



CDSS

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REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

ALL COUNTY LETTER NO. 14-XX

TO: ALL COUNTY WELFARE DIRECTORS
ALL IN-HOME SUPPORTIVE SERVICES PROGRAM MANAGERS
ALL IN-HOME OPERATIONS COORDINATORS

SUBJECT: **IMPLEMENTATION OF PROVISIONS OF SENATE BILLS 855 AND 873 RELATING TO THE IN-HOME SUPPORTIVE SERVICES AND WAIVER PERSONAL CARE SERVICES PROGRAMS**

REFERENCE: Senate Bills (SBs) 855 and 873 (Chapters 29 and XX, Statutes of 2014) and ACL 14-35, DATED MAY 27, 2014

This All County Letter (ACL) provides counties with information and instructions for implementing the provisions of Senate Bills (SBs) 855 and 873 (Chapters 29 and XX, Statutes of 2014) that establish limits on the number of hours providers in the In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) programs are permitted to work in a workweek. In addition, it provides information and instructions for implementing new policies that require that IHSS/WPCS providers receive compensation for travel time and wait time under certain circumstances. Finally, this ACL transmits new and revised forms and notices to be used by counties in implementing the provider workweek limit and travel time and wait time compensation policies.

BACKGROUND

Overtime Compensation

On October 1, 2013, the United States Department of Labor (DOL) published the Final Rule on the Application of the Fair Labor Standards Act (FLSA) to Domestic Service. The Final Rule extends the protections of the Fair Labor Standards Act (FLSA) to these

workers by effectively removing the ability of “third party” agencies to claim an exemption for personal care workers from minimum wage and overtime pay as providers of “companionship services” or as live-in providers.

The Final Rule additionally narrows the definition of “companionship services” to strictly “fellowship and protection” that may include “provision of care” (i.e. assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) only if the care is provided as part of fellowship and protection and does not exceed 20 percent of the total hours worked per person and per workweek.

In addition, the federal rules relating to pay for travel time or wait time remain the same; therefore, requirements under FLSA are applicable to IHSS providers, including compensation for providers traveling between multiple recipients and “wait time” that is associated with medical accompaniment.

As a result of the elimination of the companionship services exemption, existing FLSA overtime rules will now apply to IHSS/WPCS providers. Consequently, IHSS/WPCS providers will be required to be paid overtime, at a rate equal to one and one-half times the regular rate of pay, when their time worked exceeds 40 authorized hours per workweek.

Limit on Overtime Compensation

SB 855 added section 12300.4 to the Welfare and Institutions Code (WIC) to specify that IHSS/WPCS providers are not permitted to work a total number of authorized hours within a workweek that exceed 66, as reduced by the net percentage defined in WIC sections 12301.02 and 12301.03. The term “workweek” is defined in statute as the period beginning at 12:00 a.m. on Sunday and including the next consecutive 168 hours, terminating at 11:59 p.m. the following Saturday. The maximum 66-hour-per-week figure was derived by dividing the statutory maximum 283 authorized hours a recipient may receive each month by 4.33, the average number of weeks per month, and rounding the resulting figure up to the next whole number. WIC section 12301.02 required that a seven percent reduction in IHSS recipients’ monthly authorized hours go into effect on July 1, 2014. When the seven percent reduction is applied to the 66-hour maximum workweek limit, as required pursuant to WIC section 12300.4, the resulting figure is 61 hours. Therefore, the maximum amount of time an IHSS/WPCS provider will be permitted to work each workweek, regardless of the number of recipients for whom he/she provides services, will be between 61 and 66 hours. The specific maximum number of hours will depend on the number of service hours his/her recipient(s) is (are) authorized to receive, and more specifically, whether the recipient(s) had any documented unmet need when the seven percent reduction took effect.

WIC section 12301.02 specifies that the seven percent reduction first be applied to any documented unmet need. Documented unmet need refers to a recipient’s total number of hours of assessed need for IHSS, *excluding protective supervision*, in excess of the statutory maximum of 283 authorized hours per month. For any recipient who had

documented unmet need when the seven percent reduction took effect, the reduction would have been accounted for, in part or in full, by his/her unmet need hours. Any recipient who had up to 21.3 documented unmet need hours would actually have experienced less than a seven percent reduction in his/her authorized monthly service hours, and any recipient who had a documented unmet need of 21.3 hours or more per month would not have experienced any reduction at all in his/her monthly authorized service hours.

SB 855 also amended WIC section 12301.1(b) to specify that each recipient's total monthly authorized service hours (as adjusted by the seven percent reduction) be divided by 4.33 to establish a total weekly authorized number of service hours. Thus each recipient will have a total number of authorized hours of up to 66 per workweek. Although the majority of providers will be limited to working a maximum of 61 authorized hours per workweek, those providers who work for recipients who continue to be authorized for more than 61 weekly hours (as a result of documented unmet need) will be permitted to work up to a maximum of 66 hours per workweek.

WIC section 12301.03 specifies that the seven percent reduction will be offset if a home care services assessment provides General Fund savings upon implementation. If this were to occur in the future, the maximum number of authorized hours a provider is permitted to work each workweek would be adjusted accordingly but would not exceed 66 hours. An ACL would be released to provide the new maximum hour per workweek limits were that to occur.

Additionally, SB 873, allows a provider who works for a single recipient to work in excess of the maximum 61 to 66 hours with county approval if the additional hours of work, based on the adjustment, do not exceed the total number of hours worked that are compensable at an overtime pay rate that the provider would have been authorized to work in that month.

Compensation for Travel Time

The DOL did not make any changes to the rules relating to pay for travel time or wait time in the FLSA revised regulations. However, because IHSS/WPCS providers will no longer be exempt from the FLSA requirements, the existing FLSA travel time and wait time rules will apply to these providers as of January 1, 2015.

The DOL rules require employers to pay an IHSS employee, as defined in SB 855, for travel time when the employee is required to travel for the benefit of the employer and when the employee is required to travel from one job site to another job site during the same workday. The rules do not require an employee to be compensated for travel to and from home and the job site.

Current IHSS program regulations allow a provider to receive payment for time spent traveling with a recipient who has been authorized medical accompaniment when the provider's assistance is necessary to accomplish travel to and from appointments with

physicians, dentists, and other health care practitioners. In addition, three other IHSS service categories already allow a provider to travel to and from the destination where the service is performed: out-of-home laundry services (when laundry facilities are not available on the premises); food shopping; and other shopping/errands. Travel time is included in the total amount of time allocated when these services are authorized. A forthcoming ACL will address medical accompaniment and associated wait time.

Existing IHSS program rules do not address the requirement to compensate employees for time spent traveling from one job site to another job site during the same workday. SB 855 allows an individual who provides authorized services for more than one IHSS/WPCS recipient on the same workday to be paid for travel time, which is the time spent traveling directly from one location where an individual provides services for a recipient to another location where he/she provides services for a different recipient; specifies that, “a provider...shall not engage in travel time in excess of seven hours per week”; and requires that a provider coordinate hours of work with his/her recipients to ensure compliance with this limit.

Compensation for Wait Time

The FLSA rules require employers to pay employees for certain periods of time when they are not actively engaged in the performance of work. FLSA provides two definitions for the different types of wait time: time spent engaged to wait and time spent waiting to be engaged.

- “Engaged to wait” means that the employee is not performing work duties but he/she is unable to use the time effectively for his own purposes. These periods of time are generally unpredictable and usually of short duration. The wait time is an integral part of the job; it belongs to and is controlled by the employer.
- “Waiting to be engaged” means that the employee is completely relieved from performing work duties and he/she has enough time to enable him/her to use the time effectively for his/her own purposes. The employee must be informed in advance that he/she may leave the job and that he/she will not have to resume work until a specified time.

The FLSA rules require employers to pay an employee for time he/she spends engaged to wait; however, an employee is not required to be compensated for time he/she spends waiting to be engaged.

NEW PROGRAM REQUIREMENTS

Effective Date

The newly established requirements detailed below will become effective on January 1, 2015, the date the Final Rule is scheduled to take effect. However, if DOL delays the

effective date of the Final Rule, these requirements will become effective when the Final Rule goes into effect.

Weekly Hours Calculation

As noted above, each recipient's monthly authorized number of hours will be divided by 4.33 to establish the recipient's weekly authorized number of hours. As required by the statute, recipients will receive notice of their total monthly and weekly authorized hours. Providers will also receive notice of each of his/her recipient's monthly and weekly authorized hours. (See Forms and Notices section of this ACL for additional information about these notifications.)

Workweek Agreements

WIC section 12300.4(b)(4)(A) requires that a provider inform each of his/her recipients of the number of hours he/she is available to work for that recipient. To assist those recipients who have multiple providers with establishing a work schedule that stays within the workweek limits, CDSS has created the Recipient/Provider Workweek Agreement (SOC 2256). The SOC 2256 will be completed and signed by the recipient and each of his/her providers. It will document the number of hours each provider will work providing services for the recipient each workweek. The total number of hours in the workweek agreement must correspond to the recipient's weekly authorized hours.

Additionally, to assist IHSS providers who work for multiple recipients, with establishing a work schedule including any applicable travel to stay within the limitation for providers, CDSS created the IHSS Program Provider Workweek and Travel Agreement, (SOC 2255). The SOC 2255 will be completed and signed by the provider if he/she works for multiple providers.

Overtime Limitation

In accordance with WIC section 12300.4(d), regardless of how many recipients an individual provides services for, the maximum number of hours a provider may work each workweek is between 61 and 66. Recipients shall not authorize any provider to work hours that exceed this limit except as required under SB 873. Each recipient will be required to employ multiple providers, if necessary, to ensure that no provider works more than the maximum number of authorized hours in a workweek.

The specific number of hours a provider will be permitted to work each week will depend on multiple factors including:

- Whether the provider works for a single recipient or multiple recipients;
- The number of authorized weekly hours his/her recipient(s) receive(s); and
- Whether the recipient(s) the provider work(s) for has/have any other providers.

Additionally, under SB 873, a provider who works for a single recipient may work in excess of the maximum 61 to 66 hours with county approval if the additional hours of work, based on the adjustment, do not exceed the total number of hours worked that are compensable at an overtime pay rate that the provider would have been authorized to work in that month if the weekly hours had not been adjusted.

Travel Time

Individuals who provide services for multiple recipients on the same workday will be paid for travel time subject to the limitations set forth in this ACL. WIC section 12300.4(f) defines “travel time” as the time spent traveling directly from a location where authorized services are provided to one recipient, to another location where authorized services are to be provided to another recipient. If, while traveling between the locations where an individual provides services for two different recipients, the provider uses time to engage in purely personal business, he/she will only be paid for the time it actually takes to make the trip directly, not for the time he/she uses for personal business.

The statute prohibits a provider from engaging in travel time more than seven hours per workweek. Each provider must coordinate his/her work hours with his/her recipients to ensure that his/her travel time does not exceed the limit of seven hours per workweek. If a provider engages in travel time in excess of the seven-hour limit he/she will be paid for the travel hours reported; however, the provider will incur a violation. (See the Policy Violations section of this ACL for additional information regarding policy violations.)

When an individual provides authorized services for recipients who reside in different counties, and he/she provides authorized services for the recipients on the same day, the travel time between the locations where authorized services are provided for these recipients will be compensated based on the hourly wage in the destination county. Similarly, when a provider serves both an IHSS recipient and a WPCS recipient, and he/she provides authorized services for the recipients on the same day, the costs for travel time between the locations where authorized services are provided for these recipients will be charged to the program that authorized the services for the recipient at the destination.

Individuals who provide authorized services for multiple recipients will be required to complete and sign a travel time agreement to estimate their weekly travel time and total work hours before they are eligible to receive payment for travel time.

Travel time will not be included as part of the 61-66 hour provider workweek limitation, and a provider’s travel time will not be deducted from any recipient’s authorized service hours. Providers will be required to claim travel time separately from time spent performing authorized services on their timesheets. Travel time will be claimed on the timesheet of the recipient to whom the provider traveled.

Three-Month Transition Period

SB 855 added WIC section 12300.41 to specify that, “for three months following the effective date...timesheets submitted by providers may be paid in excess of the limitations...so long as the number of hours worked by the provider within a month do not exceed the authorized hours of the recipient or recipients served by that provider.” Assuming the DOL does not delay the effective date of the Final Rule and it goes into effect as scheduled, a three-month transition period will be in effect from January 1, 2015, through March 31, 2015. During this period, provided that a provider does not work more than his/her recipient’s (or recipients’) total monthly authorized service hours, the provider will not receive a violation for working more than the maximum number of hours per workweek (between 61 and 66) and will receive overtime compensation for the hours he/she works in excess of 40 hours per workweek. In addition, during this period, while there is a seven hour limitation on travel time, no violation will be assessed. Beginning April 1, 2015, the policies limiting both overtime and travel time will be enforced.

Adjustments to Weekly Authorized Hours

On occasion, it may be necessary for a recipient to authorize his/her provider to work more than the recipient’s weekly authorized hours. WIC section 12300.4(b)(4)(C) provides that a recipient may make such an authorization without requesting approval from the county as long as the hours worked do not result in the provider working more than 40 hours in the workweek for that recipient or, if the provider already works more than 40 hours in the workweek for the recipient, the provider is not working more overtime in the month than he/she would have without the adjustment. In either circumstance, the provider cannot work more than the recipient’s monthly authorized hours and cannot work more than the provider workweek limitation maximum.

Individuals who provide services for recipients with total monthly authorized hours of 173.2 (173 hours and 12 minutes) or fewer per month would not, under normal circumstances, be expected to work more than 40 hours per workweek.

As per SB 873, a recipient with the maximum weekly authorized hours of 61 to 66 may authorize his/her provider to work more than the recipient’s weekly authorized hours as long as the additional hours the provider works do not result in the provider working in excess of the recipient’s monthly authorized hours.

Overtime Approval/Exception Process

If a recipient would need to authorize his/her provider to work an adjusted schedule that would necessitate overtime (the provider would need to work more than 40 hours in a workweek when he/she would normally work 40 or fewer hours during the workweek), the recipient would be required to contact the county to obtain an exception to allow the provider to accrue overtime hours.

An exception thus is defined as a request by an IHSS recipient to a county to allow his/her IHSS provider to adjust his/her workweek schedule to accommodate for working additional hours during a particular workweek, which will cause the provider to work and be compensated for overtime hours.

Counties shall utilize the following criteria to determine whether to approve an exception request:

- a) The additional hours must be needed to meet an unanticipated need;
- b) The additional hours must be related to an immediate need that cannot be postponed until the arrival of a backup provider; and
- c) The additional hours must be related to a need that would have a direct and significant impact to ensure the health and/or safety of the IHSS recipient.

If the exception request meets all of the above criteria, the county shall approve the request; otherwise, the county shall deny it.

Examples of an acceptable exception request include, but are not limited to:

- An unforeseen situation (i.e. illness, wheelchair malfunction, etc.) occurs which requires the provider to provide additional services to the recipient than would otherwise be required during a typical workweek;
- Another IHSS provider has been called away from service due to illness or other family emergency and the individual listed as the emergency back-up provider (on the Individualized Back-up Plan and Risk Assessment [SOC 864]) is not available.

WIC section 12301.1(b)(1)(C) states that the county, "...shall not unreasonably withhold approval..." of an exception request.

If the county IHSS office determines that the exception request does not meet all of the above-reference criteria, the county has the option to deny approval of the exception request.

Examples of an exception request that does not meet all of the above-referenced criteria include, but are not limited to:

- The provider wants to work additional hours during a given week in order to take time off for personal business or vacation the following week;
- The recipient requests a service (such as a special meal or errand) that would take more time than is allotted for that service during a given day. The service is not a medical necessity and will have no impact on the health and/or safety of the recipient.

An IHSS recipient seeking an exception must contact the county IHSS office via telephone. The exception request must be made either prior to or immediately after the

event which caused the need for the exception request, but before the timesheet for the pay period has been submitted.

In the event the IHSS recipient, who has an authorized representative, is unable to initiate the initial contact with the county IHSS office, the recipient's authorized representative may contact the county to initiate the exception request. However, if the recipient's authorized representative is the provider for whom the exception is being requested, he/she is not permitted to contact the county on behalf of the recipient to make the exception request. This is consistent with departmental policy related to providers acting as authorized representatives for their recipients being unable to sign timesheets (as stated in ACL 12-55, dated November 1, 2012) and individual waivers to allow the providers to work for the recipients despite disqualifying felony convictions (as stated in ACL 12-19, dated April 11, 2012).

County IHSS staff should document the exception request in CMIPS II. An automatic response letter will be generated that will be sent to both the recipient and the provider within ten calendar days of the receipt of the exception request. This response letter will verify receipt of the request and inform each individual of the decision regarding acceptance or denial of the exception request.

If the county denies the exception request after the provider has worked the hours, submitted a timesheet and been paid, the recipient and the provider will also be sent a notification that the provider has been charged with a violation. This notification will detail the penalty, if any, for the violation.

If the recipient or his/her authorized representative never contacted the county to seek approval of the exception and the provider worked the excess hours and documented the hours on his/her timesheet, when the timesheet is submitted for processing, it will be placed into a hold queue and the county will be contacted to inform that office of an undocumented exception. The county IHSS office will have five business days to review the exception during which time the county office staff will attempt to contact the recipient to verify the exception to determine if it was acceptable or not. If, after five business days, the county is unable to make contact with the recipient, a violation notice will be sent to both the recipient and the provider. At that time, the recipient or his/her authorized representative may contact the county IHSS office within ten calendar days of the date on the violation notification to obtain an exception for the excess time. If the county determines that the exception is acceptable, the violation against the provider will be rescinded.

Policy Violations

In accordance with WIC sections 12300.4(b)(5), a provider who violates the limitations on overtime and/or the travel time regulations on multiple occasions will be terminated as a provider. Multiple incidents occurring in the same pay period will be counted as a single violation. Each time a provider incurs a violation, the provider and each recipient

for whom that provider works will receive notice that the provider has incurred a violation.

Violations are assessed in a four-tier process:

The first time a provider submits timesheets reporting work hours exceeding the overtime and/or travel time limits, the provider will be paid overtime and/or travel time; however, the provider will receive a written notice warning him/her that that he/she will be suspended for three months if he/she exceeds the work hour and/or travel time limits a third time.

The second time a provider exceeds the work hour and/or travel time limits, he/she will be paid overtime and/or travel time; however, the provider will receive a second written warning notice and will be required to attend a mandatory training. The time the provider spends participating in the training will be compensable. If he/she does not request a county review of the violation within ten days or does not attend the mandatory training within 14 calendar days of the written warning notice, he/she will automatically receive a third violation.

The third time a provider exceeds the work hour and/or travel time limits, or if he/she does not complete the required training, the provider will be paid overtime and/or travel time; however, the provider will be suspended as a provider for a period of three months. At the end of the suspension period, he/she will not be required to recomplete the provider enrollment requirements in order to be reinstated.

Lastly, once the three-month suspension period ends and the provider is reinstated, he/she exceeds the work hour and/or travel time limits again (for a fourth time), he/she will again be paid overtime and/or travel time; however, he/she will be terminated as provider for a period of one year. After the one-year termination period has ended, the individual will be required to complete the provider enrollment requirements, including undergoing a new criminal background check, attending provider orientation, and completing and submitting all required forms, in order to be reinstated as a provider.

Whenever a provider receives a violation notice of any kind, he/she has ten days from the date of the notice to request a county review of the violation. If the provider does not request a county review within the ten days, the violation remains in effect. Once the county receives the request, it has ten days to review and investigate the circumstances that led to the violation and send the provider a notice stating the outcome of the review and investigation.

For the third and fourth violations, if the county does not choose to rescind the violation after the county review, the provider may request an administrative written review of the violation by the CDSS Adult Program Division's Appeals Unit within ten days of the date of the notice. The notice will explain how the provider can request a State review. If the State administrative written review does not overturn the county's decision, the provider will receive written notice from CDSS of the decision and his/her suspension or

termination will take effect ten days from the date of the notice. The state will release subsequent ACL providing information about the four-tier process provider violations

The violations will add up over the course of the provider's employment as an IHSS provider. However, if after receiving a violation, the provider does not receive another violation for one year, the number of violations he/she has received will be reduced by one. As long as the provider does not receive any additional violations, for each year after the last violation, the number of violations he/she has received will be reduced by one.

However, if the provider has received a fourth violation and has been terminated from the IHSS program as a provider for one year, when the year has expired and the individual has undergone the provider enrollment requirements to be reinstated as a provider, his/her violations count will be reset to zero.

Wait Time

Under current IHSS program rules, providers are not compensated for wait time; they are only paid for the time they spend while actively engaged in performance of authorized services for recipients. However, under new program policy, providers will be eligible to receive payment for certain periods of inactivity when they are waiting to perform an authorized service. In order to determine whether wait time is compensable, a distinction will need to be made whether the provider is engaged to wait or he/she is waiting to be engaged.

During periods when the provider is engaged to wait, he/she is not actively performing work but he/she cannot effectively use the time for his/her own purposes because the time is unpredictable and of unknown duration. The provider must be paid for time he/she spends engaged to wait. An example of time spent engaged to wait would be when a provider accompanies a recipient to a medical appointment of unknown duration and the provider is required to remain at the medical office because, at any moment, he/she may be called upon to assist the recipient with returning to his/her home.

However, if the provider is informed in advance that he/she is relieved from performing work duties for a specified and generally longer period of time during which he/she is free to engage in his/her own personal business, he/she is considered to be waiting to be engaged. Time spent waiting to be engaged is not compensable. An example of time spent waiting to be engaged would be when a provider accompanies a recipient to a hemodialysis treatment that is scheduled to last for three hours. In such a case, the provider would be informed that he/she is not required to remain on the premises and that he/she need not return to retrieve the recipient until the designated time. He/she could use the time to conduct his/her own personal business or engage in personal activities, and this time would not be considered work hours for which he/she would be required to be compensated.

The only service category that this wait time policy change is applicable to is medical accompaniment. When a recipient is authorized for medical accompaniment, if all of the following conditions are met, his/her provider will be considered to be waiting to be engaged:

- The duration of the recipient's appointment is known in advance;
- The appointment is scheduled to last longer than 30 minutes; and
- The provider is not required or able to perform any other authorized service, e.g., food shopping, other shopping/errands, during the duration of the appointment.

If these conditions are met, the provider must be informed by the recipient that he/she is relieved of his/her duties until a specified time when he/she is to return to accompany the recipient home. He/she will not be paid for this time. If all of the above conditions are not met, the provider will be considered to be engaged to wait, and he/she must be paid for the time he/she spends waiting for the recipient.

STATE RESPONSIBILITIES

Informing Notices to Recipients (TEMP 3001) and Providers (TEMP 3002)

The CDSS will mail notices to all recipients and providers to inform them of the program changes related to SB 855. It is anticipated that the informing notices will be mailed beginning on November 1, 2014. Follow-up mailings will occur in December 2014 and January 2015.

A newly developed form, the Overtime and Workweek Requirements Recipient Declaration (TEMP 3000), will be enclosed with the informing notice being sent to all recipients. The notice will instruct recipients that they must sign the TEMP 3000 and return it to the county by December 15, 2014.

Those recipients who have more than one provider will also receive the SOC 2256. The informing notice will explain that a recipient who has multiple providers must complete the SOC 2256 along with his/her providers. The SOC 2256 will be used to document the hours that each provider will work for the recipient each workweek. The notice will instruct the recipient to sign the SOC 2256 and have each of his/her providers sign it. The notice will explain that the recipient is responsible for returning the completed SOC 2256 to the county no later than December 15, 2014, and the consequences of not submitting it timely.

A revised version of the Provider Enrollment Agreement (SOC 846) will be enclosed with the informing notices being sent to all providers. The informing notice will instruct providers that they must sign the revised SOC 846 and return it to the county by December 15, 2014.

Those providers who provide services to more than one recipient will also receive the newly developed Provider Workweek and Travel Time Agreement (SOC 2255). The SOC 2255 will be used to document which recipients the provider works for, how many hours the provider will work for each recipient each workweek, how many total hours the provider will work for all recipients each workweek, and how much travel time the provider will engage in each workweek. The informing notice will instruct the provider to complete the SOC 2255, sign it and return it to the county. If the provider fails to submit the completed and signed SOC 2255 to the county by December 15, 2015, he/she will not receive payment for any compensable travel time until he/she submits the completed and signed form to the county. If the provider fails to submit the completed and signed SOC 2255 to the county by March 1, 2015, he/she will be terminated as a provider as of April 1, 2015.

Prior to the mailing of the notices to recipients and providers, CDSS will provide counties with the following lists so that counties can begin outreach efforts to assist these individuals with the new requirements:

- Recipients who currently have more than one provider;
- Recipients who have a single provider but who will need to employ multiple providers so that the workweek limit is not exceeded; and
- Providers who serve more than one recipient.

Case Management, Information and Payrolling System (CMIPS) II Programming Changes and Revision of Timesheet

CDSS is working with the Office of Systems Integration and Hewlett Packard (the CMIPS II vendor) to make necessary programming changes to CMIPS II to implement the provider workweek limitations and travel and wait time compensation requirements. CDSS will release a forthcoming ACL to address these changes as well as changes to the provider timesheet associated with the new provider workweek limitations.

Revision of Provider Orientation Materials

CDSS is in the process of revising provider orientation materials to include an explanation of the overtime limitation and travel and wait time compensation requirements. New materials will be transmitted via a forthcoming ACIN.

New and Revised Forms and Notices

CDSS has revised existing forms and developed new forms and notices for use by counties in implementing the new provider work hour limitation and travel time requirements. The attached table provides the numbers, titles and intended uses of the new and revised forms and notices.

Counties should begin using the new and revised forms effective January 1, 2015. The new and revised forms, which are designated as “Required – No Substitutes Permitted,” are available in camera-ready format on the CDSS Forms/Brochures web page at:

<http://www.dss.cahwnet.gov/cdssweb/PG183.htm>

Upon completion of translations, CDSS will post Armenian, Chinese and Spanish versions of the forms on the Translated Forms and Publications web page at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm

The designated Forms Coordinator for your county must distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations, as required by the Dymally-Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and by state regulation (California Department of Social Services Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115).

Questions about accessing the forms may be directed to the Forms Management Unit at fmudss@dss.ca.gov. Questions about translations may be directed to the Language Services Unit at LTS@dss.ca.gov.

COUNTY RESPONSIBILITIES

Counties will be responsible for implementing and enforcing the new 61-66 hour workweek limitation and travel and wait time compensation requirements. Counties will be required to hire additional staff to support all operational/administrative activities to effectively implement the new statute; not limited to providing outreach and additional assistance to recipients to ensure that they understand the implications of the new requirements and that they take all the necessary steps to successfully comply with statutes. Funding is available to support the hiring of additional staff for these new activities.

Counties will be responsible for ensuring providers understand their obligations under the workweek requirements and must develop a process to assist recipients and providers in establishing a workweek agreement that identifies the hours to be worked by the recipient's provider(s). The 61-66-hour workweek limitation will represent a significant change for recipients, especially those accustomed to having all of their authorized services provided by a single individual, such as a relative provider, and who will now require multiple providers in order to remain within the new provider work hour limitations. Further, pursuant to WIC sections 12300.4(f)(5) and 12301.1(b)(2)(D), counties must provide technical assistance to recipients and providers to ensure that providers do not exceed the seven-hour per week limit on travel time and must discuss schedule changes at reassessment or other times.

Technical Support for Recipients with Multiple Providers and for Providers with Multiple Recipients

Counties must follow-up with recipients who employ multiple providers who fail to submit the SOC 2256 timely to determine whether these individuals understand the new workweek limits and provide any needed assistance in negotiating workweek agreements with their providers. If a recipient fails to submit a completed and signed SOC 2256 by March 1, 2015, the county shall send the recipient the Notice to Recipient of Failure to Complete Workweek Agreement (SOC 2270). Counties must provide copies of the signed SOC 2256 to the providers.

Counties must establish procedures to ensure that each provider with multiple recipients submits the SOC 2255. The county must provide a copy of the signed SOC 2255 form to the provider for his/her own records and retain the original in the provider's file.

The county must review the SOC 2255 to ensure that it has been completed and signed by the provider. The county may use a web-based mapping service application (e.g., Google Maps, Bing Maps, MapQuest, etc.) and/or other methods (e.g., public transit schedules/timetables) to determine whether the travel times the provider has provided for travel between service locations are reasonable. In making this determination, the county must take into consideration the mode of transit being used; traffic patterns; seasonal issues affecting road conditions, such as snow/ice; and any other factors that may impact the amount of time required to travel between the service locations.

If, after the SOC 2255 has been accepted by the county, a provider, on multiple occasions, submits timesheets reporting actual travel times that exceed the estimate he/she provided on the SOC 2255, the county must contact the provider to determine the reason the provider is claiming more travel time than he/she estimated. If, in discussing the issue with the provider, the county determines that the circumstances the provider based his/her estimated travel time on have changed, the county must require the provider to complete a new SOC 2255 with the corrected travel information.

If a provider fails to submit the completed and signed SOC 2255 by December 15, 2014, he/she will not be eligible to be paid for travel time until the completed and signed form has been received by the county. If a provider fails to submit the SOC 2255 to the county by March 1, 2015, the county shall terminate the provider effective April 1, 2015. The county shall utilize the Notice to Applicant Provider of Ineligibility Incomplete Provider Process (SOC 851) to inform the provider of his/her termination. The county shall also send the recipient the Notice to Recipient of Provider Ineligibility Incomplete Provider Process (SOC 855) to inform him/her that his/her provider has been terminated from the program and he/she will need to obtain a new provider.

A provider terminated for failing to submit the SOC 2255 may be reinstated if he/she submits the completed and signed form within 60 days, and he/she can be paid retroactively for any authorized services he/she provided to eligible recipients during that period he/she was terminated.

Required Recipient Form (TEMP 3000)

Counties must establish procedures to ensure that each recipient submits a TEMP 3000, and each recipient who employs multiple providers submits a SOC 2256. Counties shall contact recipients who fail to submit the TEMP 3000 by December 15, as required to obtain a signed copy of the form.

The county must provide the recipient with a copy of the signed TEMP 3000 form for his/her own records and retain the original in the recipient's case file. The counties must also provide copies of the signed TEMP 3000 form to each of the recipient's providers.

Required Provider Form (SOC 846)

Counties must establish procedures to ensure that each currently-enrolled provider submits a newly signed SOC 846. The county must provide a copy of the signed SOC 846 form to the provider for his/her own records and retain the original in the provider's file.

If a currently-enrolled provider fails to submit the SOC 846 to the county by March 1, 2015, the county shall terminate the provider effective April 1, 2015. The county shall utilize the Notice to Applicant Provider of Ineligibility Incomplete Provider Process (SOC 851) to inform the provider of his/her termination. The county shall also send the recipient the Notice to Recipient of Provider Ineligibility Incomplete Provider Process (SOC 855) to inform him/her that his/her provider has been terminated from the program and he/she will need to obtain a new provider.

A currently-enrolled provider terminated for failing to submit a newly signed SOC 846 may be reinstated if he/she submits the completed and signed form within 60 days, and he/she can be paid retroactively for any authorized services he/she provided to eligible recipients during that period he/she was terminated.

County Review of Provider Violations

When a county receives a request from a provider to review a violation, the county has ten days from the day of the telephone call or written request to respond to the request. The county should review and investigate the circumstances that led to the violation to determine if the violation was correctly assessed against the provider, including contacting the recipient to determine if the exception for which the provider received the violation was appropriate or not. Once the county has reviewed the violation and made a determination of the outcome of the review and investigation, the county must send a written notice to the provider informing him/her of the outcome.

Wait Time

For existing cases, the county must review all recipients who have been authorized medical accompaniment to make a determination, for each medical appointment, based on the estimated length of the appointment(s) and other factors, whether provider is engaged to wait or waiting to be engaged, and must adjust the recipients' service authorization for any time during which a provider would be engaged to wait. For cases in which the provider is determined to be engaged to wait, the county must authorize medical accompaniment accordingly. Counties shall complete this review as soon as administratively feasible but no later than the next regularly scheduled reassessment.

For new cases, any time a county worker authorizes time for medical accompaniment for a recipient, he/she must make a similar determination for each medical appointment and authorize wait time in cases where the provider would be considered to be engaged to wait.

CDSS is developing a new form which counties may use to assist in determining how much wait time should be authorized when a need for medical accompaniment has been assessed. Upon completion, the new form will be transmitted via ACL.

FORTHCOMING ACLs/ACINs

This ACL is the first in a series of ACLs and ACINs that will be transmitted to provide additional information and instructions for implementing SB 855 and SB 873. In the coming months, CDSS will release ACLs/ACINs to address the following issues:

- Changes to CMIPS II to Address Overtime Requirements and the New Timesheets
- Revised Provider Orientation Materials
- Mandatory Timesheet/Workweek Training Video and Materials
- IHSS Providers Administrative Written Review Process of the Violations
- Accompaniment to Medical Appointments and Alternative Resources
- Authorized Representative

Questions or requests for clarification regarding the information in this letter should be directed to the appropriate Bureau within the Adult Programs Division as follows:

For questions regarding:	Contact the:
<ul style="list-style-type: none"> - Work Hour Limitation Policies - Travel Time and Wait Time Policies - Usage of New and Revised Forms/Notices 	Policy and Operations Bureau at (916) 651-5350
<ul style="list-style-type: none"> - CMIPS II Procedures - Provider Timesheet Questions and Issues 	Fiscal, Administrative and Systems Bureau at (916) 653-3850
<ul style="list-style-type: none"> - Appeals Process for Suspended and Terminated Providers 	Claims, Certification and Appeals Bureau at (916) 653-1937
<ul style="list-style-type: none"> - Revised Provider Orientation Materials 	Quality Assurance and Improvement Bureau at (916) 651-3494

Sincerely,

EILEEN CARROLL
 Deputy Director
 Adult Programs Division

Attachments