May Revision of the 2017-18 Proposed Budget: Impact on California's Older Adults and People with Disabilities

Fact Sheet • June 2017

This fact sheet summarizes the key initiatives and program adjustments contained in the 2017-18 May Revision that impact California's older adults and people with disabilities.

The May Revision reflects General Fund (GF) resources of $126.6 billion and anticipated expenditures of $124 billion.

Overview

On May 11, 2017, California Governor Edmund G. Brown, Jr., released the May Revision, with updated revenue and spending estimates for the 2017-18 budget of $126.6 billion in General Fund (GF) resources and $124 billion in GF expenditures.[1] The revised budget also includes $1.6 billion in the unencumbered reserve and $8.5 billion in the Budget Stabilization Account.*

These adjustments reflect an increase in projected GF revenue of $2.5 billion since January, and an increase of $1.5 billion GF for 2017-18 expenditures above what was proposed in January. The increased expenditures include funding for counties to cover costs associated with changes to the In-Home Supportive Services funding formula, as well as investments in K-12 education, child care, and pension commitments under the California Public Employee Retirement System (CalPERS).[1,3,4]

In-Home Supportive Services (IHSS): Caseload Growth

Background: The IHSS program provides in-home personal care assistance to low-income adults who are either age 65 years and older, blind, or disabled, and to children who are blind or disabled. Services include assistance with bathing, feeding, dressing, and/or domestic services such as shopping, cooking, and housework so that individuals can remain safely in their own homes. County social workers assess individuals using a standardized assessment to authorize service hours per month based on functional need. IHSS is expected to serve 531,000 recipients in 2017-18, an 8.2 percent increase from 2016-17.[5]

Proposed Budget: It included $10.6 billion ($3.2 billion GF) for the IHSS program in 2017-18, a 6.5 percent increase over the revised 2016-17 level.[6]

May Revision: It decreases the IHSS budget by $22.5 million GF in 2016-17 and $80.8 million GF in 2017-18, due primarily to a projected decrease in costs associated with IHSS provider travel time and medical accompaniment wait time.[1]

* The Budget Stabilization Account is often referred to as the "Rainy Day Fund," in accordance with Proposition 2, the voter-approved Constitutional amendment.[2]

Coordinated Care Initiative & Related IHSS Impact

Background: Enacted as part of California's 2012-13 budget, the Coordinated Care Initiative (CCI) changed how medical care and long-term services and supports (LTSS) are provided for low-income older adults and people with disabilities who qualify for Medi-Cal and those who are dually eligible (Medicare-Medi-Cal beneficiaries) by providing care coordination and integration through Medi-Cal managed care plans in participating counties. The governor's original proposal, as outlined in the proposed 2012-13 budget, laid the groundwork for statewide implementation of CCI.[7] Further, in the initial May 2012 CMC proposal submitted to the Centers for Medicare & Medicaid Services (CMS), the state reiterated its initial intent to expand CCI statewide–four counties in 2013, eight counties in 2014, and statewide in 2015.[8] However, the enacted 2012-13 budget only provided authority to implement CCI in eight counties, without reference to potential statewide implementation.[9,10] CCI was launched in June 2014 and became fully operational a year later in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).[11]

Table 1: Changes to CCI Included in the Governor's 2017-18 Budget Proposal

Component	Coordinated Care Initiative (as enacted)[5]	Governor's 2017-18 Proposed Budget[5]	2017-18 May Revision
Mandatory Medi-Cal Managed Care	Dual enrollees in seven counties must enroll in a managed care plan for Medi-Cal services	Ends, as part of CCI, effective January 1, 2018 Proposes extension through 2019	No changes from proposed budget
Managed LTSS	Access to certain Medi-Cal LTSS is through managed care in seven counties. Health plans' capitation rates include costs for: • In-Home Supportive Services (IHSS) • Multipurpose Senior Services Program (MSSP) • Community-Based Adult Services (CBAS) • Nursing Facility Services	Ends, as part of CCI, effective January 1, 2018 Proposes extension through 2019 without IHSS	No changes from proposed budget

Table 1: (continued)

Component	Coordinated Care Initiative (as enacted)[5]	Governor's 2017-18 Proposed Budget[5]	2017-18 May Revision
Cal MediConnect	Dual enrollees in seven counties have benefits between Medicare and Medi-Cal coordinated. Health plans integrate medical and LTSS services, including: • IHSS • MSSP • CBAS • Nursing Facility Services	Ends, as part of CCI, effective January 1, 2018 Proposes extension through 2019 without IHSS	No changes from proposed budget
Universal Assessment	State is required to develop and pilot a universal assessment tool to ensure access to needed LTSS	Requirement eliminated immediately	No changes from proposed budget
Statewide Authority	State takes responsibility for negotiating IHSS worker wages and benefits in seven counties	Counties resume responsibility for negotiating IHSS worker wages and benefits, effective January 2018	Maintains proposed budget action and modifies county/ state wage cost-sharing
IHSS Funding	All counties held to their 2011-12 IHSS expenditure levels with marginal increases annually (maintenance of effort [MOE] funding model)	Counties resume responsibility for 35 percent of non-federal costs January 2018 (share of cost funding model)	Reverts back to the MOE funding model, with: • New base for county costs • Phased-in annual inflation

Program Components of CCI:

1. Cal MediConnect (CMC): California's Financial Alignment Initiative with CMS, providing dually eligible individuals the option to enroll in one managed care plan responsible for the provision of Medicare and Medi-Cal benefits;[12]

2. Mandatory enrollment in Medi-Cal Managed Care: Dually eligible individuals are required to enroll in a managed care plan for Medi-Cal services; and[12]

3. Managed long-term services and supports (MLTSS): Medi-Cal funded LTSS are accessed through a managed care plan, including IHSS, Community-Based Adult Services (CBAS), and the Multipurpose Senior Services Program (MSSP) as well as nursing facility care.[12]

CCI State-level Initiatives:

1. Statewide Public Authority: The state assumed responsibility for negotiating for IHSS worker wages and benefits in the seven counties;[11] and

2. Universal Assessment (UA): The state is required to develop and test a UA tool and process in at least two of the seven counties to ensure access to needed LTSS.[11]

Operational Provisions:

1. Medicare shared savings: CMC includes an agreement between the federal government and state to share savings achieved in Medicare expenditures;[13]

2. IHSS financing: CCI includes an IHSS funding formula establishing a maintenance-of-effort (MOE) agreement for sharing the specific costs in the IHSS program between the state and all 58 counties;[11] and

3. LTSS as managed care benefit: Participating Medi-Cal managed care plans in the seven counties receive capitated rates to cover specified LTSS.[11]

4. MSSP transition to managed care benefit: CCI statute includes requirements to transition MSSP[†] from a federal waiver to a managed care benefit in the seven CCI counties beginning January 1, 2015, or after 19 months of MSSP beneficiary enrollment into managed care. The enacted 2015-16 budget extended the MSSP transition deadline to December 31, 2017, and allowed earlier transition in a county/region when MSSP sites and managed care plans mutually agree on the early transition.[14,15]

Department of Finance Savings Determination: State law requires that the Director of Finance determine if the CCI is cost-effective on an annual basis. The law further states that if not cost-effective, CCI would cease operation in the following fiscal year.[11]

Proposed Budget: The Director of Finance completed the annual assessment of CCI and determined it was no longer cost-effective, thereby discontinuing the demonstration in the budget year (January 1, 2018). The termination of CCI meant the removal of, or significant changes to, the following components:

[†] The MSSP program is a 1915(c) Medicaid waiver program, providing care management to high-need older adults by connecting them with community-based services to help them remain in their homes.

- Removal of IHSS benefits from Medi-Cal managed care plan capitation rates: The proposed budget removed IHSS payments from Medi-Cal managed care plan rates, effective January 1, 2018. This change is anticipated to have no direct impact on IHSS benefits, services for consumers, or workers' wages.[5]

- Removal of IHSS from CMC and MLTSS: The proposed budget removed the IHSS program from CMC and MLTSS in the seven CCI counties, effective January 1, 2018. The Administration will encourage, but not require, Medi-Cal managed care plans to collaborate with IHSS county social workers for care coordination.[5]

- Elimination of Statewide Authority responsible for negotiating IHSS workers' wages and benefits in the seven CCI counties: Per the proposed budget, the seven CCI counties would re-assume responsibility for the collective bargaining process, as was the arrangement prior to CCI.[5,6]

- Re-establishment of the IHSS share of cost funding formula: The proposed budget terminated the CCI's IHSS MOE financing arrangement and reinstated the state-county share of cost (SOC) arrangement for IHSS in all 58 counties. With the SOC, counties would have resumed responsibility to cover 35 percent of the non-federal portion of IHSS program costs. The SOC financing arrangement would have yielded approximately $626 million in state GF savings with a corresponding shift of these costs to counties, resulting in "financial hardship and cash-flow problems" for the counties.[5,16]

- Discontinuation of the UA tool: The proposed budget halted efforts to establish a UA tool.[6] (see "Universal Assessment" section for more information).

- MSSP transition delay: The proposed budget proposed to further delay the full transition of the MSSP waiver into managed care plans for another two years.[6]

While the Director of Finance reported that CCI was no longer cost-effective,[17] the proposed budget estimated $20 million GF savings attributed to the CMC program.[6,18] As such, the following program components in the seven CCI counties will continue through December 31, 2019:

- CMC operation extended: Dually eligible individuals will continue to have the option to enroll and have their Medicare and Medi-Cal services organized through one managed care plan.[5]

- Mandatory enrollment in Medi-Cal managed care: Dually eligible individuals residing in the seven counties will continue to be required to enroll in a managed care plan.[5]

- MLTSS: Medi-Cal-only and dually eligible individuals in the seven counties will continue to access CBAS[‡], MSSP, as well as nursing facility care through managed care plans. Managed care plans will no longer include IHSS, but will be encouraged to work with counties to coordinate care.[5]

May Revision: It maintains the changes to CCI proposed in January, with the following adjustments to two IHSS-related components:

- Elimination of Statewide Authority responsible for negotiating IHSS workers' wages and benefits in the seven CCI counties: The May Revision continues dissolution of the Statewide Authority, and proposes to modify the state's portion of IHSS wage and benefit costs, capping state participation at $1.10 above the state hourly minimum wage. Additionally, beginning July 1, 2017, the May Revision proposes that if a county does not finish bargaining with its IHSS workers within nine months, the union may appeal to the Public Employment Relations Board.[1]

- Re-establishment of the IHSS share of cost funding formula: The May Revision maintains the MOE financing arrangement established through CCI statutory authority, with a new base for county costs and a phased-in annual inflation factor. The Administration estimates that this proposal would shift $592 million GF in new IHSS costs to counties.[1] To mitigate the financial impact to the counties and assist with the transition to the revised funding arrangement, the May Revision proposes the following:

    - General Fund assistance: Provide counties with $400 million GF in 2017-18, $330 million in 2018-19, $200 million in 2019-20, and $150 million in 2020-21 and ongoing.[1]

    - Redirect Vehicle License Fee growth: Redirect all Vehicle License Fee growth for three years from the Health, County Medical Services Program (CMSP), and Mental Health Subaccounts to IHSS. In years four and five, 50 percent of this Vehicle License Fee growth will be redirected to IHSS.[1]

    - Cost data: Revise methodology for calculating the IHSS caseload.[1]

    - Inflation factor: Establish a new base for county costs of IHSS in 2017-18 that includes services and administrative costs. An annual inflation factor, as specified by the Administration, will be phased in and applied to the base.[1]

‡ CBAS is a Medi-Cal managed care plan benefit in all 58 counties.

Accounting for the above assistance, the Administration estimates that counties will face increased IHSS program costs of approximately $141 million in 2017-18, $129 million in 2018-19, $230 million in 2019-20, and $251 million in 2020-21. The May Revision proposes that counties experiencing financial hardship due to the increased IHSS costs apply to the Department of Finance for a low-interest loan (no further details provided).[1]

Universal Assessment

Background: California's home and community-based programs operate with separate eligibility determination and assessment processes, creating inefficiencies in the administration of programs and difficulties for the consumer in accessing necessary programs and services. Current CCI authorizing statute requires the Departments of Health Care Services, Aging, and Social Services to consult with stakeholders to develop a UA process, including the development of a UA tool for IHSS, CBAS, and MSSP. The process seeks to facilitate better care coordination, enhance consumer choices, and reduce administrative inefficiencies. Assembly Bill 664 (Chapter 367, Statutes of 2015) requires the state, in consultation with a stakeholder advisory workgroup, to evaluate and report to the Legislature on outcomes and lessons of the pilot. It also extended implementation of the pilot until September 1, 2018.[19] In prior budgets, resources were set aside for development, piloting, and evaluation of the UA tool in 2-4 CCI counties.

Proposed Budget: The termination of CCI eliminated the UA effort, resulting in GF savings of $500,000 for the Department of Social Services budget.[20]

May Revision: It maintains elimination of the UA effort.

Developmental Disabilities

Background: Governed by the Lanterman Developmental Disabilities Act and the Early Intervention Services Act, California's developmental disabilities service system consists of both Regional Centers and state-operated facilities. Regional Centers provide or coordinate services that include diagnosis and assessment, care monitoring, advocacy for the protection of legal, civil, and service rights, as well as training and education for individuals and their families. The state-operated facilities consist of three developmental centers and one community facility that provide 24-hour habilitation and treatment services for residents with developmental disabilities. The Administration announced in

2015 the planned closure of the three remaining developmental centers: Sonoma, Fairview, and the general treatment area of Porterville. The secure treatment program at Porterville will remain while the Department of Developmental Disabilities works to develop new models of care that provide community-based residential and support services to individuals in the program.[5]

Proposed Budget:

- Developmental center closures: The proposed budget included $450 million ($330 million GF) for developmental center operations, an $80 million decrease over the updated 2016-17 budget. In addition, the proposed budget included $505,000 GF for costs related to developmental center closures, as well as $597,000 ($544,000 GF) and four staff positions for increased oversight of new community housing projects to support individuals moving out of the state developmental centers.[21]

- Minimum wage: The proposed budget included an increase of $72 million ($48 million GF) to cover the increase in the state minimum hourly wage.[21]

May Revision: It maintains provisions outlined in January. It also provides $7.5 million GF in 2017-18 to establish acute crisis facilities in the community, as well as two, 24-hour mobile acute crisis teams to provide in-home treatment and stabilization services. The Administration proposes to establish intensive transition and support services, including wraparound residential services, through individual evaluations, assessments, and treatment recommendations.[1]

Housing and Disability Advocacy Program

Background: Enacted as part of the "No Place Like Home" Initiative in the 2016-17 budget, the Housing and Disability Advocacy Program sought to provide matching funds for local governments to connect homeless and at-risk individuals to Supplemental Security Income (SSI) and other benefits.[22]

Proposed Budget: It halts implementation of the Housing and Disability Advocacy Program, citing "fiscal constraints," for savings of $45 million GF.[5]

May Revision: It made no changes.[1]

Supplemental Security Income/State Supplementary Payment (SSI/SSP)

Background: The federal SSI program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. The federal Social Security Administration (SSA) administers the SSI/SSP program, making eligibility determinations, grant computations, and issuing combined monthly checks to recipients. In California, the SSI payment is augmented with an SSP grant. The average monthly caseload is estimated to be 1.3 million recipients in 2017-18 (54.8 percent people with disabilities, 44.3 percent older adults, and 0.9 percent people who are blind). The SSA applies an annual cost-of-living adjustment (COLA) to the SSI portion of the grant equivalent to the year-over-year increase in the Consumer Price Index (CPI). The current CPI growth factors are 0.3 percent for 2017 and 2.6 percent for 2018. In the 2016-17 fiscal year, SSI/SSP grant levels increased to a maximum of $895.72 per month for individuals and $1,510.14 per month for couples.[5]

Proposed Budget: It included $2.9 billion GF for the SSI/SSP program, representing a 2 percent increase ($55.2 million) over the revised 2016-17 budget estimate. No policy changed for the SSP portion of the SSI/SSP grant. The budget increase reflects a higher average per person SSI/SSP payment offset by lower caseload.[5,23]

May Revision: It decreases SSI/SSP program funding by $34.1 million GF in 2016-17 and $37.3 million GF in 2017-18, based on updated caseload and average cost-per-person/couple projections.[1]

Independent Living Centers

Background: Independent Living Centers advocate for disability rights and provide services and supports for people with disabilities to live in the community. The 2016-17 budget included a $705,000 GF augmentation to the Department of Rehabilitation for the administration of independent living services in three regions in California.[24]

Proposed Budget: It eliminated $705,000 GF in ongoing supplemental funding for the three Independent Living Centers included in the 2016-17 Budget Act.[5]

May Revision: It maintains the elimination of ongoing supplemental funding.

Home and Community-Based Services Waivers

Nursing Facility/Acute Hospital (NF/AH) Waiver Renewal

Background: The NF/AH Waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. Services include private duty nursing, case management, and personal care services.[25] Department of Health Care Services (DHCS) developed and released a NF/AH Waiver renewal approved by CMS in November 2016. Enhancements in the renewal application include increased waiver capacity, localized comprehensive care management, a new enrollment standard that 60 percent of enrollments are from institutional settings, a shift to an aggregate cost neutrality, and integration of the In-Home Operations Waiver.[6]

Proposed Budget: It included $9.8 million ($4.9 million GF) for the NF/AH Waiver in the DHCS budget and proposed statutory changes to align with the renewal application submitted to CMS.[6]

May Revision: It decreases funding to $8.9 million ($4.5 million GF) to reflect anticipated lower costs related to a phase-in for new enrollees.[18]

San Francisco Community Living Support Benefit Waiver/Assisted Living Waiver

Background: The San Francisco Community Living Support Benefit (CLSB) Waiver allows San Francisco city and county to offer community-based alternatives to residents of Laguna Honda Hospital or those at risk of institutionalization who are eligible for Medi-Cal.[26] CMS approved the CLSB Waiver for a five-year period, with an effective date of July 1, 2012. The San Francisco Department of Public Health uses the waiver to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. Waiver services include care coordination, enhanced care coordination, community living supports, behavior assessment and planning, as well as accessibility adaptations, and home-delivered meals.[27]

Proposed Budget: It sought to integrate the CLSB into the Assisted Living Waiver (ALW) and double the existing ALW capacity in San Francisco. Individuals participating in the CLSB would have transitioned to the ALW in July 2017.[6]

May Revision: It expands this proposal to transition people to other services, including, but not limited to, other ongoing waiver programs.[18]

Next Steps in the Budget Process

The California 2017-18 budget requires approval by the Senate and the Assembly. The Legislature continues to work through the budget process through a series of budget subcommittee hearings in each house, extending through the end of May. Each subcommittee votes on its respective issue area(s) in the budget and submits a report to the full budget committee for a vote. Next, the budget bill will be sent to the full membership of the Senate and Assembly for a vote. From the floor, each house's budget bill is referred to a joint budget conference committee where differences between the houses can be resolved. The Conference Committee votes on the proposed version, which, if passed, is sent to the floor of each house simultaneously. By law, the Legislature must approve the budget by June 15 in time for the governor to sign it by July 1. Finally, the governor has the authority to "blue pencil" (reduce or eliminate) any appropriation contained in the budget.[28]

Key Budget Dates

- June 15, 2017 – Deadline for Legislature to approve final budget
- July 1, 2017 – Deadline for Governor to sign the budget

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