

2017-2018 Proposed Budget: Impact on California's Older Adults and People with Disabilities

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This fact sheet summarizes the key initiatives and program adjustments in the proposed 2017-2018 Governor's Budget that impact the state's older adults and people with disabilities.



Governor Brown's proposed 2017-2018 budget reflects General Fund resources of \$125 billion and anticipated expenditures of \$123 billion, keeping spending flat.

Overview

On January 10, 2017, the California Department of Finance (DOF) released the 2017-2018 proposed budget from Governor Edmund G. Brown, Jr., outlining the state's projected revenues and spending plan for the fiscal year beginning on July 1, 2017, and ending June 30, 2018. The budget includes total General Fund (GF) resources of \$125 billion and anticipated expenditures of \$123 billion. The budget includes \$1.6 billion in the unencumbered reserve, and a \$1.6 billion deposit to the Budget Stabilization Account to bring its balance to about \$8 billion.*

Revenue is lower than expected, creating ongoing budget deficits of \$1 billion to \$2 billion. To address this issue, the governor proposes \$3.2 billion in budget solutions that include elimination of one-time spending commitments in the 2016-2017 enacted budget and implementation delays of several capital projects.^{2,3} This fact sheet addresses items impacting older adults and people with disabilities.

Coordinated Care Initiative

Background: Enacted as part of California's 2012-2013 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 are eligible for Medi-Cal and those who are dually eligible (have both Medicare and Medi-Cal) 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 2012-2013 budget, laid the groundwork for statewide implementation of CCI.⁴ Further, in the initial May 2012 Cal MediConnect (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 2015.⁵ However, the enacted 2012-2013 budget only provided authority to implement CCI in eight counties, without reference to potential statewide implementation.^{6,7} 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).⁸

* The Budget Stabilization Account is often referred to as the "Rainy Day Fund," in accordance with Proposition 2, the voter-approved Constitutional amendment.¹

Table 1: Changes to CCI Included in the Governor’s 2017-2018 Budget Proposal

Component	Coordinated Care Initiative (as enacted) ²	Governor’s 2017-2018 Budget Proposal ²
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 2018 Proposes extension through 2019
Managed LTSS	Access to certain Medi-Cal LTSS is through managed care in seven counties. Health plans’ capitation rates include costs for: <ul style="list-style-type: none"> • 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 2018 Proposes extension through 2019 without IHSS
Cal MediConnect	Dual enrollees in seven counties have benefits between Medicare and Medi-Cal coordinated. Health plans integrate medical and LTSS services, including: <ul style="list-style-type: none"> • IHSS • MSSP • CBAS • Nursing Facility Services 	Ends as part of CCI, effective January 2018 Proposes extension through 2019 without IHSS
Universal Assessment	State is required to develop and pilot a universal assessment tool to ensure access to needed LTSS	Requirement eliminated immediately
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
IHSS Funding	All counties held to their 2011-2012 IHSS expenditure levels with marginal increases annually	Counties resume responsibility for 35 percent of non-federal costs, effective January 2018

Components of CCI that impact service delivery include:

1. CMC, California’s Financial Alignment Initiative with CMS, providing dual eligible individuals the option to enroll in one managed care plan responsible for the provision of Medicare and Medi-Cal benefits;⁸

2. Mandatory enrollment of dual eligible individuals into a managed care plan for Medi-Cal services; and⁸
3. Managed long-term services and supports (MLTSS) in which Medi-Cal funded LTSS must be accessed through a managed care plan, including In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and the Multipurpose Senior Services Program (MSSP) as well as nursing facility care.⁸

State-level changes in CCI include:

1. The state assumed responsibility for negotiating for IHSS worker wages and benefits with the seven counties;⁹ and
2. The state is required to develop and test a universal assessment (UA) tool and process in at least two of the counties to ensure access to needed LTSS.⁹

Changes to financing health care and LTSS in CCI include:

1. Agreement between the federal government and state to share savings achieved in Medicare expenditures through CMC;¹⁰
2. Establishment of a maintenance-of-effort agreement for sharing the specific expenditures in the IHSS program between the state and counties;⁹ and
3. Capitated rates for the participating Medi-Cal managed care plans that included the new responsibility of paying for specified LTSS.⁹
4. Transitioning MSSP from a federal waiver to a managed care benefit. 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. CCI statute included requirements to transition the program beginning January 1, 2015, or after 19 months of MSSP beneficiary enrollment into managed care. The enacted 2015-2016 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.¹¹ In addition, both the MSSP sites and managed care plans would be required to meet readiness criteria developed by the Department of Health Care Services (DHCS), California Department of Aging (CDA), MSSP providers, managed care plans, and stakeholders.¹²

Department of Finance Savings Determination:

The authority for CCI in state law requires that the Director of Finance determine if the demonstration 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.⁹

Proposed Budget: Since 2015, the Administration has indicated that without improved participation in the program and continuation of an allowable managed care tax, CCI would not meet savings requirements. Even with the recent enactment of an allowable managed care tax, the Director of Finance estimates that CCI is no longer cost-effective, and is thereby discontinuing it in the budget year (January 1, 2018).¹³ The budget estimates GF savings of \$626.2 million in 2017-2018, once the county share of non-federal IHSS costs revert to 35 percent as prior to implementation of CCI.²

Termination of CCI means the removal of, or significant changes to, the following components:

- **Removal of IHSS benefits from Medi-Cal managed care plan capitation rates:** Medi-Cal managed care plan rates will no longer include IHSS payments. This change is anticipated to have no direct impact on IHSS benefits, services for consumers, or workers' wages.²
- **Removal of IHSS from CMC and MLTSS:** The IHSS program will operate independently from CMC and MLTSS in the seven CCI counties. The state will encourage, but not require, Medi-Cal managed care plans to collaborate with IHSS county social workers for care coordination. The state indicates that this change will not impact individuals' IHSS benefits or services.²
- **Elimination of statewide authority responsible for negotiating IHSS workers' wages and benefits in the seven CCI counties:** The seven counties will re-assume responsibility for the collective bargaining process, as was the arrangement prior to CCI.^{2,14}
- **Re-establishment of the IHSS funding formula:** The state-county cost sharing arrangement for IHSS will be reinstated in all 58 counties. To this end, the counties will resume responsibility to cover 35 percent of the non-federal portion of IHSS program costs, which is projected to result in local "financial hardship and cash-flow problems."²
- **Discontinuation of the UA tool:** The state will halt efforts to establish a UA tool.¹⁴
- **MSSP transition delay:** The state will further delay the full transition of the MSSP waiver into managed care plans for another two years.¹⁴

While the Director of Finance reports that CCI is no longer cost-effective,¹³ the Administration indicates that several components showed potential to achieve savings.

The following components will continue in the seven CCI counties through December 31, 2019:

- **CMC operation extended:** Dual eligible individuals will continue to have the option to enroll and have their Medicare and Medi-Cal services organized through one managed care plan.²
- **Mandatory enrollment in Medi-Cal managed care:** Dual eligible individuals residing in the seven counties will continue to be required to enroll in a managed care plan.²
- **MLTSS:** Eligible Medi-Cal and dual 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.²

Taking into account the changes specific to the IHSS program noted above, the budget projects a savings of \$20 million GF through 2019 if these components are continued.² It should be noted that continuation of CMC will require revisions to the three-way contracts between the state, CMS, and the health plans. New statutory language will be needed to specify authority and provisions for CMC, mandatory Medi-Cal managed care for dual eligible individuals, and MLTSS (see Table 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 DHCS, CDA, and the California Department of Social Services (CDSS) 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, 2018.¹⁵ In prior budgets, resources were set aside for development, piloting, and evaluation of the UA tool in 2-4 CCI counties.

[†] CBAS is a Medi-Cal managed care plan benefit in all 58 counties.

Proposed Budget: The termination of CCI eliminates the UA effort, resulting in GF savings of \$500,000 for the CDSS budget.¹⁶ However, the state recognizes that some of the UA questions identified through the UA stakeholder process cover important topics that could be useful for the IHSS in-home assessment, and notes that it will consider how these elements may be used by the program. In a public stakeholder call on January 12, 2017, the state clarified that there will be no further work on UA as the project is terminated.¹⁷

While CDSS may incorporate elements of the UA tool into the IHSS assessment, the UA pilot is terminated.

In-Home Supportive Services

Background: The IHSS program provides in-home personal care assistance to low-income adults who are either 65 years of age 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 2017-2018, an 8.2 percent increase from 2016-2017.²

Proposed Budget: The budget includes \$10.6 billion (\$3.2 billion GF) for the IHSS program in 2017-2018, a 6.5 percent increase over the revised 2016-2017 level. Elimination of CCI will revert the IHSS state-county funding ratio to the level prior to CCI. The counties will again be responsible for 35 percent of the non-federal share of costs, resulting in a state savings of \$626.2 million GF in 2017-2018. The Administration acknowledges this shift could result in “financial hardship and cash-flow problems” for the counties.²

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 (DDS) works to develop new models of care that provide community-based residential and support services to individuals in the program.²

Proposed Budget:

- **Developmental center closures:** The budget includes \$450 million (\$330 million GF) for developmental center operations, an \$80 million decrease over the updated 2016-2017 budget. In addition, the proposed budget includes \$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.³
- **Minimum wage:** The budget includes an increase of \$72 million (\$48 million GF) to cover the increase in the state minimum hourly wage.³

Housing and Disability Advocacy Program

Background: Enacted as part of the No Place Like Home Initiative in the 2016-2017 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.¹⁸

Proposed Budget: The budget halts implementation of the Housing and Disability Advocacy Program, citing fiscal constraints, for a savings of \$45 million GF.²

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 2017-2018 (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 2016-2017 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.²

Proposed Budget: The budget includes \$2.9 billion GF for the SSI/SSP program, representing a 2 percent increase (\$55.2 million) over the revised 2016-2017 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 a lower caseload.^{2,19}

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 budget included a \$705,000 GF augmentation to the Department of Rehabilitation for the administration of independent living services in three regions in California.²⁰

Proposed Budget: The budget eliminates \$705,000 GF in ongoing supplemental funding for the three Independent Living Centers included in the 2016 Budget Act. The stated reason for this decrease is that these centers already receive a larger share of federal Independent Living Discretionary Grant Program funds than other centers.²

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.²¹ DHCS developed and released a NF/AH Waiver renewal proposal in 2016, now currently under review by CMS. 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 aggregate cost neutrality, and integration of the In-Home Operations Waiver.¹⁴

Proposed Budget: The budget includes \$9.8 million (\$4.9 million GF) for the NF/AH Waiver and proposed statutory changes to align with the renewal application submitted to CMS.¹⁴

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.²² 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 support benefit, behavior assessment and planning, environmental accessibility adaptations in Direct Access to Housing (DAH) sites, and home-delivered meals in DAH sites.²³

Proposed Budget: DHCS plans to integrate the CLSB into the Assisted Living Waiver (ALW) and double the existing ALW capacity in San Francisco. Individuals participating in the CLSB will transition to the ALW in July 2017.¹⁴

Next Steps in the Budget Process

California's 2017-2018 Governor's Budget requires approval by the Senate and the Assembly. The Legislature will deliberate the budget through a series of budget subcommittee hearings in each house, from March through May.

In May 2017, the governor will release an updated revenue forecast, referred to as the "May Revision," which accounts for changes in revenues and proposed changes to expenditures within the January budget. Each subcommittee votes on its respective issue area(s) in the budget and submits a report to the full budget committee 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 a compromise 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. California’s constitution requires a majority (50 percent plus one) vote of each house of the Legislature, and a forfeiture in pay to legislators if the budget is not enacted by the June 15 deadline.²⁴ Finally, the governor has the authority to “blue pencil” (reduce or eliminate) any appropriation contained in the budget.²⁵



Key Budget Dates

- May 2017 – Release of Governor’s Budget May Revision
- June 15, 2017 – Deadline for Legislature to approve final budget
- July 1, 2017 – Deadline for Governor to sign the budget

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