Summary of the Enacted 2016-17 Budget: Impact on California's Older Adults and People with Disabilities

Fact Sheet • July 2016

On June 27, 2016, California Governor Edmund G. Brown, Jr. signed California's 2016-17 budget. The enacted budget outlines the state's spending plan for the fiscal year beginning on July 1, 2016 and ending June 30, 2017. The budget includes program modifications that impact the health and human services delivery system serving older adults and people with disabilities.

The enacted budget reflects General Fund resources of $125.2 billion and anticipated expenditures of $122.5 billion.

Overview

California's enacted budget includes total resources of $125.2 billion General Fund (GF) and total expenditures of approximately $122.5 billion GF and $2.7 billion in the Regular Reserve. Recognizing that California may be approaching another recession, the budget increases the Rainy Day Fund to $6.7 billion, as required by Proposition 2. The budget provides limited one-time investments including affordable housing, drought relief, and infrastructure repairs. Finally, the budget provides for implementation of the state's minimum wage increase, as well as the new Managed Care Organization (MCO) tax financing package that includes rate adjustments for community-based providers serving individuals with developmental disabilities.[1]

This fact sheet addresses budget items impacting older adults and people with disabilities included in the 2016-17 budget.

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.[2,3] The main components include: 1) 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 (MLTSS). CCI is fully operational in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).[4] In July 2015, the Centers for Medicare & Medicaid Services (CMS) communicated intent to extend the demonstration for up to two years,[5] and the Department of Health Care Services (DHCS) responded with a non-binding letter of intent indicating interest in potentially considering an extension of CCI.[6] Under current law, the Director of Finance is required on an annual basis to determine whether CCI is cost effective. If CCI is not shown to be cost effective, it will cease operation in the following fiscal year.[7]

Proposed Budget: The proposed budget included continued implementation of CCI in 2016, with a caveat that without a federally-approved MCO tax and improved enrollment into the pilot, CCI would cease operations in January 2018.[7]

May Revision: The May Revision reflected passage of the MCO tax (described below).[8]

Enacted Budget: The enacted budget reflects passage of the MCO tax and therefore provides for the continued implementation of CCI in 2016-17.[1]

Managed Care Organization Tax

Background: California's MCO tax, a revenue tax on Medi-Cal managed care plans authorized in Senate Bill 78 (2013), has been a critical component of Medi-Cal program funding that includes certain Medi-Cal LTSS. Past federal guidance called on California to adjust its MCO tax structure to comply with federal Medicaid regulations.[9,10]

Governor Brown called for a special session in 2015 to address health care financing. The special session focused on passing legislation to enact 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 In-Home Supportive Services (IHSS) service hours beyond 2015-16; and;
- Identify funding to increase rates for Medi-Cal providers, including those serving people with developmental disabilities.[10]

Proposed Budget: The January budget included a revised MCO tax, which attempted to address the federal guidance and bring the tax into compliance with Medicaid regulations.[7] The budget proposed to use $236 million of the MCO tax revenue to accomplish the issues listed above.[11]

May Revision: The governor and Legislature agreed to revisions in California's MCO tax structure during the special session. The May Revision reflected budget adjustments related to the new MCO tax, as follows:

- MCO Tax: Chapter 2, Statutes of 2016, Second Extraordinary Session (SBX2 2), authorized a tax on the enrollment of Medi-Cal managed care plans and commercial health plans for three

years, reducing GF spending in Medi-Cal by approximately $1.1 billion in 2016-17, and over $1.7 million in 2017-18 and 2018-19. SBX2 2 also included provisions that reduced other taxes paid by health plans, which were agreed to by the State as part of the negotiations with the managed care plans to reach agreement on the new MCO tax. The May Revision reflects a decrease of $300 million GF to account for a reduction in insurance tax and corporation tax revenue from affected health plans.[8]

- New Investments: Chapter 3, Statutes of 2016, Second Extraordinary Session (ABX2 1), included new expenditures with the passage of the MCO tax. These investments include:

    - Developmental Services—$287 million in GF expenditures for various developmental services programs, including rate adjustments for community-based providers serving individuals with developmental disabilities.[8]

    - Retiree Health Prefunding—$240 million GF set aside in a trust fund to pay for future retiree health care benefits.[8]

    - Medi-Cal Rates—$135 million GF for increased Medi-Cal rates for Intermediate Care Facilities for the Developmentally Disabled and forgiveness of recoupments for Distinct Part Nursing Facilities.[8]

    - UC PRIME—$2 million GF for the University of California, San Joaquin Valley Program in Medical Education.[8]

Passage of the MCO tax provides for the continued implementation of CCI in 2016-17.

Enacted Budget: The enacted budget includes adjustments for the MCO tax and the new investments outlined above.[1,12,13]

Long-Term Services and Supports

In-Home Supportive Services (IHSS)

Background: The IHSS program provides in-home personal care assistance to low-income adults who

are age 65 or 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 491,000 recipients per month on average in 2016-17, a 4.8 percent increase from the projections made in 2015.[14]

After implementation delays due to court challenges, federal enforcement of new regulations under the Fair Labor Standards Act (FLSA) began on January 1, 2016. These regulations 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.[7] 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 included $9.2 billion ($3 billion GF) for the IHSS program in 2016-17, an 8.4 percent increase over the revised 2015-16 level.[7]

- Federal Overtime Regulations: The proposed 2016-17 budget anticipated the state's implementation of the federal overtime rules for IHSS providers to begin February 1, 2016. Implementation of the regulations was 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 work weeks, and those who work for multiple people will be paid travel time (up to seven hours/week) between IHSS recipients.[7]

- Restoration of the 7 Percent Across-the-Board Reduction: The proposed 2016-17 budget continued 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 was estimated to be $236 million in 2016-17.[7]

May Revision:

- IHSS Caseload: The May Revision included increases of $131.7 million GF in 2015-16 and $183.1 million GF in 2016-17 to reflect increases in the number of people in the program, average service hours per person, and average cost per person.[8]

- Federal Overtime Regulations: The May Revision included an additional $3.6 million GF in 2015-16 and $22.2 million GF in 2016-17 for costs related to exempting providers who meet specified criteria from IHSS overtime restrictions. Specifically, exemptions would be available for live-in family care providers who, as of January 31, 2016, reside in the home of two or more disabled minor or adult children or grandchildren for whom they provide services. This exemption is expected to affect roughly 1,000 providers. The Administration would consider a second type of exemption on a case-by-case basis for IHSS recipients with extraordinary circumstances, and anticipated about 5,000 providers to be affected. Under both exemptions, the maximum number of hours a provider may work cannot exceed 360 hours per month.[14]

- Compliance with Fair Labor Standards Act: The May Revision decreased $65.8 million GF in 2015-16 due to the revised implementation schedule for the IHSS provider payment of overtime, travel, and medical accompaniment to comply with federal FLSA rules and the provisions of SB 855.[8]

- Restoration of the 7 Percent Across-the-Board Reduction: The May Revision included an increase of $265.8 million GF to restore the 7 percent reduction to IHSS, using proceeds from the MCO tax. The Administration noted that this restoration would remain in effect until June 30, 2019, when the MCO tax is scheduled to expire.[14]

- Minimum Wage Increase: The May Revision included an increase of $18.4 million GF to cover the 50 cent increase in the state minimum hourly wage, effective January 1, 2017.[18] The increase would impact the 36 counties paying wages below $10.50 in 2016-17. On average, the cost per hour for services would increase to $13.33.[14]

Enacted Budget: The enacted budget includes $10.6 billion for the IHSS program in 2016-17 and addressed the following areas:[19]

- Federal Overtime Regulations: The enacted budget includes $437.3 million GF in 2016-17 to implement federal overtime provisions, including compliance with the FLSA and state limits on overtime usage. Certain providers are exempted from state limits on overtime usage, including live-in family care providers who, as of January 31, 2016, reside in the home of and provide services to two or more disabled minor or adult children or grandchildren. Additional exemptions will be considered on a case-by-case basis for recipients with extraordinary circumstances.[1]

- Restoration of the 7 Percent Across-the-Board Reduction: The enacted budget includes $265.8 million GF to reflect the restoration of the 7 percent across-the-board reduction, using proceeds of the MCO tax. The restoration will remain in effect through the duration of the MCO tax, which is scheduled to expire on June 30, 2019.[1]

- Minimum Wage Increase: The enacted budget includes an increase of $18.4 million GF to cover the 50-cent increase in the state minimum hourly wage, effective January 1, 2017.[1,18]

Community-Based Adult Services

Background: Community-Based Adult Services (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 authorizing hours. There are currently 242 CBAS centers serving approximately 32,500 Medi-Cal participants. As of 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 with the goal of improving the quality and providing additional protections to individuals that receive services under Medicaid. As a result, state responsibilities related to CBAS monitoring and oversight have increased due to the need for coordination with the Medi-Cal managed care plans and new federal requirements.[20-22]

Proposed Budget: The proposed budget included $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.[20] In addition, the proposed budget includes $705,000 in funding ($319,000 GF) to Department

of Aging (CDA) for four additional staff positions working to ensure compliance with current state statutes as well as new federal requirements for CBAS provider certification.[21]

May Revision: No changes were reflected in the May Revision.

Enacted Budget: The enacted budget includes $705,000 ($319,000 GF) for CDA to support four additional positions and one Nurse Evaluator II needed to ensure compliance with the current state statutes as well as new federal requirements for CBAS provider certification.[23]

Universal Assessment

Background: California's HCBS 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 CCI, existing law requires the Department of Social Services (DSS), DHCS, and CDA to consult with stakeholders to develop a universal assessment (UA) process, including the development of a UA tool for IHSS, CBAS, and the 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.[24]

Proposed Budget: The proposed budget included over $3 million ($1.51 million GF) to support the pilot and its implementation. The proposed budget further provided that the pilot would 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 are to coordinate a UA stakeholder workgroup to obtain input for the development of the UA tool and work directly with the counties to ascertain any operational issues that need to be addressed.[25,26]

May Revision: The May Revision decreased the budget by $2.5 million ($1.26 million GF) for 2016-17 to reflect a delayed timeline for UA implementation. However, DSS submitted a planning schedule to the Assembly Budget Committee showing completion of UA piloting testing during 2016-17, despite the 85 percent reduction in GF support.[27]

Enacted Budget: The enacted budget includes $232,000 ($117,000 GF) for two positions to enable the ongoing workload of the CMIPS II project for the UA tool.[28] The enacted budget did not resolve the discrepancy between the planning and implementation timeline and reduced budget support, as proposed in the May Revise.[29]

Program of All-Inclusive Care for the Elderly

Background: The Program of All-Inclusive Care for the Elderly (PACE) provides a comprehensive medical/social service delivery system using an interdisciplinary team (IDT) approach that provides and coordinates all needed preventive, primary, and acute care and LTSS. The PACE model affords eligible older adults, who would otherwise reside in nursing homes, to remain independent and in their homes for as long as possible.[30] The PACE plan receives a monthly Medicaid and/or Medicare capitation payment for each enrolled participant and retains full risk for the cost of all Medicare and Medi-Cal services as well as any additional services determined necessary by the PACE IDT. Eleven PACE organizations currently serve nearly 6,000 seniors statewide in 12 counties.[31]

Proposed Budget: The proposed 2016-17 budget included provisions to modernize the PACE program, including removing the cap on the number of PACE organizations, adjusting the rate-setting methodology, removing the not-for-profit requirement and provisions enabling DHCS to seek flexibility from CMS on several issues. These include the composition of the PACE IDT, the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.[32]

May Revision: The May Revision proposed modifications to rate methodology provisions, based on stakeholder feedback.[33]

Enacted Budget: The enacted budget includes provisions to modernize PACE as outlined above, including amendments proposed in the May Revision.[34]

Developmental Disabilities

Background: Governed by the Lanterman Developmental Disabilities Act (the 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, and 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. By the end of 2016-17, the Administration estimates it will serve approximately 303,000 of these individuals in the community and 847 individuals in state-operated developmental centers.[8]

Proposed Budget:

- Developmental Center Closures: The proposed 2016-17 Budget included $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 closures and the relocation of individuals into the community.[7]

- Developmental Services Provider Rate Increases: The Administration tied any additional targeted spending proposals (e.g., rate increases) to extension of the MCO tax, as discussed in the prior section.[7]

- 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.[22,35] In implementing the CMS HCBS final rule, the proposed budget included $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 to models that are more integrated in the community and consistent with the federal HCBS regulations.[7]

May Revision:

- Developmental Center Closures: The May Revision proposed a number of policies to facilitate the closure process, including: extending specified managed care provisions to Medi-Cal eligible individuals transitioning from developmental centers; allowing developmental center employees to become community-based service providers through specified processes; and incentivizing developmental center staff during the closure process to maintain services during the transition.[8]

- Policy Changes Through the MCO Tax: The May Revision included an additional $6.6 million GF in 2016-17 to implement changes authorized by ABX2 1 including resources to oversee implementation of cultural programs and competitive integrated employment activities, contract for a provider rate study, and reports on adjustments to provider rates.[8]

- Regional Center Rate Increases: The May Revision included $287 million GF ($473.2 million total funds) in additional funding from the MCO enrollment tax to fund targeted rate increases for regional center providers.[8]

- Minimum Wage: The May Revision included an increase of $12 million GF to cover the 50 cent increase in the state minimum hourly wage, effective January 1, 2017, pursuant to Chapter 4, Statutes of 2016 (SB 3).[8]

Enacted Budget: The enacted budget includes $50 million GF for specified program investments in the developmental services system, as well as $287 million GF as outlined in Chapter 3, Statutes of 2016, Second Extraordinary Session (ABX 2 1). In addition, the enacted budget includes an increase of $12 million GF to cover the 50 cent increase in the state minimum hourly wage, effective

January 1, 2017.[18] Finally, the enacted budget specifies the policies and provides the funding to facilitate the developmental center closure process, as outlined above.[1]

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

Background: The federal Supplemental Security Income (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/State Supplementary Payment (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. Beginning 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).[7]

Proposed Budget: The proposed budget included $2.9 billion GF for the SSI/SSP program, representing a 2.8 percent increase ($76.8 million) over the revised 2015-16 budget. The budget 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.[7]

May Revision: The May Revision maintained a cost-of-living increase as proposed in the January budget, effective January 1, 2017. The May Revision decreased GF spending by $19.4 million in 2015-16 and $44 million GF in 2016-17, reflecting slower SSI/SSP caseload growth and a smaller than anticipated COLA.[14]

Enacted Budget: The enacted budget includes increases of $36.5 million GF in 2016-17 and $74.8 million in 2017-18, reflecting a 2.76 percent increase to the SSP portion of the SSI/SSP grant, effective January 1, 2017. This translates into per month amounts of $4.32 for individuals and $10.94 for couples. In addition, the enacted budget includes one-time funding of $45 million GF for SSI outreach to homeless persons with disabilities who may be eligible for disability benefits.[29]

Medi-Cal Policy

Medi-Cal 2020: California's New 1115 Waiver

Background: California's new 1115 waiver, referred to as "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, CBAS, CCI, 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: Locally-based pilot programs integrate physical health, behavioral health, and social services systems to improve members' overall health and well-being, and may choose to expand access to supportive housing options for high-risk populations.[36]

- Public Hospital Redesign and Incentives in Medi-Cal (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.[36]

- Global Payment Program: Designated Public Hospitals are incentivized to provide ambulatory primary and preventive care to the remaining uninsured by rewarding the provision of care in more appropriate settings outside the emergency room and inpatient hospital.[36]

Proposed Budget: The proposed budget included 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.[11]

May Revision: The May Revision included $2.2 billion in federal funding for implementation of Medi-Cal 2020.[8]

Enacted Budget: The enacted 2016-17 budget includes $2.2 billion in federal funding for implementation of Medi-Cal 2020.[1]

Medicaid Managed Care Regulations

Background: Noting that the health care delivery landscape has changed substantially both within and outside the Medicaid program, CMS finalized changes to the Medicaid managed care regulatory structure to help accomplish the triple aim of: 1) improved health outcomes, 2) a better beneficiary experience, and 3) managing costs. CMS additionally seeks to align managed care with other sources of coverage such as Medicare Advantage and Exchange plans.[37] The changes will impact all Medicaid Managed Care Plans, including Cal MediConnect and MLTSS. The rules are intended to improve accountability in the Medicaid managed care program; strengthen protections for individuals and appeals processes; monitor provider networks; and strengthen program integrity safeguards.[38]

May Revision: The May Revision included $5 million GF and 38 positions within DHCS to implement the federal regulations.[38]

Enacted Budget: The enacted 2016-17 budget includes an increase of $5 million GF and 38 positions to implement the federal regulations.[1]

Medi-Cal Estate Recovery Provisions

Background: Federal Medicaid law requires states to recover against the estates of Medicaid (Medi-Cal) beneficiaries for certain services, and gives states the option of collecting against the estates of beneficiaries for additional services. As such, the federal government requires states to recover against the estates of people who received Medi-Cal if they were: 1) permanently institutionalized; or 2) age 55 or older and received nursing facility services, HCBS, or related hospital and prescription drug services. Previously, California opted to collect against estates for all medical care incurred for these beneficiaries, meaning the state could recover the total amount spent for Medi-Cal services including the premium payments paid to a health plan for a beneficiary, even if the beneficiary received few or no health care services.[32]

The Administration will limit Medi-Cal estate recovery to federal requirments, such as institutional and community-based LTSS (versus all medical costs).

Enacted Budget: The enacted budget limits Medi-Cal recovery to what is federally required, namely, financial recovery for the costs of long-term care services such as nursing homes and HCBS. Further, the enacted budget prohibits recovery from the estate of a deceased Medi-Cal beneficiary who is survived by a spouse or registered domestic partner. The new provisions of the law will be in effect for Medi-Cal beneficiaries who pass away on or after January 1, 2017.[34] The budget includes $5.7 million GF in 2016-17 and $28.9 million GF ongoing to implement these provisions.[39]

Health Information Meaningful Use

Background: Effective coordination of health care and LTSS often requires the use and exchange of protected health information between an individual's health plan, doctors, specialists, and other community-based providers. While the California Office of Health Information Integrity (CalOHII) has developed guidance for state departments on the use and exchange of protected health information, no such guidance has been developed for non-state organizations. The absence of guidance on state and federal laws regarding the handling of protected health information can create confusion among non-state entities resulting in barriers to information sharing that effect treatment and care coordination. California Health Care Foundation (CHCF) has agreed to fund the development of standardized guidelines for non-state organizations.[40]

May Revision: The May Revision provided CalOHII the authority to use $800,000 provided by CHCF to develop guidelines on the use and exchange of sensitive and protected health information for non-state entities.[40]

Enacted Budget: The enacted budget includes budget authority for $800,000, through support from CHCF, to develop guidelines on the use and exchange of sensitive and protective health information for non-state entities.[41]

Supplemental Funding

The following items were included as part of the final budget.

Senior Nutrition: The Home Delivered Meals program provides temporary meals support to people age 60 or older who are homebound by reason of illness, incapacity, or disability, or who are

otherwise isolated.[42] The enacted budget includes a one-time increase of $2 million GF for the Home Delivered Meals program.[23]

Adult Protective Services: The Adult Protective Services (APS) program provides 24/7 emergency response to reports of abuse and neglect of elders and dependent adults. APS investigates over 150,000 reports of elder and dependent adult abuse per year in California.[43] The enacted budget includes a one-time expenditure of $3 million GF for statewide training of APS staff.[1]

The enacted budget included several one-time expenditures for policies and programs affecting older adults and people with disabilities, which were subject to past budget reductions.

Early Detection and Diagnosis of Alzheimer's Disease: California Alzheimer's Disease Centers (CADCs) provide training and education, and advance Alzheimer's diagnosis and treatment. The enacted budget provides one-time expenditure of $2.5 million GF to the state's network of CADCs to develop Alzheimer's early detection and diagnosis tools and to conduct targeted outreach to health professionals.[7,34,44]

Long-Term Care Ombudsman Program: The Long-Term Care Ombudsman Program investigates and endeavors to resolve complaints made by, or on behalf of, individual residents in long-term care facilities including nursing homes, residential care facilities for the elderly, and assisted living facilities. The enacted budget includes $1 million to the Long-Term Care Ombudsman Program, drawn from the Department of Public Health's Health Citations Penalty Account, to enable unannounced monitoring visits, complaint investigation, as well as volunteer recruitment, training, and supervision.[23]

Independent Living Centers: Independent Living Centers advocate for disability rights and provide services and supports for people with disabilities to live in the community. The enacted budget includes a one-time $705,000 GF augmentation to the Department of Rehabilitation for the administration of independent living services in in three regions in California.[45]

Traumatic Brain Injury (TBI) Program: In coordination with consumers and their families, seven service providers throughout California provide a coordinated post-acute care service model for

persons with TBI, including supported living, community reintegration, and vocational supportive services. The enacted budget included a $360,000 augmentation to the TBI Fund from the Driver Training Penalty Assessment Fund to maintain services to Californians with traumatic brain injury.[45]

California Senior Legislature: The California Senior Legislature (CSL) was established in 1980 to provide model legislation and advocate for the needs of California's older adults. The CSL is primarily funded by donations through an income tax check-off on state income tax returns. However, tax check-off contribution yields were not sufficient this year to sustain the program's operating expenses and one staff position. The enacted budget includes $500,000 GF on a one-time basis for the CSL as a relief appropriation, allowing the CSL program to continue by funding its basic administrative costs.[46]

Housing/No Place Like Home: The enacted budget includes provisions for the No Place Like Home Initiative, which seeks to prevent and address homelessness throughout California. The initiative provides $2 billion for the construction and rehabilitation of permanent supportive housing for homeless individuals with mental illness. The Department of Housing and Community Development will administer the program to finance the construction, rehabilitation, and preservation of permanent supportive housing units for individuals with mental conditions who are homeless, chronically homeless, or at-risk of chronic homelessness. The initiative will be financed through a $2 billion bond financed by Proposition 63 revenues (a one percent tax on incomes great than $1 million established to fund mental health services).[1]

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For more information, contact Megan Burke at MBurke@TheSCANFoundation.org