2016-2017 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 California's proposed 2016-17 budget that impact the state's older adults and people with disabilities.

Governor Brown's proposed 2016-17 budget reflects General Fund resources of $125.8 billion and anticipated expenditures of $122.6 billion.

Overview

On January 7, 2016, California Governor Edmund G. Brown, Jr. released the proposed 2016-17 budget, outlining the state's projected revenues and his spending plan for the fiscal year beginning on July 1, 2016, and ending June 30, 2017. The proposed budget reflects an improved fiscal picture for California, with total General Fund (GF) resources of $125.8 billion and anticipated expenditures of $122.6 billion.[1] The budget includes $2.2 billion in the unencumbered reserve, and a $3.6 billion deposit to the Budget Stabilization Account (BSA)* to bring its balance to more than $8 billion.[2] This fact sheet addresses items impacting older adults and people with disabilities.

Managed Care Organization Tax

Background: California's Managed Care Organization (MCO) tax, a revenue tax on Medi-Cal managed care plans authorized in Senate Bill 78 (2013), is a critical component of Medi-Cal program funding that includes certain Medi-Cal long-term services and supports (LTSS). According to federal guidance, California's current MCO tax is inconsistent with federal Medicaid regulations. The current MCO tax will no longer be allowed after the current federal authority expires on June 30, 2016.[4,5]

The governor called for a special session in 2015 to address health care financing, which continued into 2016 as no viable solutions were agreed upon for the MCO tax. The purpose of the special session is to consider and act upon legislation necessary to enact permanent and sustainable funding through a new MCO tax and/or alternative fund sources in order to:

- Stabilize Medi-Cal funding through $1.1 billion in financing from the MCO tax;
- Continue restoration of 7 percent reduction in IHSS service hours beyond 2015-16; and
- Identify funding to increase rates for Medi-Cal providers, including those serving people with developmental disabilities.[5]

Proposed Budget: The budget proposes a revised MCO tax which attempts to address the federal guidance and bring the tax into compliance with Medicaid regulations.[1] The new MCO tax is anticipated to net approximately $1.35 billion in tax revenue annually for deposit into a special

*The BSA is often referred to as the "Rainy Day Fund," in accordance with Proposition 2, the voter-approved Constitutional amendment.[3]

fund. The administration proposes to use $236 million of the MCO tax revenue to continue restoration of a previous 7 percent reduction in service hours provided through the In-Home Supportive Services (IHSS) program and place the remaining revenue (approximately $1.1 billion) in the special fund reserve. In addition, the budget links any targeted rate increases for services and supports to persons with developmental disabilities (above what is proposed in the budget) to be funded by the new MCO tax revenue.[2] The revised MCO tax will require approval from both the legislature through a two-thirds vote and the federal government for implementation.

Medi-Cal 2020: California's New 1115 Waiver

Background: On December 30, 2015, the Department of Health Care Services (DHCS) received federal approval of a new 1115 waiver, referred to as "Medi-Cal 2020," effective January 1, 2016 through December 31, 2020.[1] Medi-Cal 2020 builds on the state's previous "Bridge to Reform" waiver, which included provisions to transition older adults and people with disabilities into Medi-Cal managed care plans, and expand the reach of managed care plans across the state. It extends authority for Medi-Cal managed care, Community-Based Adult Services, the Coordinated Care Initiative, and the Drug Medi-Cal system. In addition, the waiver calls for an independent assessment of access to care and network adequacy for managed care beneficiaries, and establishes several new initiatives including:

- Whole Person Care Pilot Program: This pilot is a locally-based effort to integrate systems providing physical health, behavioral health, and social services to improve members' overall health and well-being. Pilot programs may also choose to expand access to supportive housing options for high-risk populations.[6] The waiver renewal authorized up to $1.5 billion in federal funding for the pilots over the five years. Eligible applicants for the pilot are counties and groups of counties, and the lead entities will provide the non-federal share of expenditures.[1]

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME): Under PRIME, Designated Public Hospital systems and District Municipal Public Hospitals will be required to improve outcomes in physical and behavioral health integration and outpatient primary and specialty care delivery. PRIME also includes incentives for meeting certain performance measures for quality and efficiency. Over the course of the five years, combined federal and state funding for PRIME will not exceed $7.46 billion.[6]

- Global Payment Program: Under this program, Designated Public Hospitals are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings outside the emergency room and inpatient hospital. The federal funding for the program will be a combination of the Disproportionate Share Hospital funding for participating hospitals (currently earned for inpatient services only) and $236 million in federal funding for the first year. An independent assessment of uncompensated care will be completed in the spring and will be used by federal officials to determine the amount and sources for any additional funding beyond 2017.[6]

- Dental Transformation Initiative (DTI): Up to $750 million in federal funding is available for DTI, including incentive payments to Medi-Cal dental providers who meet certain requirements related to preventive services and continuity of care for children.[6]

Proposed Budget: The proposed budget includes implementation of Medi-Cal 2020, comprised of an initial $6.2 billion in federal funding over five years, with the potential for additional federal funding in the Global Payment Program after the initial year of the waiver.

Long-Term Services and Supports

Coordinated Care Initiative

Background: The Coordinated Care Initiative (CCI) changes how medical care and LTSS are provided for low-income older adults and people with disabilities in participating counties.[7,8] The main components of the CCI include: 1) provisions of Cal MediConnect, California's Dual Eligible Integration Demonstration; 2) mandatory enrollment of dual eligible beneficiaries (individuals eligible for both Medicare and Medi-Cal) into Medi-Cal managed care; and 3) integration of Medi-Cal-funded LTSS into managed care. The CCI is fully operational in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).[9] In July 2015, CMS communicated intent to extend the demonstration for up to two years[10], and DHCS responded with a non-binding letter of intent indicating interest in potentially considering an extension of the CCI.[11] Under current law, the Director of Finance is required on an annual basis to determine whether the CCI is cost effective. If the CCI proves not to be cost effective, it will cease operation in the following fiscal year.[1]

Proposed Budget: The proposed budget continues implementation of the CCI in 2016. The Brown Administration will continue to seek ways to improve participation in the program and extend an allowable MCO tax. If the MCO tax is not extended, the budget projects net GF costs for the CCI to be approximately $130 million in 2016-17 and beyond. The budget indicates that without a federally-approved MCO tax and improved enrollment into the pilot, the CCI will cease operations in January 2018.[1]

The future of the CCI depends on:

1) Increased enrollment
2) Approval of a new MCO tax

Universal Assessment (UA)

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. As part of the CCI, existing law requires the departments of Aging (CDA), Social Services (DSS), and DHCS to consult with stakeholders to develop a UA process, including the development of a UA tool for In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (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 the 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.[12]

Proposed Budget: The proposed 2016-17 budget includes $3 million ($1.51 million GF) to support the pilot and its implementation. The proposed budget further provides that the pilot will be built into the DSS Case Management, Information, and Payrolling System (CMIPS) II platform, with two staff positions dedicated to policy and program development. These staff will coordinate a UA stakeholder workgroup to obtain input for the development of the UA tool and will work directly with the counties to ascertain any operational issues that need to be addressed.[13,14]

In-Home Supportive Services (IHSS)

Background: The IHSS program provides in-home personal care assistance to low-income adults who are either over 65 years of age, 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 490,000 recipients per month on average in 2016-17, a 4.9 percent increase from the projections made in 2015.[1]

In 2013, the United States Department of Labor issued new regulations under the Fair Labor Standards Act (FLSA) that require overtime pay for domestic workers, compensation for providers who travel between multiple recipients, compensation for wait time associated with medical accompaniment, and compensation for time spent in mandatory provider training. In December 2014, the regulations were voided by a federal district court, which ruled that a portion of the overtime pay regulations exceeded administrative authority. In August 2015, a U.S. Court of Appeals upheld the regulations. The ruling was then appealed to the U.S. Supreme Court, and in October 2015, the Supreme Court denied a request to delay implementation of the regulations in conjunction with the appeal. The Court has not yet decided whether to consider the case.[1] Additionally, the 2013-14 budget implemented an 8 percent across-the-board reduction in IHSS hours, and a 7 percent across-the-board reduction annually thereafter.[15] The 2015-16 budget temporarily restored the 7 percent reduction in IHSS hours, and called for an ongoing fund source to be established through the special legislative session on health care financing.[16,17]

Proposed Budget: The proposed budget includes $9.2 billion ($3 billion GF) for the IHSS program in 2016-17, an 8.4 percent increase over the revised 2015-16 level.[1]

- Federal Overtime Regulations: Federal enforcement of the FLSA Home Care Rule began January 1, 2016. The proposed 2016-17 budget anticipates the state's implementation of the federal overtime rules for IHSS providers to begin February 1, 2016. Implementation of the regulations is estimated to cost $700.4 million ($331.3 million GF) in 2015-16 and $942 million ($443.8 million GF) annually thereafter. Per Chapters 29 and 488, Statutes of 2014 (SB 855 and SB 873), IHSS providers are limited to 66-hour workweeks, and those who work for multiple people will be paid travel time (up to seven hours/week) between IHSS recipients.[1]

- Restoration of 7 Percent Across-the-Board Reduction: The proposed 2016-17 budget continues restoration of the 7 percent across-the-board reduction in service hours with proceeds from the MCO tax, effective July 1, 2016. The cost of the 7 percent restoration of service hours is estimated to be $236 million in 2016-17.[1]

Community-Based Adult Services (CBAS)

Background: The CBAS program, a benefit under California's 1115 Medicaid Waiver, was created after the elimination of the Adult Day Health Care (ADHC) Medi-Cal benefit in 2012. CBAS is a licensed community-based day health program that provides services to older adults and people with disabilities who are at risk of needing institutional care. Medi-Cal managed care plans are responsible for determining eligibility and the number of authorized hours. The CBAS program is administered under an interagency agreement, with DHCS, CDA, and California Department of Public Health. With the shift from ADHC to CBAS, the administration predicted program reductions in FY 2012-13, resulting in a reduction in state staff positions overseeing CBAS. However, there are currently 241 CBAS centers serving approximately 32,000 Medi-Cal participants. Additionally, as of March 17, 2014, CMS established new regulations impacting how home and community-based services (HCBS) are delivered under Medi-Cal. These federal HCBS regulations set forth new requirements under which states may provide HCBS long-term services and supports, with the goal of improving the quality of HCBS and providing additional protections to individuals that receive services under Medicaid. On August 14, 2015, the DHCS submitted California's Statewide Transition Plan for home and community-based settings to CMS for approval. As a result, state responsibilities related to monitoring and oversight of CBAS has increased due to the need for coordination with the Medi-Cal managed care plans and new federal requirements.[18-20]

Proposed Budget: The proposed budget includes $1.1 million ($491,000 GF) in limited-term resources to DHCS to comply with the CMS HCBS Final Rule, which includes funding for continued work to monitor and oversee quality of the CBAS program, coordinate CBAS with HCBS Statewide Transition Plan activities, and ensure ongoing compliance of CBAS providers with the HCBS Final Rule.[18] In addition, the proposed budget includes $705,000 in funding ($319,000 GF) to CDA for four additional staff positions working to ensure compliance with current state statutes as well as new federal requirements for CBAS provider certification.[19]

Other Program Proposals

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 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 factor is a projected 1.7 percent for 2017. In January 2016, maximum SSI/SSP grant levels are $889 per month for individuals and $1,496 per month for couples. The average monthly caseload is estimated to be 1.3 million recipients in 2016-17 (71 percent people with disabilities, 28 percent older adults, and 1 percent people who are blind).[1]

Proposed Budget: The proposed budget includes $2.9 billion GF for the SSI/SSP program, representing a 2.8 percent increase ($76.8 million) over the revised 2015-16 budget. It also includes $40.7 million GF for a cost-of-living increase to the SSP portion of the grant, effective January 1, 2017. This would increase the maximum SSI/SSP monthly grant levels by $17 for individuals and $31 for couples and represents the first state-provided cost-of-living increase since 2006.

Developmental Disabilities

Background: Governed by the Lanterman Developmental Disabilities Act (Lanterman 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. Regional Centers are expected to serve 302,000 people with developmental disabilities in the community and 847 people in state-operated residential facilities by the end of 2016-17.[1]

Proposed Budget:

- Developmental Center Closures: The proposed 2016-17 Budget includes $146.6 million ($127.2 million GF) to develop community resources to transition individuals from developmental centers to the community, and $18 million ($12 million GF) to cover administrative costs related to developmental center closure and the relocation of individuals into the community.[1]

- Developmental Services Provider Rate Increases: The administration notes that any additional targeted spending proposals (e.g., rate increases) would be funded from the proposed extension of the MCO tax, as discussed above.[1]

The first cost-of-living increase for the State Supplementary Payment grant since 2006 will increase monthly maximums by $17 for individuals and $31 for couples.

- Federal Home and Community-Based Services Regulations: As mentioned above, CMS established new regulations impacting how HCBS are delivered under Medi-Cal with the goal of improving the quality of HCBS and providing additional protections to individuals that receive services under Medicaid. California's State Transition Plan covers all existing programs impacted by the federal home and community-based settings requirements, including the HCBS Waiver for Californians with Developmental Disabilities and the DDS 1915(i) State Plan program.[20,21] In implementing the CMS HCBS final rule, the proposed budget includes $80 million ($50 million GF) for the following targeted investments in the developmental services system:

    - $46 million ($26 million GF) to adjust rates for four bed homes;
    - $17 million ($12 million GF) to improve caseloads for regional center case managers, in accordance with federal law; and
    - $15 million ($11 million GF) to target rate increases to providers who are transitioning previous services, such as segregated day programs and sheltered workshops, to models that are more integrated in the community and consistent with the federal HCBS regulations.[1]

Next Steps in the Budget Process

The governor's proposed budget requires approval by the Senate and the Assembly. The Legislature will deliberate the governor's proposed budget through a series of budget subcommittee hearings in each house, from March through May.

In May, 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 in time to be enacted 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 passed by the June 15 deadline.[22] Finally, the governor has the authority to "blue pencil" (reduce or eliminate) any appropriation contained in the budget.[23]

Key Budget Dates

- May 2016 – Governor releases the May Revision
- June 15, 2016 – Deadline for Legislature to pass final budget bill
- June 30, 2016 – Deadline for Governor to sign the budget
- July 1, 2016 – New fiscal year begins

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