magnitude of the programs were also significantly smaller than California's program. It was noted by the workgroup that these complexities and differences in programs make it very difficult to make a direct comparison between the various states and how their programs are managed; however, this information allowed the workgroup to see the various possibilities of statewide collective bargaining in home and community-based services programs.

IN-HOME SUPPORTIVE SERVICES PROVIDER RETENTION AND RECRUITMENT

As part of the AB 102 mandate, the workgroup was tasked with exploring how statewide bargaining could potentially impact IHSS provider retention and recruitment. This section of this report focuses on the discussions of the group regarding both available research on this topic and actions the State has taken to provide benefits meant to strengthen the IHSS workforce. As discussed with the workgroup, measuring provider retention rates within the IHSS program have been historically difficult to quantify. Although CDSS maintains the CMIPS system for payrolling, recipients are responsible for hiring and firing providers and are not required to update that information contemporaneously with taking the employment action. The CDSS has found that provider turnover data is inconsistent because there is often a delay in reporting when a provider is terminated or quits. Additionally, because more than 70 percent of providers are related to the recipient they serve, turnover for a majority of IHSS cases is minimal, which can mask issues with recruitment and retention for non-relative providers.

The workgroup began its discussions by acknowledging the challenges with IHSS provider recruitment and retention and expressed significant concerns about provider shortages and how to ensure the IHSS program had sufficient providers to serve all eligible recipients. There was discussion by the workgroup about the impact of statewide bargaining model on wages. Some suggested statewide collective bargaining would likely result in higher wages, although the workgroup acknowledged that is not a guaranteed result. In discussions many workgroup members expressed that while statewide bargaining could potentially level the playing field for providers in counties that experience budgeting challenges, it could also potentially reduce or eliminate the flexibility of bargaining higher wages at the local county level. There were also concerns that statewide bargaining also ties IHSS provider wages to the fluctuating state budget, which could hinder the collective bargaining process and delay any potential gains in wages.

Additionally, UC Berkeley presented findings that suggest retention plays a large part in the outcomes of recipients of home and community-based services. For instance, the research showed that increases in wages for home care workers correlated with decreases in worker

turnover rates, especially for non-family caregivers. UC Berkeley also found that continuity of care correlated with better health and well-being among recipients of these services and increased ability for recipients of services to complete activities of daily living. Finally, the studies suggested increased wages are associated with a positive impact on patient outcomes in skilled nursing settings.

UC Berkeley presented on research specific to IHSS that showed that wages had a strong association with continuity of care and provider retention, especially for non-family caregivers. UC Berkeley also presented on research across other industries that show wage increases have the greatest impact on worker retention, and benefit increases have the second greatest impact.

As of July 1, 2024, hourly IHSS wages range from the minimum wage of $16.00/hour in Kern[14] and Siskiyou counties to $21.50/hour in San Francisco County. The unweighted average IHSS wage across California is $17.52/hour (to see each individual county's wage, see Appendix C). As of July 1, 2024, 35 counties provide health, dental and/or vision benefits based on collective bargaining agreements. Additionally, some counties provide other benefits to IHSS providers (to see all benefits offered, see Appendix D). The State does not have data to quantify the impact of wages and benefits on IHSS provider recruitment and retention across different counties.

Additionally, IHSS providers receive certain benefits related to their employment because of changes in state law. Beginning in July 2018, sick leave became available for current, active IHSS program providers on an annual basis. The IHSS providers initially accrued 8 hours of sick leave annually, then it increased to 16 hours in 2020, and to 24 hours in 2022. Recent legislation[15] increased the accrual of paid sick leave for IHSS providers to 40 hours per year, effective July 1, 2024.

The IHSS providers also have the opportunity to contribute to an Individual Retirement Account (IRA), by having funds directly debited from their bank account, through the CalSavers program since 2021. Beginning January 1, 2024, IHSS providers were able to voluntarily opt-in to deduct CalSavers contributions directly from their paychecks to make it more convenient for providers to contribute to their retirement account. The CDSS continues to outreach to providers about this benefit. The CDSS is unable to track providers who contribute to CalSavers directly debited from their bank account, but as of August 12, 2024, 504 IHSS providers have opted-in to deduct contributions directly from their paychecks.

In Fiscal Year 2021-22, California made a one-time investment in the IHSS workforce through the IHSS Career Pathways program funded by the federal Home and Community-Based Services Spending Plan. The IHSS Career Pathways program was a pilot training project to incentivize, support, and fund training for IHSS providers. Career Pathways allowed IHSS providers to take training classes in five different pathways to help enhance their skills to

[14] Kern County is implementing a wage supplement effective August 1, 2024, that will increase the hourly wage in Kern County to $16.60/hour. This is point in time information and may differ based on when the report is published.

[15] Senate Bill 616 (Chapter 309, Statutes 2023)

better serve IHSS recipients and to support the recruitment, retention, and advancement of providers. As of August 31, 2024, the program has served more than 51,000 providers. The IHSS Career Pathways classes ended on September 17, 2024, with the program concluding on December 31, 2024. The CDSS is required to submit a final report to the Legislature about the program by September 2025, which will include information about its impact on recruitment and retention of IHSS providers.

FISCAL IMPACTS OF STATEWIDE COLLECTIVE BARGAINING

As required by AB 102, the workgroup discussed the potential fiscal impacts of statewide collective bargaining as it relates to the growth in provider wages and benefits. The CDSS presented the current funding structure of the program, as well as the cost for each dollar increase in wages and/or benefits as prepared by the CDSS Fiscal and Estimates team. The estimates and methodology used to put together the calculations in this section are consistent with the methodology used by CDSS in developing the annual Governor's budget.

All information related to costs in this report relies on point-in-time assumptions. Different assumptions would result in a change to the cost estimates presented in this report, which could be upwards of billions in additional State General Fund costs. Additionally, the report assumes continued receipt of federal funds for the IHSS program pursuant to current law. The fiscal implications of any changes in federal policy could also be upwards of billions in additional State General Fund costs.

The first section below reflects cost assumptions for the fiscal impacts of a potential statewide collective bargaining model based on the 2024-25 May Revision. These assumptions were presented to the workgroup in June 2024. However, since the final workgroup meeting, IHSS caseload has changed significantly based on recent updates in the 2025-26 Governor's Budget. The second section reflects the estimates under the revised caseload growth rate of 7.5 percent, which more accurately reflects the updated costs associated with a statewide collective bargaining model compared to the model used in the first section based on a caseload growth rate of 4.01 percent. Caseload projections continue to increase year-over-year at a significant rate over the budget multi-year window.

Cost Assumptions Presented to the Workgroup (Based on the 4.01 Percent Caseload Growth).

- The potential implementation date for any rate increases would be July 1, 2027.
- For purposes of the workgroup, CDSS estimates that the Services part of the IHSS program will grow by a cumulative 8.56 percent annually due to the increase in caseload, hours per case, and cost per hour. This rate of growth is for paid cases, not authorized cases and includes:
    - Caseload growth of 4.01 percent[16];
        - Please note, that caseload is the most variable of the three cost drivers so changes in actual caseload growth will impact actual costing.
    - Hours per case increase at 1.24 percent; and
    - Cost per hour growth of 3.1 percent which includes estimated minimum wage increases of $0.50 each year.

[16] The exact caseload growth in the 2024-25 May Revision is 4.00826% but is rounded for the report.

- The federal share would be 54.89 percent of the total cost. The non-federal portion of any increases were split by the historical 65 percent State/35 percent County which equates to 29.32 percent for the state and 15.79 percent for the county for the total cost.
- The State participation cap would be eliminated in the statewide collective bargaining model as the limit to the State's participation would be expressed via approval during the statewide collective bargaining process.
- For purposing of costing, CDSS increased the County MOE by only the 4 percent inflation factor which impacts the overall costs of wage increases.

To estimate the annual caseload growth of the IHSS program, CDSS used the estimated monthly paid caseload for Individual Provider cases for FY 2024/25 and multiplied it by the annual caseload growth rate of 4.01 percent to determine the caseload for the next seven years. Figure 10 represents the estimated caseload growth by fiscal year based on CDSS' 4.01 percent growth assumption (actual caseload growth may differ):

Fiscal Year	Monthly Paid Cases
FY 2024-25	703,072
FY 2025-26	731,253
FY 2026-27	760,564
FY 2027-28	791,049
FY 2028-29	822,756
FY 2029-30	855,734
FY 2030-31	890,034
FY 2031-32	925,709

Figure 10: Estimated Monthly Paid Cases

To calculate the average number of hours per IHSS recipient's case, CDSS multiplied the hours per case for each county in the previous 12 months by the hourly growth rate for each case of 1.24 percent. Figure 11 shows the estimated increase in hours per case over the next eight years.

Fiscal Year	Hours per Case
FY 2024-25	125.1
FY 2025-26	126.7
FY 2026-27	128.2
FY 2027-28	129.8
FY 2028-29	131.4
FY 2029-30	133.1
FY 2030-31	134.7
FY 2031-32	136.4

Figure 11: Estimated Average Monthly Hours per Case

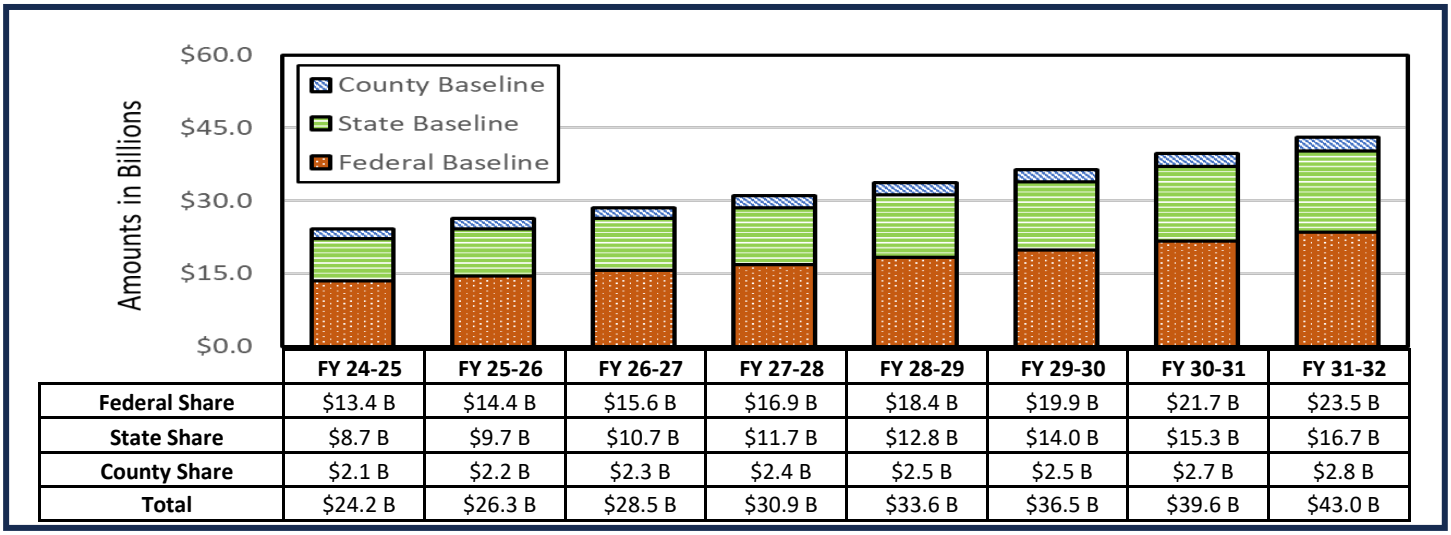
The CDSS then calculated the estimated annual increase in total caseload hours by multiplying the estimated caseload by the estimated hours per case, which is represented in Figure 12:

Fiscal Year	Monthly Paid Caseload	Hours per Case	Months per Year	Estimated Total Paid Hours per Year
FY 2024-25	703,072	125.1	12	1,055,451,686.4
FY 2025-26	731,253	126.7	12	1,111,797,061.2
FY 2026-27	760,564	128.2	12	1,170,051,657.6
FY 2027-28	791,049	129.8	12	1,232,137,922.4
FY 2028-29	822,756	131.4	12	1,297,321,660.8
FY 2029-30	855,734	133.1	12	1,366,778,344.8
FY 2030-31	890,034	134.7	12	1,438,650,957.6
FY 2031-32	925,709	136.4	12	1,515,200,491.2

Figure 12: Estimated Paid Hours Increase

To estimate the baseline growth in annual services costs, CDSS used the IHSS Services line item included in the FY 2024-25 Appropriation Table for the Governor's Budget as the starting point for IHSS Services Costs. The CDSS then applied an 8.56 percent growth rate to show the estimated annual increases in the cost of the program. As stated above, the 8.56 percent rate includes the growth in caseload, recipient's hours per a case and hourly wage rate, including the minimum wage increases. Additionally, to calculate the county share of the wage increases, CDSS used the estimated MOE for the FY 2024-25 as included in the 2024-25 May Revision and added the 4 percent inflation factor in subsequent years.

- Figure 13 represents the estimated baseline growth of the Services costs of the IHSS program under current conditions. With the statutory increases to minimum wage, under current law, estimated growth in caseload and hours per case, the **cost of the IHSS program is estimated to grow by $18.8 Billion Total Funds (TF) from FY 2024-25 to FY 2031-32.** Using the current funding structure associated with the IHSS program, the Federal and State costs for IHSS Services will almost double, while county share will remain flat due to the current MOE.



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Share	$13.4 B	$14.4 B	$15.6 B	$16.9 B	$18.4 B	$19.9 B	$21.7 B	$23.5 B
State Share	$8.7 B	$9.7 B	$10.7 B	$11.7 B	$12.8 B	$14.0 B	$15.3 B	$16.7 B
County Share	$2.1 B	$2.2 B	$2.3 B	$2.4 B	$2.5 B	$2.5 B	$2.7 B	$2.8 B
Total	$24.2 B	$26.3 B	$28.5 B	$30.9 B	$33.6 B	$36.5 B	$39.6 B	$43.0 B

Figure 13: Estimated Baseline Growth in Annual IHSS Services Costs

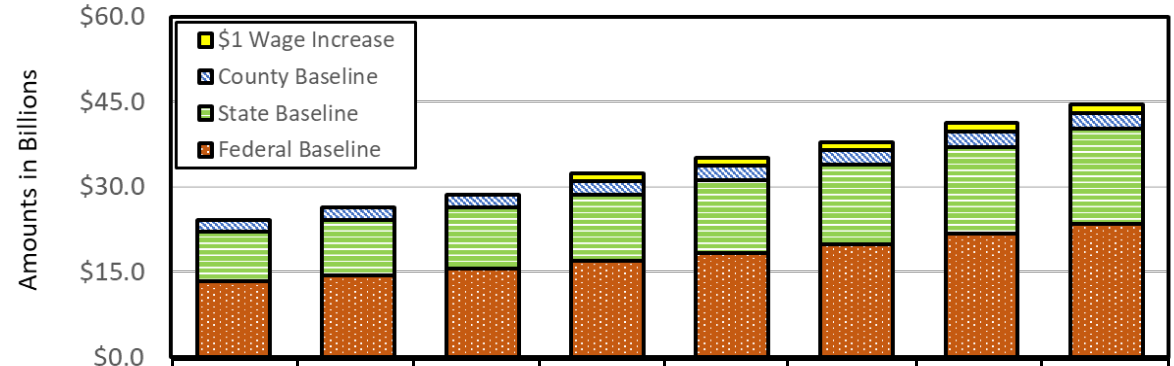
The CDSS was mandated to calculate the cost impacts of increasing wages and/or benefits dollar for dollar. From the estimated total paid hours per year in Figure 12, one can estimate the cost of $1 increase in **Benefits** by multiplying $1 by the total paid hours per year and separating the costs into federal (54.89 percent), state (29.32 percent) and county (15.79 percent). It is critical to note that the figures with cost estimates in this section do not include the potential costs for non-wage benefits such as transportation, healthcare, retirement, PPE, life insurance, dental, tuition reimbursement, training, and other provider benefits. The costs of non-wage benefits were not included in these estimates because these benefits can vary widely based on negotiations and could potentially cost billions of dollars in addition to the increased costs of wage increases, depending on the type of benefits that would be included under a potential statewide bargaining model.

To estimate the cost for each initial **Wage** increase, assuming an implementation date of July 1, 2027, CDSS utilized the number of hours multiplied by the increased wage rate, factoring in overtime hours based on the current utilization rates[17]. Once the estimated, initial cost for each wage increase was complete, CDSS then calculated the impact to future year's costs by applying the rates for caseload growth (4.01 percent) and hours per case growth (1.24 percent). The following tables represent the total costs for each wage increase in dollar increments.

- Figure 15 represents the total fiscal impact to the program for a $1 statewide wage increase. Conservatively, the initial cost would be $1.3 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $32.2 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $44.6 billion TF,

[17] The original Fiscal Impact presented to the workgroup in June 2024 did not consider the impact of $1 wage increases on providers' travel costs, as required by the Fair Labor Standards Act (FLSA). The impact of $1 increase on travel costs is an estimated $1.8 million TF/$1.0 million SGF in FY 2027-28. Onward, travel costs are estimated to increase annually $150,000 TF/$75,000 SGF.

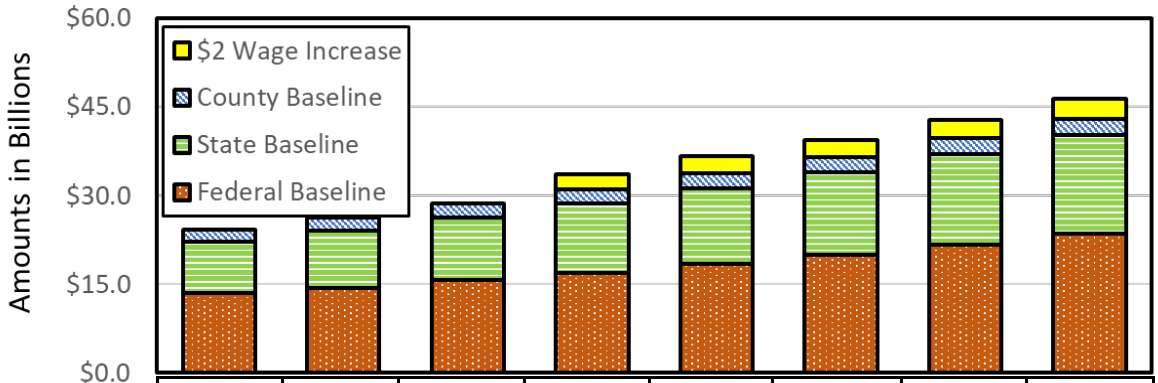
with $17.2 billion GF by FY 2031-32, **a State General Fund increase of 60.7 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$0.7 B	$0.8 B	$0.8 B	$0.8 B	$0.9 B
State Cost of Wage Increase				$0.4 B	$0.4 B	$0.4 B	$0.4 B	$0.5 B
County Cost of Wage Increase				$0.2 B	$0.2 B	$0.2 B	$0.2 B	$0.3 B
Total Cost of Wage Increase				$1.3 B	$1.4 B	$1.4 B	$1.5 B	$1.6 B
Total Federal Cost	$13.4 B	$14.4 B	$15.6 B	$17.6 B	$19.1 B	$20.7 B	$22.5 B	$24.4 B
Total State Cost	$8.7 B	$9.7 B	$10.7 B	$12.0 B	$13.2 B	$14.4 B	$15.7 B	$17.2 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$2.6 B	$2.7 B	$2.8 B	$2.9 B	$3.0 B
Grand Total	$24.2 B	$26.3 B	$28.5 B	$32.2 B	$35.0 B	$37.9 B	$41.1 B	$44.6 B

Figure 15: Estimated Growth in Annual Program Costs With a $1/hr. Increase in All Wages

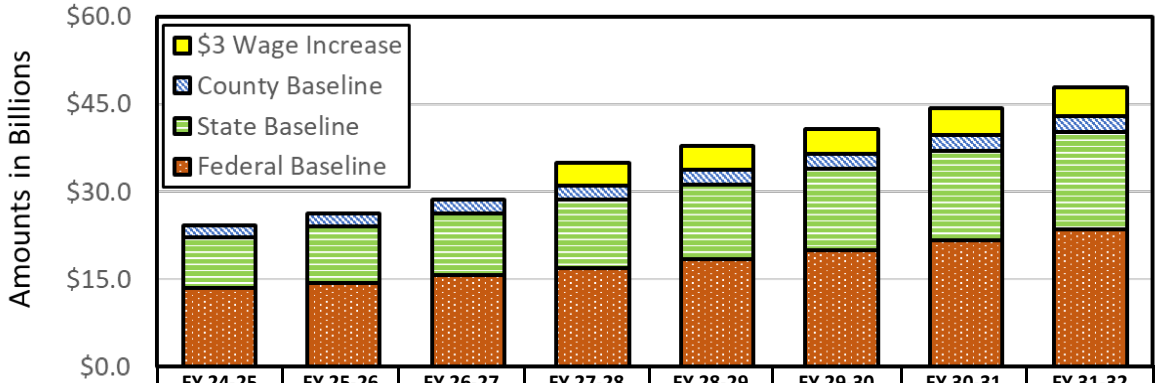
- Figure 16 represents the total fiscal impact to the program for a $2 statewide wage increase. Conservatively, the initial cost would be $2.6 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $33.5 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $46.2 billion TF, with $17.7 billion GF by FY 2031-32, **a State General Fund increase of 65.4 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$1.4 B	$1.5 B	$1.6 B	$1.7 B	$1.8 B
State Cost of Wage Increase				$0.8 B	$0.8 B	$0.8 B	$0.9 B	$0.9 B
County Cost of Wage Increase				$0.4 B	$0.4 B	$0.4 B	$0.5 B	$0.5 B
Total Cost of Wage Increase				$2.6 B	$2.7 B	$2.9 B	$3.0 B	$3.2 B
Total Federal Cost	$13.4 B	$14.4 B	$15.6 B	$18.4 B	$19.9 B	$21.5 B	$23.3 B	$25.3 B
Total State Cost	$8.7 B	$9.7 B	$10.7 B	$12.4 B	$13.6 B	$14.8 B	$16.2 B	$17.7 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$2.8 B	$2.9 B	$3.0 B	$3.1 B	$3.3 B
Grand Total	$24.2 B	$26.3 B	$28.5 B	$33.5 B	$36.3 B	$39.4 B	$42.6 B	$46.2 B

Figure 16: Estimated Growth in Annual Program Costs With a $2/hr. Increase in All Wages

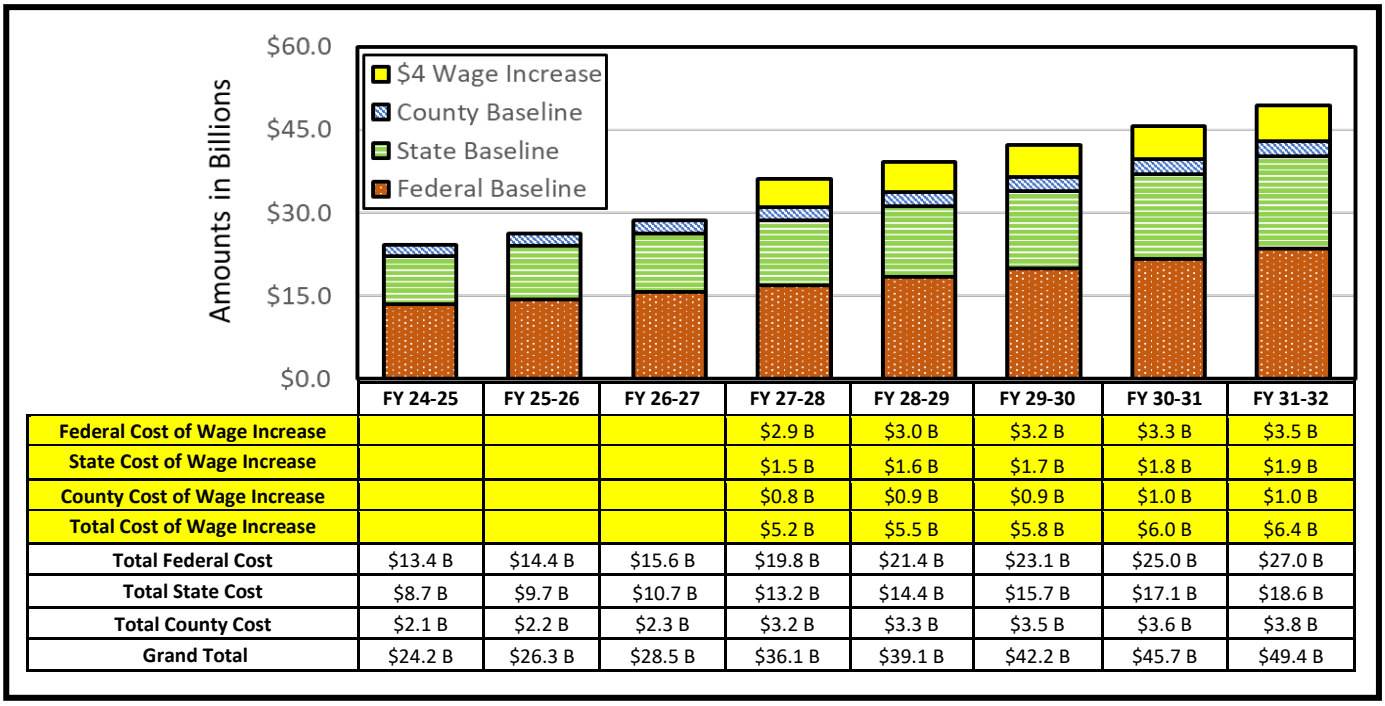
- Figure 17 represents the total fiscal impact to the program for a $3 statewide wage increase. Conservatively, the initial cost would be $3.9 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $34.8 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $47.8 billion TF, with $18.1 billion GF by FY 2031-32, **a State General Fund increase of 69.2 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$2.1 B	$2.3 B	$2.4 B	$2.5 B	$2.6 B
State Cost of Wage Increase				$1.1 B	$1.2 B	$1.3 B	$1.3 B	$1.4 B
County Cost of Wage Increase				$0.6 B	$0.6 B	$0.7 B	$0.7 B	$0.8 B
Total Cost of Wage Increase				$3.9 B	$4.1 B	$4.3 B	$4.6 B	$4.8 B
Total Federal Cost	$13.4 B	$14.4 B	$15.6 B	$19.1 B	$20.6 B	$22.3 B	$24.2 B	$26.1 B
Total State Cost	$8.7 B	$9.7 B	$10.7 B	$12.8 B	$14.0 B	$15.2 B	$16.6 B	$18.1 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$3.0 B	$3.1 B	$3.2 B	$3.4 B	$3.5 B
Grand Total	$24.2 B	$26.3 B	$28.5 B	$34.8 B	$37.7 B	$40.8 B	$44.1 B	$47.8 B

Figure 17: Estimated Growth in Annual Program Costs With a $3/hr. Increase in All Wages

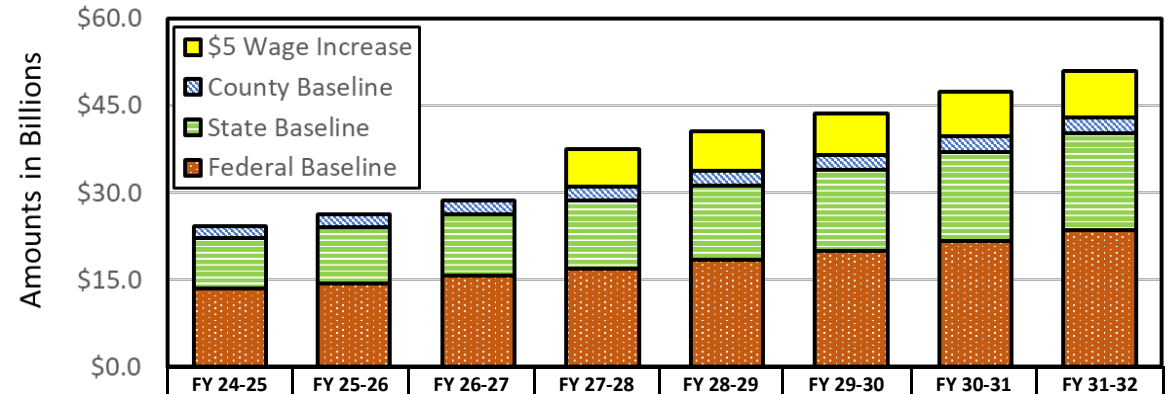
- Figure 18 represents the total fiscal impact to the program for a $4 statewide wage increase. Conservatively, the initial cost would be $5.2 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $36.1 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $49.4 billion TF, with $18.6 billion GF by FY 2031-32, **a State General Fund increase of 73.4 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$2.9 B	$3.0 B	$3.2 B	$3.3 B	$3.5 B
State Cost of Wage Increase				$1.5 B	$1.6 B	$1.7 B	$1.8 B	$1.9 B
County Cost of Wage Increase				$0.8 B	$0.9 B	$0.9 B	$1.0 B	$1.0 B
Total Cost of Wage Increase				$5.2 B	$5.5 B	$5.8 B	$6.0 B	$6.4 B
Total Federal Cost	$13.4 B	$14.4 B	$15.6 B	$19.8 B	$21.4 B	$23.1 B	$25.0 B	$27.0 B
Total State Cost	$8.7 B	$9.7 B	$10.7 B	$13.2 B	$14.4 B	$15.7 B	$17.1 B	$18.6 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$3.2 B	$3.3 B	$3.5 B	$3.6 B	$3.8 B
Grand Total	$24.2 B	$26.3 B	$28.5 B	$36.1 B	$39.1 B	$42.2 B	$45.7 B	$49.4 B

Figure 18: Estimated Growth in Annual Program Costs With a $4/hr. Increase in All Wages

- Figure 19 represents the total fiscal impact to the program for a $5 statewide wage increase. Conservatively, the initial cost would be $6.5 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $37.4 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $51 billion TF, with $19.1 billion GF by FY 2031-32, **a State General Fund increase of 78.5 percent since 2026-27.**

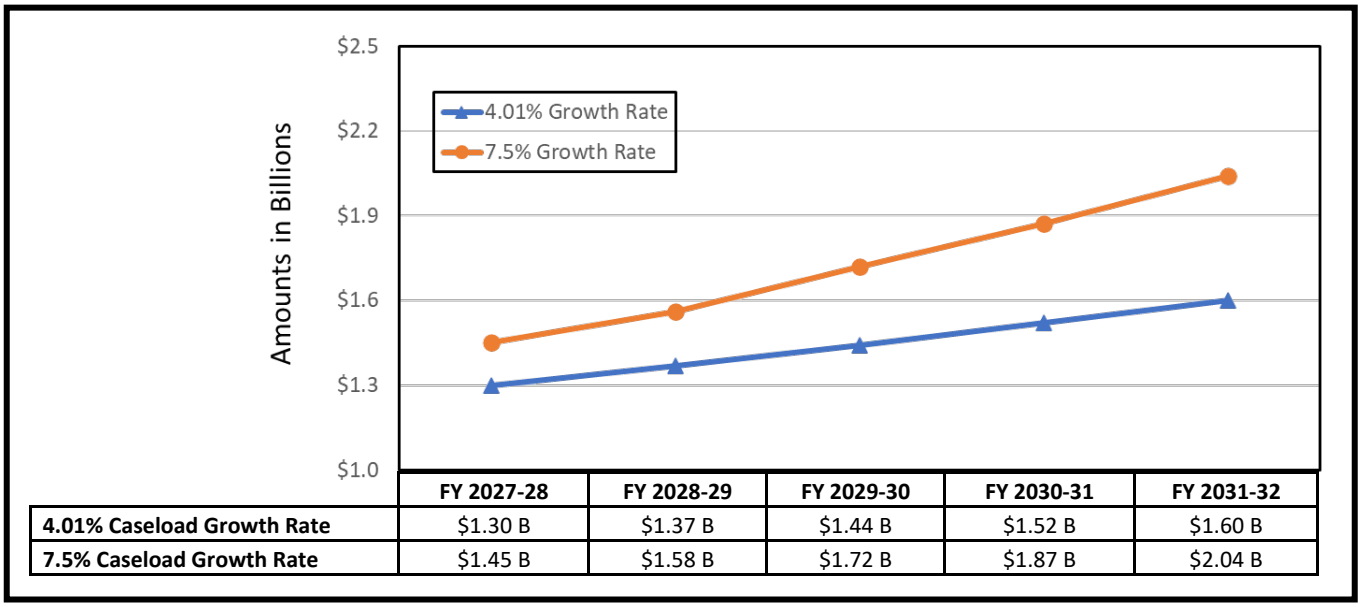


	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$3.6 B	$3.8 B	$4.0 B	$4.2 B	$4.4 B
State Cost of Wage Increase				$2.0 B	$2.0 B	$2.1 B	$2.2 B	$2.3 B
County Cost of Wage Increase				$1.0 B	$1.1 B	$1.1 B	$1.2 B	$1.3 B
Total Cost of Wage Increase				$6.5 B	$6.8 B	$7.2 B	$7.6 B	$8.0 B
Total Federal Cost	$13.4 B	$14.4 B	$15.6 B	$20.5 B	$22.1 B	$23.9 B	$25.8 B	$27.9 B
Total State Cost	$8.7 B	$9.7 B	$10.7 B	$13.6 B	$14.8 B	$16.1 B	$17.5 B	$19.1 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$3.4 B	$3.5 B	$3.7 B	$3.8 B	$4.0 B
Grand Total	$24.2 B	$26.3 B	$28.5 B	$37.4 B	$40.4 B	$43.7 B	$47.2 B	$51.0 B

Figure 19: Estimated Growth in Annual Program Costs With a $5/hr. Increase in All Wages

Revised 2025-26 Governor's Budget Caseload Assumptions (Based on the 7.5 Percent Caseload Growth).

Since presenting the initial fiscal estimate (based on the 4.01 percent caseload growth rate) to the workgroup in June 2024, the caseload growth rate for the IHSS program increased to 7.5 percent from FY 2024-25 to FY 2025-26 as reflected in the 2025-26 Governor's Budget. This revised model adjusts the caseload percentage, hours per case, and cost per hour to include the most updated numbers included in the 2025-26 Governor's Budget. However, caseload projections continue to increase year-over-year at a significant rate over the budget multi-year window, with program expenditures to also significantly increase. As shown in Figure 20, this higher caseload growth rate of 7.5 percent will have a greater impact on the cost of a $1 wage increase than the previous 4.01 percent caseload growth rate. In addition, the figures with cost estimates do not include the potential costs for non-wage benefits such as transportation, healthcare, retirement, PPE, life insurance, dental, tuition reimbursement, training, and other provider benefits. The costs of non-wage benefits were not included in these estimates because these benefits can vary widely based on negotiations and could potentially cost billions of dollars, depending on the type of benefits that would be included under a potential statewide bargaining model.



	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32
4.01% Caseload Growth Rate	$1.30 B	$1.37 B	$1.44 B	$1.52 B	$1.60 B
7.5% Caseload Growth Rate	$1.45 B	$1.58 B	$1.72 B	$1.87 B	$2.04 B

Figure 20: Estimated Cost in $1 Statewide Wage Increase Based on 2024-25 May Revision vs 2025-26 Governor's Budget Caseload Growth Rates

Due to the impact of the increased caseload growth rate, CDSS revised the fiscal impact of statewide collective bargaining that was originally presented to the workgroup, with the more current 7.5 percent caseload growth rate, as shown in this section. In preparing the revised fiscal impact, CDSS used the following assumptions similar to the fiscal impact for the 4.01 percent:

- The potential implementation date for any rate increases would be July 1, 2027.
- The federal share would be 54.89 percent of the total cost. The non-federal portion of any increases were split by the historical 65 percent State/35 percent County which equates to 29.32 percent for the state and 15.79 percent for the county for the total cost.
- The State participation cap would be eliminated in the statewide collective bargaining model as the limit to the State's participation would be expressed via approval during the statewide collective bargaining process.
- For the purpose of costing, CDSS increased the County MOE by the 4 percent inflation factor, which impacts the overall cost of wage increases.

For the revised fiscal impact of the 7.5 percent caseload growth rate, CDSS updated the following growth rates to those listed in the 2025-26 Governor's Budget:

- Instead of 8.56 percent cumulative growth rate, CDSS estimates that the Services part of the IHSS program will grow by a cumulative 11.77 percent annual rate due to the increase in caseload, hours per case, and cost per hour. This rate of growth is for paid cases, not authorized cases and includes:
    - Caseload growth of 7.5 percent (revised from 4.01 percent);
        - Please note, that caseload is the most variable of the three cost drivers so changes in actual caseload growth will impact actual costing.

- Hours per case increase at 1.2 percent (revised from 1.29 percent); and Cost per hour growth of 2.74 percent (revised from 3.1 percent) which includes estimated minimum wage increases of $0.50 each year.

If any of these assumptions were to grow beyond the current trend, actual costs would be higher.

To estimate the annual caseload growth of the IHSS program, CDSS used the estimated monthly paid caseload for Individual Provider cases for FY 2024-25 and multiplied it by the annual caseload growth rate of 7.5 percent to determine the caseload for the next seven years. Figure 21 represents the revised estimated caseload growth by fiscal year based on the 7.5 percent caseload growth assumption (actual caseload growth may differ):

Fiscal Year	Monthly Paid Cases
FY 2024-25	716,822
FY 2025-26	770,584
FY 2026-27	828,378
FY 2027-28	890,506
FY 2028-29	957,294
FY 2029-30	1,029,091
FY 2030-31	1,106,273
FY 2031-32	1,189,243

Figure 21: Estimated Monthly Paid Cases

To calculate the average number of hours per IHSS recipient's case, CDSS multiplied the hours per case for each county in the previous 12 months by the hourly growth rate for each case of 1.2 percent. Figure 22 shows the estimated increase in hours per case over the next eight years.

Fiscal Year	Hours per Case
FY 2024-25	124.1
FY 2025-26	125.6
FY 2026-27	127.1
FY 2027-28	128.6
FY 2028-29	130.1
FY 2029-30	131.7
FY 2030-31	133.3
FY 2031-32	134.9

Figure 22: Estimated Average Monthly Hours per Case

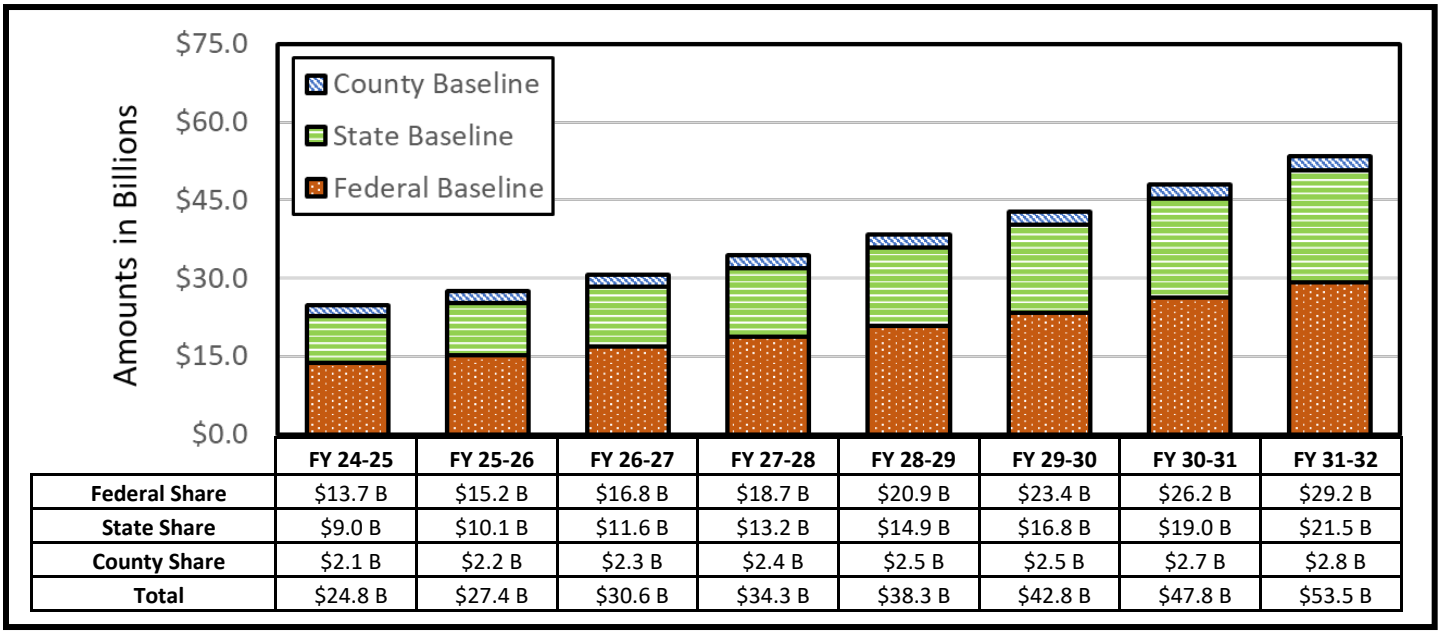
The CDSS then calculated the estimated annual increase in total caseload hours by multiplying the estimated caseload by the estimated hours per case, which is represented in Figure 23:

Fiscal Year	Monthly Paid Caseload	Hours per Case	Months per Year	Estimated Total Paid Hours per Year
FY 2024-25	716,822	124.1	12	1,067,491,322
FY 2025-26	770,584	125.6	12	1,161,424,205
FY 2026-27	828,378	127.1	12	1,263,441,821
FY 2027-28	890,506	128.6	12	1,374,229,068
FY 2028-29	957,294	130.1	12	1,494,527,541
FY 2029-30	1,029,091	131.7	12	1,626,375,657
FY 2030-31	1,106,273	133.3	12	1,769,594,273
FY 2031-32	1,189,243	134.9	12	1,925,147,318

Figure 23: Estimated Paid Hours Increase

To estimate the baseline growth in annual services costs, CDSS used the IHSS Services line item included in the 2025-26 Governor's Budget as the starting point for IHSS Services Costs. The CDSS then applied a 11.77 percent growth rate to show the estimated annual increases in the cost of the program. The 11.77 percent rate includes the growth in caseload, recipients' hours per a case and hourly wage rate, including the minimum wage increases. Additionally, to calculate the county share of the wage increases, CDSS used the estimated MOE for the FY 2024-25 as included in the 2025-26 Governor's Budget and added the 4 percent inflation factor in subsequent years.

- Figure 24 represents the estimated baseline growth of the Services costs of the IHSS program under current conditions. With the statutory increases to minimum wage, under current law, estimated growth in caseload and hours per case, the cost of the IHSS program is estimated to grow by $28.7 billion TF from FY 2024-25 to FY 2031-32. Using the current funding structure associated with the IHSS program, the Federal costs for IHSS Services will double, the State costs will increase by approximately 2.5 times and the county share will increase, but more gradually due to the current MOE.



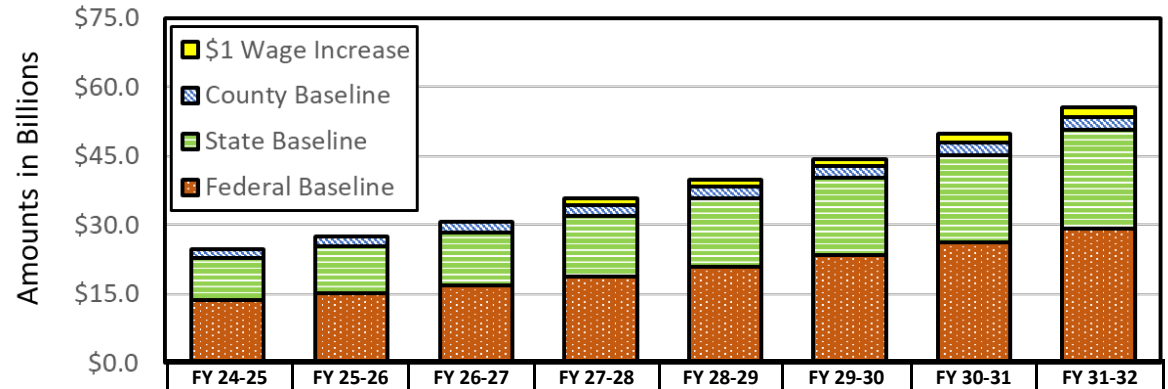
	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Share	$13.7 B	$15.2 B	$16.8 B	$18.7 B	$20.9 B	$23.4 B	$26.2 B	$29.2 B
State Share	$9.0 B	$10.1 B	$11.6 B	$13.2 B	$14.9 B	$16.8 B	$19.0 B	$21.5 B
County Share	$2.1 B	$2.2 B	$2.3 B	$2.4 B	$2.5 B	$2.5 B	$2.7 B	$2.8 B
Total	$24.8 B	$27.4 B	$30.6 B	$34.3 B	$38.3 B	$42.8 B	$47.8 B	$53.5 B

Figure 24: Estimated Baseline Growth in Annual IHSS Services Costs

The CDSS was mandated to calculate the cost impacts of increasing wages and/or benefits dollar for dollar. From the estimated total paid hours per year in Figure 23, one can estimate the cost of $1 increase in benefits by multiplying $1 by the total paid hours per year and separating the costs into federal (54.89 percent), state (29.32 percent) and county (15.79 percent). It is critical to note that the figures with cost estimates in this section do not include the potential costs for non-wage benefits such as transportation, healthcare, retirement, PPE, life insurance, dental, tuition reimbursement, training, and other provider benefits. The costs of non-wage benefits were not included in these estimates because these benefits can vary widely based on negotiations and could potentially cost billions of dollars, depending on the type of benefits that would be included under a potential statewide bargaining model.

To estimate the cost for each initial wage increase, assuming an implementation date of July 1, 2027, CDSS utilized the number of total paid hours multiplied by the increased wage rate, factoring in overtime hours and travel costs based on the current utilization rates. Once the estimated, initial cost for each wage increase was complete, CDSS then calculated the impact to future year's costs by applying the rates for caseload growth (7.5 percent) and hours per case growth (1.2 percent). The following tables represent the total costs for each wage increase in dollar increments.

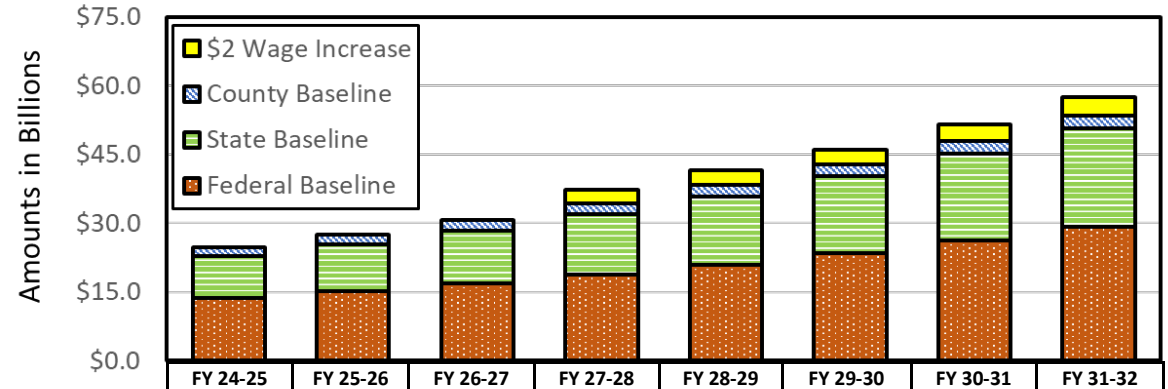
- Figure 26 represents the total fiscal impact to the program for a $1 statewide wage increase. The initial cost would be $1.5 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $35.7 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $55.5 billion TF, with $22.1 billion GF by FY 2031-32, **a State General Fund increase of 90.5 percent since 2026-27**.



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$0.8 B	$0.9 B	$0.9 B	$1.0 B	$1.1 B
State Cost of Wage Increase				$0.4 B	$0.5 B	$0.5 B	$0.6 B	$0.6 B
County Cost of Wage Increase				$0.2 B	$0.3 B	$0.3 B	$0.3 B	$0.3 B
Total Cost of Wage Increase				$1.5 B	$1.6 B	$1.7 B	$1.9 B	$2.0 B
Total Federal Cost	$13.7 B	$15.2 B	$16.8 B	$19.5 B	$21.8 B	$24.3 B	$27.2 B	$30.3 B
Total State Cost	$9.0 B	$10.1 B	$11.6 B	$13.6 B	$15.4 B	$17.3 B	$19.6 B	$22.1 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$2.6 B	$2.7 B	$2.8 B	$2.9 B	$3.1 B
Grand Total	$24.8 B	$27.4 B	$30.6 B	$35.7 B	$39.9 B	$44.5 B	$49.7 B	$55.5 B

Figure 26: Estimated Growth in Annual Program Costs With a $1/hr. Increase in All Wages

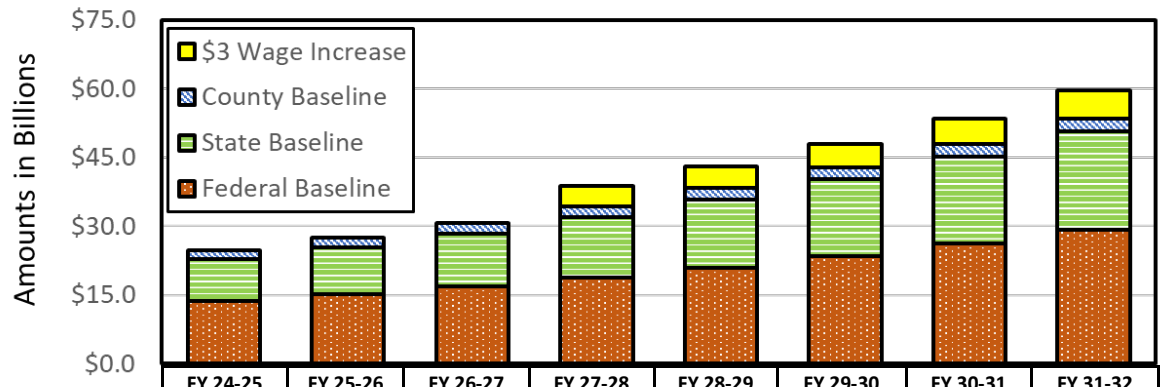
- Figure 27 represents the total fiscal impact to the program for a $2 statewide wage increase. The initial cost would be $2.9 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $37.2 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $57.5 billion TF, with $22.7 billion GF by FY 2031-32, **a State General Fund increase of 95.7 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$1.6 B	$1.7 B	$1.9 B	$2.0 B	$2.2 B
State Cost of Wage Increase				$0.9 B	$0.9 B	$1.0 B	$1.1 B	$1.2 B
County Cost of Wage Increase				$0.5 B	$0.5 B	$0.5 B	$0.6 B	$0.6 B
Total Cost of Wage Increase				$2.9 B	$3.2 B	$3.4 B	$3.7 B	$4.0 B
Total Federal Cost	$13.7 B	$15.2 B	$16.8 B	$20.3 B	$22.7 B	$25.3 B	$28.2 B	$31.5 B
Total State Cost	$9.0 B	$10.1 B	$11.6 B	$14.0 B	$15.8 B	$17.9 B	$20.1 B	$22.7 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$2.8 B	$3.0 B	$3.1 B	$3.2 B	$3.4 B
Grand Total	$24.8 B	$27.4 B	$30.6 B	$37.2 B	$41.4 B	$46.2 B	$51.6 B	$57.5 B

Figure 27: Estimated Growth in Annual Program Costs With a $2/hr. Increase in All Wages

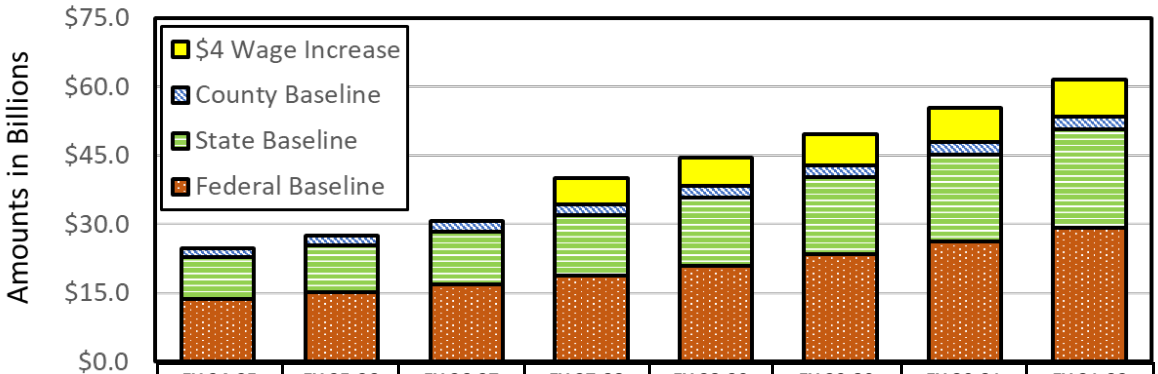
- Figure 28 represents the total fiscal impact to the program for a $3 statewide wage increase. The initial cost would be $4.4 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $38.6 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $59.6 billion TF, with $23.3 billion GF by FY 2031-32, **a State General Fund increase of 100.9 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$2.4 B	$2.6 B	$2.8 B	$3.1 B	$3.3 B
State Cost of Wage Increase				$1.3 B	$1.4 B	$1.5 B	$1.7 B	$1.8 B
County Cost of Wage Increase				$0.7 B	$0.8 B	$0.8 B	$0.9 B	$1.0 B
Total Cost of Wage Increase				$4.4 B	$4.7 B	$5.2 B	$5.6 B	$6.1 B
Total Federal Cost	$13.7 B	$15.2 B	$16.8 B	$21.1 B	$23.5 B	$26.2 B	$29.2 B	$32.6 B
Total State Cost	$9.0 B	$10.1 B	$11.6 B	$14.4 B	$16.3 B	$18.4 B	$20.7 B	$23.3 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$3.0 B	$3.2 B	$3.4 B	$3.5 B	$3.7 B
Grand Total	$24.8 B	$27.4 B	$30.6 B	$38.6 B	$43.0 B	$48.0 B	$53.4 B	$59.6 B

Figure 28: Estimated Growth in Annual Program Costs With a $3/hr. Increase in All Wages

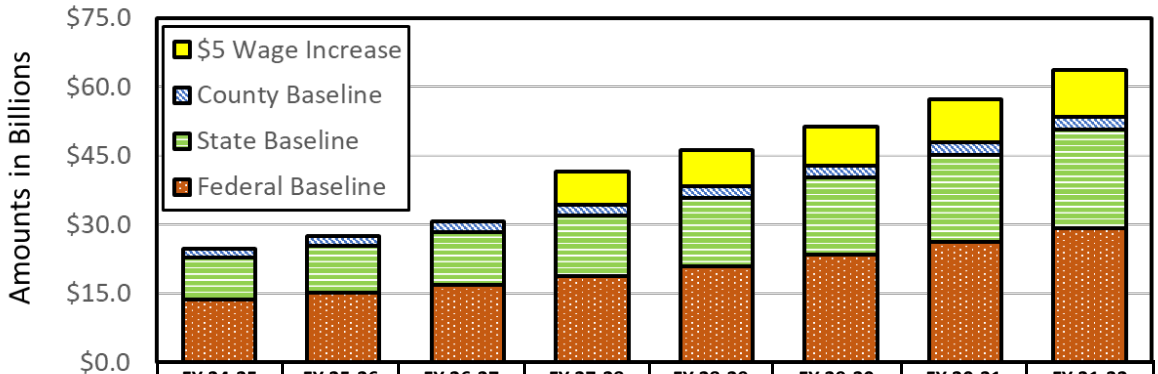
- Figure 29 represents the total fiscal impact to the program for a $4 statewide wage increase. The initial cost would be $5.8 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $40.1 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $61.6 billion TF, with $23.9 billion GF by FY 2031-32, **a State General Fund increase of 106 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$3.2 B	$3.5 B	$3.8 B	$4.1 B	$4.4 B
State Cost of Wage Increase				$1.7 B	$2.9 B	$2.0 B	$2.2 B	$2.4 B
County Cost of Wage Increase				$0.9 B	$1.0 B	$1.0 B	$1.2 B	$1.3 B
Total Cost of Wage Increase				$5.8 B	$6.3 B	$6.9 B	$7.5 B	$8.1 B
Total Federal Cost	$13.7 B	$15.2 B	$16.8 B	$21.9 B	$24.4 B	$27.2 B	$30.2 B	$33.7 B
Total State Cost	$9.0 B	$10.1 B	$11.6 B	$14.9 B	$16.8 B	$18.9 B	$21.2 B	$23.9 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$3.3 B	$3.5 B	$3.6 B	$3.8 B	$4.0 B
Grand Total	$24.8 B	$27.4 B	$30.6 B	$40.1 B	$44.6 B	$49.7 B	$55.3 B	$61.6 B

Figure 29: Estimated Growth in Annual Program Costs With a $4/hr. Increase in All Wages

- Figure 30 represents the total fiscal impact to the program for a $5 statewide wage increase. The initial cost would be $7.3 billion TF, with the costs split between federal, state, and county funds and would bring the overall costs of the program to $41.5 billion TF in FY 2027-28. Based on the current program rules and estimated rate of growth, if nothing changed, the program could cost $63.6 billion TF, with $24.5 billion GF by FY 2031-32, **a State General Fund increase of 111.2 percent since 2026-27.**



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Federal Cost of Wage Increase				$4.0 B	$4.3 B	$4.7 B	$5.1 B	$5.6 B
State Cost of Wage Increase				$2.1 B	$2.3 B	$2.5 B	$2.8 B	$3.0 B
County Cost of Wage Increase				$1.2 B	$1.3 B	$1.4 B	$1.5 B	$1.6 B
Total Cost of Wage Increase				$7.3 B	$7.9 B	$8.6 B	$9.3 B	$10.2 B
Total Federal Cost	$13.7 B	$15.2 B	$16.8 B	$22.7 B	$25.3 B	$28.1 B	$31.3 B	$34.8 B
Total State Cost	$9.0 B	$10.1 B	$11.6 B	$15.3 B	$17.2 B	$19.4 B	$21.8 B	$24.5 B
Total County Cost	$2.1 B	$2.2 B	$2.3 B	$3.5 B	$3.7 B	$3.9 B	$4.1 B	$4.4 B
Grand Total	$24.8 B	$27.4 B	$30.6 B	$41.5 B	$46.2 B	$51.4 B	$57.2 B	$63.6 B

Figure 30: Estimated Growth in Annual Program Costs With a $5/hr. Increase in All Wages

Workgroup Discussion on Cost Estimates

The workgroup discussed various aspects relating to the cost estimates, including understanding the modeling and assumptions used to create the estimates. Additionally, the workgroup discussed sustainability and the cost drivers of the program. Many workgroup members noted that the cost drivers and pressures are going to increase regardless of whether collective bargaining happens at the state or county level.

Impact to State and County Staffing Costs

In exploring the costs associated with wage increases, CDSS did not include any costs related to bargaining activities or administrative activities, as it wasn't part of the legislative mandate for the workgroup. Other non-wage benefits that could be bargained include transportation, healthcare, retirement, PPE, life insurance, dental, tuition reimbursement, training, and other provider benefits. The costs of non-wage benefits were not included in these estimates because these benefits can vary widely based on negotiations, potentially costing billions of dollars, depending on the type of benefits that would be included under a potential statewide bargaining model. In addition, the process for statewide or regional collective bargaining will need to be determined by the legislature in future legislation. It is assumed that any shift of collective bargaining responsibilities to the State will result in an increase to State Operations costs and a subsequent decrease to Local Assistance costs for the county.

Realignment

AB 102 mandated that the workgroup explores potential implications on the current county-state realignment structure. The CDSS presented a very high-level overview of realignment and then representatives from CSAC and CWDA presented information regarding realignment and its impacts on IHSS funding at the county level. This section of the report includes the information as it was provided to the workgroup.

In 1991, the Legislature shifted significant fiscal and programmatic responsibility for many health and human services programs, including health, mental health, and social services costs from the state to counties, referred to as 1991 Realignment. The intent of the 1991 Realignment was to provide dedicated funding sources, by increasing the sales tax a half cent and vehicle licensing fee, to cover those transferred costs and some flexibility in spending the funds to meet local needs.

Realignment dollars are meant to fund at least 16 different programs in the health and human services area. Counties often shift dollars from program to program based on funding needs. It was noted that the caseload growth in the IHSS program has put significant cost pressures on counties because funds must be shifted from other programs to cover the increased costs due to caseload growth.

Realignment caseload growth in social services is funded through sales tax growth; however, sales tax revenues are distributed two years after the costs occur. Locally negotiated wage increases must be covered with local funds for the first two years before the counties can confirm whether sales tax revenues will fully cover the increases.

In reviewing the fiscal impacts of increasing wages in dollar increments, CSAC and CWDA identified potential increases in county costs ranging from 12.7 percent to 46.4 percent, depending on the dollar amount of the increase. They anticipated that county costs would be significantly higher than available Realignment revenues, and the wage increases, as estimated in this report, would potentially result in unfunded caseload growth, where funding is diverted from other health and mental health programs and require a large amount of investment from counties' General Funds.

Based on the information presented by CSAC and CWDA, statewide bargaining has the potential to impact the current county-state realignment structure. In general, increases to wages and benefits, as well as growth in caseload and hours per case result in additional costs to the program and will impact Realignment funding in the future. To quantify the magnitude of the impacts was beyond the scope of the workgroups mandate. However, impacts to Realignment may need to be considered in any potential shift to statewide bargaining. Additionally, larger Realignment analyses, like the one published by the LAO, may provide additional information to help guide further discussions.

POTENTIAL FUNDING SOURCES

Funding for IHSS is complex and program growth has been significant over the last five years, increasing by approximately $9 billion TF. In addition to caseload growth, hours per case and cost per hour has also increased. Cost per hour increases are attributable to both increases in the State minimum wage and increases in locally negotiated wages and benefits.

As described above, based on current policies, required statutory minimum wage increases and growth in the program[18], the cost of the IHSS program is estimated to increase by $28.7 billion TF from FY 2024-25 to FY 2031-32. The State's share will almost double from the current $8.7 billion GF in FY 2024-25 to $16.7 billion GF in FY 2031-32, which does not account for any additional statewide dollar increases in provider wages. The fiscal impact to the program for each $1 per hour statewide wage increase would be at least an additional $1.5 billion per year, with the costs split between federal, state, and county funds.

Part of the AB 102 mandate was to explore potential funding sources for potential increases in program costs should a statewide collective bargaining model be adopted. The workgroup noted that any increases in wages and benefits will add additional cost pressures to the program, and funding will be needed. Some workgroup members expressed concerns that there was disparity between counties as it relates to both their budgets and their prioritization of allocating funding to support increases to the IHSS program.

The workgroup identified three sources of funding to support increased costs. The workgroup did not make recommendations related to pursuing particular funding sources.

The first identified option was increased Federal Medical Assistance Percentages (FMAP). The FMAP is used to reimburse states for the federal share of Medicaid expenditures. The IHSS

[18] Based on estimated annual growth rates for caseload growth, hours per case increases and cost per hour growth as defined in the 2025-26 Governor's Budget.

program is a service of Medi-Cal, California's Medicaid Program, and qualifies for FMAP. California receives 50 percent FMAP for most services; however, at times the federal government has allowed for additional percent points to be added to the base percentage. Historically, additional temporary increases to FMAP have been made available during emergencies, such as the COVID-19 Pandemic. Permanent increases in FMAP have typically been tied to a large programmatic change, like the creation of CFCO. States that adopted the CFCO program, including California, receive an additional six percent on top of their set FMAP for cases that meet the CFCO level of need. Today, DHCS and CDSS work cooperatively to maximize claiming for federal funding and make efforts to pursue any potential federal funding whenever it becomes available. A permanent increase in FMAP would require legislative action at the federal level.

The second identified option was to increase the amount of available state GF dollars. As described above, the State currently contributes significant GF to fund the IHSS program. However, unlike option one, the State has decision making authority over its use of GF. This approach creates additional cost pressures to the overall State budget.

The third identified option was to identify new revenue to fund additional IHSS costs. A tax increase could be linked to State legislative action and/or to a ballot initiative put forward to the voters in California that would be used exclusively to fund the additional state costs related to the IHSS program. Before pursuing a new tax, additional analysis on the type and structure of the tax would need to be completed. California has not pursued an exclusive tax related to the IHSS program so workgroup members flagged that this approach contains a high degree of uncertainty.

LEGISLATIVE IMPACTS

Legislative considerations were discussed as part of the analysis performed by the workgroup. The IHSS program rules are included in Welfare and Institutions Code (WIC) and most aspects of collective bargaining, including roles and responsibilities, are codified. This section identifies the various WIC sections that would likely require revision as part of any legislative process to codify and implement potential changes to the collective bargaining method for IHSS providers. Given the complexity of these changes, this list may not be comprehensive and additional updates to other statutory provisions may be needed. Also, for purposes of this report, the list below includes existing statutory sections that may need to be updated but does not include any details on how they should be updated. It is assumed that any updates would be part of the legislative process.

Employer of Record

- WIC section 12301.6 and section 12302.25 define the role of county established Public Authorities/Non-Profit Consortiums as Employer of Record for IHSS for the purposes of bargaining.
- WIC section 12301.61 defines the ability of IHSS collective bargaining parties who are unable to come to agreement to request mediation, a review by a fact-finding panel and if needed, a determination by PERB of a penalty of withholding of Realignment funding.

County Maintenance of Effort and State Cap

- WIC section 12306 to section 12306.1 established the county MOE.
- WIC section 12306.16 which adjusts each county's IHSS MOE levels based on provider wage, health benefit, non-health benefit and health benefit premium increases that are locally negotiated, mediated, imposed, or adopted by ordinance, contract mode rate increases, and the appropriate inflation factors.
- WIC section 12306.1 established the state cap and 10 percent option for counties to incentivize county participation in the collective bargaining process.

Public Authorities and Non-Profit Consortiums

- WIC section 12300.6 identified Public Authorities and Non-profit Consortiums as the entities responsible for administering the IHSS Back-Up Provider System.
- WIC section 12301.24 establishes the requirements for IHSS provider orientations for Public Authorities/Non-profit Consortiums.
- WIC section 12301.6 (e) outlines the roles of Public Authorities/Non-Profit Consortiums to administer the IHSS provider registry, process the results of provider fingerprints, and provide training for IHSS providers and recipients.
- WIC section 12301.6 (h) defines the role of the Public Authorities and Non-Profit Consortiums to enroll IHSS providers.
- WIC section 12305.81 (c) defines the rules for IHSS provider eligibility related to convictions for specific crimes and removal from the county IHSS provider registry.

In addition to the existing statutory provisions included in this section, there was also discussion regarding the possibility of other changes in procedures or structure that would require legislative changes, including roles and responsibilities of the PAs/NPCs, aspects of liability related to discrimination and harassment, and other employment related issues. It is important to note that IHSS providers are considered household employees and many of the laws related to these issues do not apply in an individual's home. Neither the state nor county have the authority to take adverse employment action against a provider because IHSS is a self-directed program, and that authority lies with the IHSS recipient who employs the provider.

SUMMARY

Pursuant to the requirements of AB 102, this report is providing the Legislature with an analysis of the costs and benefits of transitioning IHSS collective bargaining from the current county model to a statewide or regional model. The CDSS and the workgroup discussed the concepts of statewide and regional bargaining, the fiscal impacts, retention and recruitment of IHSS providers, potential funding sources, and legislative considerations. The information in this report represents the conversations of the workgroup and should not be considered recommendations or endorsements by CDSS. **Finally, the fiscal analysis in this report relies on point-in-time assumptions. Different assumptions would result in a**

change to the cost estimates presented in this report, which could be upwards of billions in additional State General Fund costs. Additionally, the report assumes continued receipt of federal funds for the IHSS program pursuant to current law. The fiscal implications of any changes in federal policy could also be upwards of billions in additional State General Fund costs.

APPENDIX A

Workgroup members were provided this report for review and were invited to submit comment letters, if they desired. On the following pages are the comment letters CDSS received.

April 4, 2025

Response to the report to the Legislature on the In-Home Supportive Services Collective Bargaining

The CA IHSS Consumer Alliance (CICA) is writing this response as a member of the Statewide Committee which met to analyze the issues affecting and impact of Statewide Bargaining per Assembly Bill 102. Three of CICA's members were part of the committee; two IHSS Consumers and one IHSS Advocate.

CICA is a Statewide member organization of IHSS Public Authority Advisory Boards and Governing Boards. We currently have 25 counties as members, several other Statewide partner organizations and individual IHSS Consumers, Providers, and Advocates as members. CICA's mission is to educate and inform our members on all issues affecting the IHSS program and assist the County members in fulfilling their legal mandate to give recommendations on the improvement of the IHSS program.

The current IHSS program was developed with the involvement of IHSS Consumers, independent living advocates, the unions and others. The overriding purpose was for the IHSS Consumers to ensure control over how the program was structured. The Consumers held and still hold the Independent Living philosophy of Nothing About Us Without Us. The Consumers currently have the responsibility to hire, manage, and if necessary, fire their providers. They also have the required responsibility to sign the provider's time cards. The Public Authorities, Counties and State Have their own responsibilities.

While we recognize the importance of collective bargaining for wages and benefits for the IHSS providers, for many different reasons, we are extremely concerned about the negative impacts of moving from County collective bargaining to a Statewide Bargaining model.

We are very concerned about the potential for the loss of Consumer Control if the bargaining moves to the State. This move would make the program more provider driven than consumer driven prioritizing provider interests more than Consumer interests. Recognizing the importance of bargaining it will remove local control at the County level for management of the program and place it in a centralized decision making entity. Local Advisory Boards would lose any influence they have over labor related issues. A Statewide Advisory Board would be very difficult to implement, not to mention having nuanced knowledge of local issues. A Statewide AC would reduce the influence that local ACs have on IHSS policy. A past development of a Statewide Advisory Council was disbanded and found not workable by appointed members.

We are pleased that the committee discussion included the importance of Consumers being involved in the bargaining process. Consumers are adamant that providers have decent wages, benefits and auxiliary benefits. Consumers are also aware of issues that are not often considered negotiable items that might greatly improve the workforce environment. This not only helps with the available pool of qualified workers but also ensures in the long-term relationship

of the consumer/provider. Very few Counties currently have Consumers involved in negotiations. CICA is very interested in changing this situation at the County level.

California is a very diverse State with wide differences between economic, social, and geography issues. Local bargaining can take into account these differences. It would be very difficult at the State level. As the report points out there is widespread variation in not only negotiated wages but medical benefits and other auxiliary benefits. We are very concerned that these existing benefits could be affected and potentially lost if bargaining is changed.

The local Public Authorities have legally mandated functions that they are required to perform. Because they function in their local Counties, they have the ability to adjust to local conditions. The possibility of the Statewide Authority taking over some of these functions is particularly concerning. Especially for the provider registry and the urgent care registry. It seems impossible that this would work. You would be eliminating the county flexibility for specialized training and hiring procedures unique to local recipients' profiles. The loss of the Public Authorities at the local level would be devastating. We would like to see their functions enhanced not depleted.

A great deal of the report dealt with fiscal implications. We recognize how expensive this IHSS program is for the Federal, State, and County governments. However, it is the right thing to do! Having Seniors and People with Disabilities remain in their homes avoiding institutional settings is philosophically and financially imperative.
We know the program is going to grow as our state ages and more people become aware of it. We are also very concerned about the threats to Medicare and Medicaid at the Federal level.
We also see the need to explore enhanced funding sources as stated in the report
We do think that changing how the program works and moving it to the State will be more expensive. For this reason alone, we recommend keeping bargaining the way it currently is.

We are also concerned with the possibility of labor disputes if differences cannot be negotiated. If they occur at the state level are all counties affected. Currently only the one county negotiating would be affected. The report also explained the repercussions for Counties that currently refuse to negotiate. We would like the legislature to look at making fines/penalties more effective so Counties will participate and negotiate at the local level.

We are grateful to have had the opportunity to be on the committee looking at all the ramifications of statewide bargaining. We would like to have the opportunity to discuss the issues involved with local County bargaining and how it can be improved so it works for the Counties, State and Unions.

CALIFORNIA IN-HOME SUPPORTIVE SERVICES CONSUMER ALLIANCE
Educating & Empowering

Sincerely,

Mark Gordon
CICA Treasurer
Butte County AB Chair

Cynde Soto
CICA Vice President
Los Angeles PASC Chair

Janie Whiteford CICA
CICA President
Santa Clara County AC Chair

April 4, 2025

Ms. Jennifer Troia, Director
California Department of Social Services
744 P Street
Sacramento, CA 95814

RE: In-Home Supportive Services Statewide Collective Bargaining Report

Dear Director Troia:

On behalf of the California State Association of Counties (CSAC), the California Association of Public Authorities for IHSS (CAPA), and the County Welfare Directors Association of California (CWDA), we are writing to provide feedback on the In-Home Supportive Services (IHSS) Statewide Collective Bargaining Report to the Legislature. Our associations are appreciative of the collaborative approach that the California Department of Social Services (CDSS) undertook to comprehensively examine this issue. This letter serves to reinforce the feedback we provided throughout the workgroup process as well as provide comments on a few specific elements of the report.

As members of the CDSS workgroup, we want to first acknowledge the significant undertaking of this effort and the consideration given to the viewpoints of all members of the workgroup. The IHSS program serves more than 834,000 consumers[1] in California and allows qualified aged, blind, or disabled persons to receive supportive services from a provider to help them live at home. IHSS services are delivered by over 737,000 providers, with 72 percent related to the IHSS consumer.[2] Counties have proudly partnered with the state to financially support and administer the IHSS program since it was realigned in 1991. Counties, including social services agencies and public authorities (PAs), continue to play a major role in the financing of services and in the administration of the program to support both consumers and their providers. The collective commitment of everyone involved in this process to strengthen the IHSS program was evident throughout.

County Input on IHSS Report

CSAC, CWDA and CAPA brought a collaborative spirit to our engagement on this workgroup. The broad framing for our input was that if IHSS collective bargaining were to transition to the state level, it must do so in a manner that maintains the consumer-driven foundation of the IHSS program while mitigating for any fiscal, legal and administrative impacts to counties, and attracting an adequate number of quality providers to sustain the

[1] Per Monthly CMIPs Report (February 2025)
[2] Ibid.

growth of the program. With that in mind, below are the key considerations that we shared in this process and want to highlight as this report is publicly released.

- We appreciate the Department's analysis of the various cost scenarios for state-negotiated increases in wages and benefits. The scenarios illustrate the magnitude of cost for nominal increases in wages (however, benefits are not explicitly costed out). The report also highlights the dynamic nature of the program which makes future forecasting and budgeting challenging. The future state/county fiscal role and responsibility is not addressed directly in the report, and counties continue to emphasize that the state should be responsible for the full nonfederal share of cost for any negotiated wage and benefit increases agreed to under statewide collective bargaining, as the state would be solely responsible for agreeing to wage and benefit increases and counties would have no ability to manage the associated costs within Realignment funding and county budgets. This is especially critical given the significant and continued growth of the IHSS program and persistent underfunding of local administration of the program.
- We appreciate the brief discussion related to Realignment (pages 40-41) as well as the deeper review of this issue included in the UC Berkeley Labor Center study commissioned by CDSS as part of this analysis.[3] Clarifying the state fiscal responsibility for state-level negotiated changes to wages and benefits is paramount given the existing fiscal cost pressures counties face in the IHSS Program. Currently, counties contribute financially towards the IHSS program through a maintenance of effort (MOE) where county costs grow annually by a four percent inflation factor and the county share of locally negotiated wage and benefit increases. According to the UC Berkeley Labor Center study, county costs are growing at a faster rate than Realignment revenues (6.5 percent vs. 4.6 percent between FY 2017-18 and FY 2024-25), likely resulting in decreased funding available for other realigned programs. This trend is likely to continue under the status quo of county-level collective bargaining. Furthermore, the UC Berkeley Labor Center notes the potential cost implications of statewide collective bargaining for MOE and 1991 Realignment are overshadowed by the existing long-term challenge of funding a rapidly growing IHSS program, *"absent future reforms of the MOE, if county expenditures for IHSS provider wages continue to increase (beyond existing wage supplements tied to increases in the state's minimum wage), the County MOE will likely grow at a higher rate than sales tax Realignment revenues. As a result, counties will have less revenue available to pay for other realigned programs."* The report goes further to note that structural changes would be necessary to shift to statewide collective bargaining, including a change to the current state-county cost sharing and maintenance of effort formula.
- The report briefly notes that non-economic issues, which are currently often raised in collective bargaining, can have fiscal (and legal) impacts upon counties. Shifting to statewide collective bargaining will require the state to acknowledge this possibility,

[3] Analysis of the Potential Impacts of Statewide or Regional Collective Bargaining for In-Home Supportive Services Providers: Final Report to California Department of Social Services (December 2024). Linked here.

to work with counties to mitigate legal risks to counties, and the state should also fully fund the costs of any new mandates or increased county and PA workload that result from items agreed to in statewide bargaining. This should include costs for workload increases or potential downstream impacts associated with any non-economic proposals that may be agreed to by the state.

- The report briefly touches upon the functions performed by county social services agencies and PAs, which are not currently bargained at the local level, including payroll processing, provider registries, backup providers, and provider orientations. Counties are concerned that these administrative duties, which are currently mandated through state law and/or regulated through CDSS, could come under the scope of representation. We urge caution in broadening the scope of representation beyond wages and benefits, and feel that continued legislative and departmental oversight over program administration is appropriate.
- To the extent that statewide bargaining were to be constructed in a manner in disagreement with any of the above points, then counties must have a formal role in the statewide bargaining process in order to be able to manage and have input on potential increased county costs and new mandates as well as the programmatic and legal implications to counties.

Feedback on Specific Report Language

There are specific elements of this report that we want to acknowledge, provide additional context, or share concerns.

IHSS Program Funding and the MOE (pages 12-15)

The report notes that only 6 percent of the overall IHSS budget currently supports program operations, specifically: county administrative costs for eligibility determinations and redeterminations, direct assistance to consumers and providers, other PA activities including registry services, orientations, criminal background checks, and provider training, and finally, State-level payroll processing. Chronic underfunding of county and PA administrative costs have resulted in unacceptably high social worker caseloads, in some counties 500-600 cases per worker, resulting in delays in assessments and reassessments as mandated by the State. This underfunding also results in challenges in scheduling and holding provider orientations and clearing providers to deliver care to IHSS consumers. While these issues are not the subject of this report, our associations express the dire need to address the chronic and significant underfunding of county and PA administration and believe the desired improvement to IHSS provider recruitment and retention will not be achieved unless this long-standing issue is addressed.

IHSS Collective Bargaining Overview (pages 15-16)

The description of how the existing collective bargaining Realignment withholding provision works lacks key details. It's important to note that a county is only subject to the 10 percent penalty if PERB determines that all of the following four conditions are met: (1) A county and provider union have completed the full IHSS mediation and factfinding process; (2) the

factfinding panel has issued recommended settlement terms that are more favorable to the union; (3) the county has an expired IHSS collective bargaining agreement; and (4) the county and union have not reached an agreement within 90 days after the release of the factfinding recommendations.

Statewide Bargaining (pages 18-19)
There are many complex elements to consider when determining the scope of representation and any potential county participation in that process. We appreciate that the description in this section acknowledges that counties could face additional fiscal, administrative/workload, and legal impacts and that a county role must be correlated with what those potential impacts and risks are for counties.

The current process of local collective bargaining also allows for cost-of-living adjustments and other benefits to providers to facilitate and enhance their availability to serve IHSS recipients, such as transportation assistance, health care benefits, personal protective equipment (PPE), and training and tuition reimbursement. Should bargaining move to the state, there must be consideration of how these services will be offered to providers with no loss of current benefits. Additionally, the report does not address how the current agreements between counties and unions will transfer seamlessly to the state, including agreements for non-economic benefits, and additional discussion of this process should be explored. In several counties, provider health benefits are linked to county health plans, enabling providers direct access to health care services through these plans at reduced cost. There needs to be consideration to how these benefits would be maintained under a statewide collective bargaining structure.

Stakeholder Involvement (page 21)
We appreciate the report's acknowledgment of the importance of IHSS recipient voice in collective bargaining, as counties have strived to embrace consumer voice in program administration and collective bargaining at the local level. We also appreciate the opportunity to reflect on the concerns used in the prior state-level collective bargaining under the Coordinated Care Initiative (CCI), which implemented the IHSS Stakeholder Advisory Committee, comprised of IHSS consumers, to inform statewide bargaining. We note of the options discussed, the report does not include an option used in some counties to have IHSS consumers directly advising the administrators of the IHSS Program to respond to non-economic terms that may also be collectively bargained, and the resulting impact on consumers. If the state assumes collective bargaining, consumers should play a role in both the economic and non-economic terms and conditions under consideration.

Employer of Record (page 22)
We appreciate the acknowledgement that core duties should remain with public authorities even if bargaining is transferred to the state level and that there are complexities in determining how these duties and responsibilities need to be addressed. We emphasize that currently, decisions made at the local level over the operation/delivery of provider

services, including registries, training, enrollments and orientations, are ultimately consumer-focused activities informed by local consumer advisory committees to support IHSS service delivery. Any shift of decision-making over the administration of PAs functions through regional or statewide collective bargaining must ensure a robust engagement process both consumers and PAs and assurance that county and consumer voice will be factored into decision-making.

Scope of Bargaining (pages 22-24)

We appreciate the acknowledgement that there was input in favor of a narrow scope of bargaining, that the need for local considerations on some of these items favors a narrower scope, and that a broader scope of bargaining could have unintended impacts and state mandates on county administration. Our associations expressed concerns about the nuanced non-economic factors that may impact county budgets and administrative workload that were not detailed in the report. Those concerns also include increased new liability concerns that may result from new mandates imposed through statewide collective bargaining. For example, what is the responsibility of the local PA and/or county to manage harassment and/or discrimination claims made by a provider against their employer (i.e., the IHSS recipient)? Should any non-economic factors be added to the statewide collective bargaining approach, counties would have concerns regarding the cost, workload, and legal implications, and would need to have a mechanism to inform any final decisions and receive adequate funding and liability protections for implementation.

IHSS Provider Wages and Retention and Recruitment (pages 25-27)

We note that the hourly IHSS wages cited in this section and displayed in the appendix are from nearly a year ago (July 1, 2024) and have not been updated in the same manner as other data points in this report such as the updated caseload growth rate for cost projections. Counties and provider unions have continued to reach agreements and there are increased hourly wages that are in effect and not shown in this report.

One of the possible opportunities with a statewide approach listed was opportunities to address provider recruitment and retention. We agree that IHSS provider recruitment and retention is a critical area to be addressed, as IHSS providers provide direct service delivery to IHSS consumers, and greater provider stability directly correlates to improved health and well-being outcomes. As the report notes, there are many different avenues to support improved IHSS provider recruitment and retention, through statewide initiatives such as IHSS Career Pathways, investments into county social workers and PAs who support both consumers and providers, and other investments which are not subject to collective bargaining, and rather, are investments made through State Budget process. In other words, improving IHSS provider recruitment and retention is critical, but can be addressed outside of the collective bargaining process.

Fiscal Impacts of Statewide Collective Bargaining (pages 27- 41)

Our associations expressed concerns during the workgroup process with the cost share premise that was utilized for calculating the fiscal impacts of increased wages and benefits. All of the fiscal impacts displayed in this section show a county share of costs of 35 percent of the non-federal share. Counties provided input that counties should not have a share of costs for wage and benefits increases agreed to by the state in state bargaining as counties would have no control over those costs or ability to manage within Realignment and county budgets.

The county costs shown in these figures are not realistic within the current construct of Realignment and would result in significant cuts to other health and human services programs that counties are mandated to provide. This broader Realignment context is not shown in these cost projection figures. The existing county IHSS maintenance of effort (MOE) was enacted for the purpose of having county IHSS costs fit within Realignment and allowing health and mental health to receive general growth. This was outlined in the Department of Finance's Senate Bill 90: 1991 Realignment Report.

The UC Berkeley Labor Center report clearly explains that county IHSS costs are growing faster than Realignment revenues and that the proposed cost projection scenarios where counties have a share of cost in statewide bargaining increases will result in decreased funding for health, mental health, and other social services programs within Realignment. We believe these cost projection scenarios would more accurately reflect the potential state costs if they were not done in a manner that shows a county 35 percent share that does not fit within 1991 Realignment.

In addition, this section presents the current trajectory of IHSS Program growth, multiple scenarios for wage increases, and the resulting non-federal cost impacts over time. Importantly, the report excludes that these cost estimates do not include the potential costs for non-wage benefits that are collectively bargained at the county level, and for which we anticipate will be collectively bargained at the state level (e.g. transportation stipends, tuition reimbursement, health, life insurance, etc.). Additionally, the impacts of population changes or policy changes were not considered, and caseload growth is likely underestimated. Given that the report's estimates do not reflect the full array of cost drivers, the report is likely understating the potential costs of statewide collective bargaining.

We do appreciate the acknowledgement of county Realignment concerns on page 41. We would also note that the county cost increases estimated on that page were based on the initial cost projections shared with the workgroup and would actually be higher now based on the recalculated cost projections that start on page 34.

Finally, for this section, we want to note concerns with the language in the *Impact to State and County Staff Costs* (page 40) subsection that implies that there would be a decrease in

Local Assistance costs for counties and commensurate increase to State Operations costs as a result of the shift in duties related to collective bargaining. We believe however that the county cost savings would be minimal, given the infrequent periodicity of local collective bargaining activities and management-level staff and leadership who actively engage in these activities. Our larger concern is that county administrative costs may increase as a result of non-economic areas that could be collectively bargained at the state level, which are likely to have an increased cost impact on county staff workload.

Thank you again for your commitment to this issue and leadership of a meaningful engagement process that will provide valuable insights for policy makers to consider for any legislative or budget efforts related to statewide bargaining. IHSS is a vital program for older adults and people with disabilities that families rely on to care for their loved ones. Our organizations are committed to continuing to engage on the concept of statewide bargaining in a collaborative manner and strengthening the overall program.

Sincerely,

Justin Garrett
Senior Legislative Advocate
California State Association of Counties

Monica Nino
County Administrator
Contra Costa County
CSAC Workgroup Representative

Kim Rothschild
Executive Director
California Association of Public Authorities

Kim Britt
Public Authority Director
Yolo County IHSS Public Authority
CAPA Workgroup Representative

Carlos Marquez III
Executive Director
County Welfare Directors Association

Randy Morris
Human Services Director
Santa Cruz County
CWDA Workgroup Representative

APPENDIX B

IHSS STATEWIDE COLLECTIVE BARGAINING WORKGROUP MEMBERS

IHSS Stakeholders

Organization	Workgroup Members
County Welfare Directors Association (CWDA)	Eileen Cubanski, Randy Morris
California State Association of Counties (CSAC)	Justin Garrett, Monica Nino
California Association of Public Authorities (CAPA)	Kim Rothschild, Kim Britt
Service Employees International Union (SEIU)	Brandi Wolf, Tiffany Whiten, Blanca Carias (IHSS provider)
United Domestic Workers (UDW)	Matthew Maldonado, Malik Bynum, William Reed
California IHSS Consumer Alliance (CICA)	Janie Whiteford, Mark Gordon (consumers)
Personal Assistance Services Council (PASC)	Cynde Soto (consumer)
Bet Tzedek Legal Services	Kim Selfon
Disability Rights California	Crystal Padilla

State Representatives

Organization	Workgroup Members
California Department of Social Services (CDSS)	Claire Ramsey, Leora Filosena
California Department of Human Resources (CalHR)	Steven Gonzalez-Lederer, Malayna Babb
California Public Employment Relations Board (PERB)	Felix DeLaTorre
California Department of Health Care Services (DHCS)	Xiomara Watkins-Breschi

APPENDIX C

The following information is current as of July 1, 2024.

County	Authorized Recipients	Active or Leave Ind. Providers	Wage	Benefits	Non-Health Benefits	Expiration of Existing Collective Bargaining Agreement	Bargaining Status	Union
Alameda	30,656	29,092	$19.50	Yes	No	9/30/2024	MOU has not expired	SEIU Local 2015
Alpine	26	20	$16.50	No	No	6/30/2021	Impasse	UDW
Amador	496	395	$17.50	Yes	No	6/30/2025	MOU has not expired	SEIU Local 2015
Butte	4,479	4,086	$16.50	Yes	Yes	12/31/2023	Currently Negotiating	UDW
Calaveras	594	544	$16.99	Yes	Yes	6/30/2027	MOU has not expired	SEIU Local 2015
Colusa	434	381	$16.50	No	No	12/31/2025	MOU has not expired	SEIU Local 2015
Contra Costa	15,795	14,772	$18.43	Yes	Yes	8/31/2026	MOU has not expired	SEIU Local 2015
Del Norte	394	374	$17.60	No	No	4/30/2025	MOU has not expired	SEIU Local 2015
El Dorado	1,972	2,037	$16.50	Yes	No	12/31/2024	MOU has not expired	UDW
Fresno	26,889	25,492	$16.60	Yes	No	12/31/2022	Currently Negotiating	SEIU Local 2015
Glenn	620	628	$16.75	No	No	6/30/2026	MOU has not expired	SEIU Local 2015
Humboldt	2,610	2,171	$17.50	No	No	9/30/2026	MOU has not expired	SEIU Local 2015
Imperial	8,366	7,188	$17.15	Yes	No	6/30/2024	Currently Negotiating	UDW
Inyo	190	182	$16.75	No	No	9/30/2023	Currently Negotiating	SEIU Local 2015
Kern	15,158	12,944	$16.00	No	No	6/30/2027	MOU has not expired	UDW
Kings	3,601	3,213	$16.60	No	No	6/3/2025	MOU has not expired	SEIU Local 2015
Lake	2,573	2,363	$16.65	No	No	12/31/2023	No Negotiations reported	SEIU Local 2015
Lassen	292	247	$16.65	No	No	12/31/2025	MOU has not expired	SEIU Local 2015
Los Angeles	270,751	227,392	$18.00	Yes	No	12/31/2024	MOU has not expired	SEIU Local 2015
Madera	3,259	3,045	$16.50	No	No	12/31/2022	Currently Negotiating	UDW

County	Authorized Recipients	Active or Leave Ind. Providers	Wage	Benefits	Non-Health Benefits	Expiration of Existing Collective Bargaining Agreement	Bargaining Status	Union
Marin	2,281	2,053	$18.00	Yes	No	3/31/2024	Currently Negotiating	SEIU Local 2015
Mariposa	326	309	$16.60	No	No	12/31/2022	Currently Negotiating	UDW
Mendocino	2,129	1,947	$17.00	No	No	12/31/2022	Currently Negotiating	SEIU Local 2015
Merced	5,264	4,821	$16.60	No	No	12/31/2022	Currently Negotiating	UDW
Modoc	193	172	$16.85	No	No	11/31/2024	MOU has not expired	SEIU Local 2015
Mono	40	35	$16.50	No	No	12/31/2023	No Negotiations reported	UDW
Monterey	6,713	6,090	$18.74	Yes	No	4/30/2025	MOU has not expired	SEIU Local 2015
Napa	1,661	1,654	$20.00	Yes	Yes	6/30/2027	MOU has not expired	SEIU Local 2015
Nevada	1,065	1,028	$16.90	Yes	No	12/31/2026	MOU has not expired	UDW
Orange	48,772	40,985	$18.00	Yes	Yes	12/31/2024	MOU has not expired	UDW
Placer	4,864	4,876	$17.60	Yes	Yes	12/31/2025	MOU has not expired	UDW
Plumas	354	292	$16.90	Yes	No	12/31/2026	MOU has not expired	UDW
Riverside	53,118	45,916	$18.00	Yes	Yes	12/31/2025	MOU has not expired	UDW
Sacramento	38,532	36,157	$18.15	Yes	No	6/30/2027	MOU has not expired	SEIU Local 2015
San Benito	885	840	$16.80	Yes	No	12/31/2019	Currently Negotiating	SEIU Local 2015
San Bernardino	45,026	39,315	$18.10	Yes	Yes	12/31/2026	MOU has not expired	SEIU Local 2015
San Diego	43,663	39,305	$18.50	Yes	Yes	12/31/2025	MOU has not expired	UDW
San Francisco	27,787	26,619	$21.50	Yes	Yes	6/30/2027	MOU has not expired	SEIU Local 2015
San Joaquin	9,881	8,494	$16.50	Yes	No	3/31/2023	No Negotiations reported	SEIU Local 2015
San Luis Obispo	2,778	2,552	$18.64	Yes	Yes	6/30/2024	Currently Negotiating	UDW
San Mateo	7,781	7,871	$20.80	Yes	Yes	12/31/2026	MOU has not expired	SEIU Local 2015
Santa Barbara	4,769	4,203	$18.17	Yes	Yes	6/30/2025	MOU has not expired	UDW

County	Authorized Recipients	Active or Leave Ind. Providers	Wage	Benefits	Non-Health Benefits	Expiration of Existing Collective Bargaining Agreement	Bargaining Status	Union
Santa Clara	33,820	35,198	$19.54	Yes	Yes	1/31/2024	No Negotiations reported	SEIU Local 2015
Santa Cruz	3,371	3,050	$18.75	Yes	No	6/30/2024	Currently Negotiating	SEIU Local 2015
Shasta	4,426	4,209	$17.60	No	No	12/31/2024	MOU has not expired	SEIU Local 2015
Sierra	48	45	$16.90	Yes	No	12/31/2026	MOU has not expired	UDW
Siskiyou	584	503	$16.00	No	No	No MOU	Currently Negotiating	SEIU Local 2015
Solano	6,445	6,387	$17.20	Yes	No	6/30/2024	Currently Negotiating	SEIU Local 2015
Sonoma	7,850	7,064	$17.35	Yes	Yes	9/30/2023	Currently Negotiating	SEIU Local 2015
Stanislaus	8,534	7,621	$17.25	Yes	No	12/31/2024	MOU has not expired	UDW
Sutter	1,785	1,484	$16.40	Yes	No	12/31/2022	Currently Negotiating	UDW
Tehama	1,390	1,259	$17.00	No	No	3/18/2027	MOU has not expired	SEIU Local 2015
Trinity	244	197	$17.35	No	No	6/30/2025	MOU has not expired	SEIU Local 2015
Tulare	8,073	7,365	$16.60	No	No	6/30/2024	Currently Negotiating	SEIU Local 2015
Tuolumne	592	552	$17.00	No	No	6/30/2024	Currently Negotiating	UDW
Ventura	9,648	8,943	$18.25	No	No	7/27/2024	MOU has not expired	SEIU Local 2015
Yolo	3,474	3,406	$16.75	Yes	No	9/30/2023	No Negotiations reported	SEIU Local 2015
Yuba	1,332	1,248	$16.65	Yes	No	12/31/2022	Currently Negotiating	SEIU Local 2015

APPENDIX D

The following information is current as of July 1, 2024.

County	Health Benefit	Breakout of Non-Health Benefits	Other benefits included in the MOU
Alameda	Health, Dental, Vision	PPE	Training
Alpine	N/A	None	Training
Amador	Health, Dental, Vision	PPE	Training
Butte	Health, Dental, Vision	PPE	Training
Calaveras	Health, Dental, Vision	PPE	No
Colusa	N/A	None	No
Contra Costa	Health, Dental, Vision	PPE, Pension	No
Del Norte	N/A	PPE	Training
El Dorado	Dental, Vision	PPE	No
Fresno	Health, Dental	None	No
Glenn	N/A	PPE	Training
Humboldt	N/A	PPE	Training
Imperial	Health, Dental, Vision	None	No
Inyo	N/A	PPE	No
Kern	N/A	PPE	Training
Kings	N/A	PPE	No
Lake	N/A	PPE	Training
Lassen	N/A	None	No
Los Angeles	Health, Dental	PPE	No
Madera	N/A	PPE	No
Marin	Health, Dental, Vision	PPE, Transportation	No
Mariposa	N/A	PPE	Training
Mendocino	N/A	PPE	Training
Merced	N/A	PPE	No
Modoc	N/A	None	No
Mono	N/A	None	No
Monterey	Health	PPE	No
Napa	Health, Dental, Vision	PPE	No
Nevada	Health, Dental, Vision	Life Insurance (Not yet Implemented)	No
Orange	Health, Dental, Vision	PPE	No
Placer	Dental, Vision	PPE	No
Plumas	Health, Dental, Vision	Life Insurance (Not yet Implemented)	No
Riverside	Health, Dental, Vision	PPE, Life Insurance	Training

County	Health Benefit	Breakout of Non-Health Benefits	Other benefits included in the MOU
Sacramento	Health, Dental, Vision	PPE	Training
San Benito	Dental, Vision	Transportation	No
San Bernardino	Health, Dental, Vision	PPE	Training
San Diego	Health, Dental, Vision	Life Insurance, PPE, Transportation	No
San Francisco	Health, Dental, Vision	PPE, Transportation	Job Development Fund
San Joaquin	Health, Dental, Vision	PPE	Training
San Luis Obispo	Dental, Vision	PPE, Life Insurance	Training
San Mateo	Health, Dental, Vision	Transportation, PPE	Job Development Fund
Santa Barbara	Dental, Vision	Life Insurance	Training, Replacement Caregiver Stipend
Santa Clara	Health, Dental, Vision	Transportation passes, PPE	Training, Tuition Reimbursement, Life Enhancement Fund
Santa Cruz	Health, Dental, Vision	PPE	No
Shasta	N/A	PPE	Training
Sierra	Health, Dental, Vision	Life Insurance (Not yet Implemented)	No
Siskiyou	N/A	N/A	No
Solano	Health, Dental, Vision	PPE	No
Sonoma	Health, Dental, Vision	PPE	Training Stipend
Stanislaus	Dental, Vision	PPE	Training
Sutter	Dental, Vision	PPE	Training Incentives
Tehama	N/A	None	Training
Trinity	N/A	PPE	Training
Tulare	N/A	None	No
Tuolumne	N/A	PPE	Training
Ventura	N/A	PPE	Training
Yolo	Health, Dental, Vision	PPE	Training
Yuba	Health, Dental, Vision	PPE	No