2016-2017 May Revision: Impact on California's Older Adults and People with Disabilities

Fact Sheet • May 2016

This fact sheet summarizes the key initiatives and program adjustments contained in the 2016-17 May Revision that impact California's older adults and people with disabilities.

The May Revision reflects General Fund (GF) resources of $124.9 billion and anticipated expenditures of $122.2 billion.

Overview

On May 13, 2016, California Governor Edmund G. Brown, Jr. released the "May Revision," with updated revenue and spending estimates for the 2016-17 budget of $124.9 billion in General Fund (GF) resources, and $122.2 billion in GF expenditures. The revised budget also includes $1.8 billion in regular reserves and $6.7 billion in the Rainy Day Fund, for total reserves of $8.5 billion.[1] Further, the May Revision reflects budget initiatives passed this year, including the Managed Care Organization (MCO) tax, the rate increase for Developmental Disability Services, restoration of the 7 percent In-Home Supportive Services (IHSS) hours reduction, and the minimum wage increase.

The Brown Administration reports that income tax and sales tax revenues have not kept pace with what was forecast in the January proposed budget, thereby reducing estimated tax revenues by $1.9 billion. Due to reduced estimated GF revenues for 2016-17, the May Revision reflects a decrease of $1.6 billion from the January proposed budget to repay budget debts, per the requirements of the *2014 Rainy Day Budget Stabilization Fund Act*.[1,2] While the Brown Administration anticipates that the budget will remain balanced over the next two years, by 2019-20 the state could face a $4 billion deficit due to the expiration of temporary taxes authorized under Proposition 30.* Even if the taxes are extended, Governor Brown expressed caution that it would "barely balance" the longer-term budget outlook. Therefore, the May Revision proposes no new significant ongoing spending. The Governor's priority is in "fully filling" the state's Rainy Day Fund before a new recession may begin.[4]

Long-Term Services and Supports

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. As part of the Coordinated Care Initiative (CCI; described below), existing law requires the Departments of Aging (CDA), Social Services (DSS), and Health Care Services (DHCS) to consult with stakeholders to develop a universal assessment (UA) process, including the development of a UA tool for IHSS,

* Proposition 30 increased the personal income tax for seven years on California taxpayers earning more than $250,000 and increased sales and use tax by one-quarter of one percent for four years.[3]

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.[5]

FY 2016-17 funding for universal assessment pilot decreased to reflect continued implementation delays.

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.[6,7]

May Revision: The May Revision decreases 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.[8]

Coordinated Care Initiative

Background: CCI changes how medical care and LTSS are provided for low-income older adults and people with disabilities in participating counties.[9,10] 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. CCI is fully operational in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).[11] In July 2015, the Centers for Medicare & Medicaid Services (CMS) communicated intent to extend the demonstration for up to two years,[12] and DHCS responded with a non-binding letter of intent indicating interest in potentially considering an extension of CCI.[13] 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.[14]

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.[14]

May Revision: The May Revision reflects passage of the MCO enrollment tax (described below).[4]

In-Home Supportive Services

Background: The IHSS program provides in-home personal care assistance to low-income adults who are either 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.[16]

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.[14] 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.[17] 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 healthcare financing.[18,19]

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.[14]

- 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 workweeks,

and those who work for multiple people will be paid travel time (up to seven hours/week) between IHSS recipients.[14]

- 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.[14]

May Revision:

- IHSS Caseload: The May Revision includes 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.[4]

- Federal Overtime Regulations: The May Revision includes 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 will 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 will consider a second type of exemption on a case-by-case basis for IHSS recipients with extraordinary circumstances, and is anticipating 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.[16]

- Compliance with Fair Labor Standards Act: The May Revision decreases $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.[4]

- Restoration of the 7 Percent Across-the-Board Reduction: The May Revision includes an increase of $265.8 million GF to restore the 7 percent reduction to IHSS, shifting the funding source from the MCO enrollment tax to GF. The Administration notes that this restoration will remain in effect until June 30, 2019, when the MCO enrollment tax is scheduled to expire.[16]

- Minimum Wage Increase: The May Revision includes an increase of $18.4 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). The increase impacts the 36 counties that are currently paying wages below $10.50 in 2016-17. On average, the cost per hour for services will increase to $13.33.[16]

Community-Based Adult Services

Background: 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 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 are reflected in the May Revision.

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.[15]

May Revision: The May Revision provides 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.[15]

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.[23,24]

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 IHSS service hours beyond 2015-16; and
- Identify funding to increase rates for Medi-Cal providers, including those serving people with developmental disabilities.[24]

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.[14] The budget proposed to use $236 million of the MCO tax revenue to accomplish the issues listed above.[25]

May Revision: The governor and Legislature agreed to revisions in California's MCO tax structure

during the special session. The May Revision reflects budget adjustments related to the new MCO enrollment tax, as follows:

- MCO enrollment 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 billion in 2017-18 and 2018-19. SBX2 2 also included provisions that reduced other taxes paid by health plans. 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.[4]

Approved by California lawmakers and CMS, the new MCO enrollment tax will go into effect July 1, 2016.

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

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

    - 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.

    - UC PRIME—$2 million GF for the University of California, San Joaquin Valley Program in Medical Education.[4]

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.[26]

- 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.[26]

- 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.[26]

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.[25]

May Revision: The May Revision includes $2.2 billion in federal funding for implementation of Medi-Cal 2020 in FY 2016-17.[4]

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.[27] 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.[28]

May Revision: The May Revision includes $5 million GF and 38 positions within DHCS to implement the new federal regulations.[28]

Other Program Proposals

Supplemental Security Income/State Supplementary Payment

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).[14]

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.[14]

May Revision: The May Revision maintains the cost-of-living increase as proposed in the January budget, effective January 1, 2017. The May Revision decreases 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.[16]

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.[4]

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 closure and the relocation of individuals into the community.[14]

- 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.[14]

- 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.[22,29] 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.[14]

May Revision:

- Developmental Center Closures: The May Revision proposes 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 per specified processes; and incentivizing developmental center staff during the closure process to maintain services during the transition.[4]

- Policy Changes through the MCO Enrollment Tax: The May Revision includes 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 report on adjustments to provider rates.[4]

- Regional Center rate Increases: The May Revision includes $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.[4]

- Minimum Wage: The May Revision includes 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).[4]

Next Steps in the Budget Process

The 2016-17 budget requires approval by the Senate and the Assembly. The Legislature continues to deliberate the 2016-17 proposed budget 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.[30]

Key Budget Dates

- June 15, 2016 – Deadline for Legislature to Approve Final Budget
- July 1, 2016 – Governor Must Sign the Budget

References

1. Assembly Budget Committee. Highlights of governor's proposed 2016-17 May revision. 2016; http://abgt.assembly.ca.gov/sites/abgt.assembly.ca.gov/files/May%20Revise%20Highlights%202016.pdf. Accessed May 17, 2016.

2. California Attorney General. Proposition 2, State Budget Stabilization Account. Legislative Constitutional Amendment. 2014; http://vig.cdn.sos.ca.gov/2014/general/pdf/proposition-2-title-summary-analysis.pdf. Accessed May 18, 2016.

3. Ballotpedia. California proposition 30, sales and income taxe increase (2012). 2012; https://ballotpedia.org/California_Proposition_30,_Sales_and_Income_Tax_Increase_(2012). Accessed May 18, 2016.

4. California Department of Finance. May Revision 2016-17. 2016; http://www.ebudget.ca.gov/FullBudgetSummary.pdf. Accessed May 17, 2016.

5. Assembly Bill 664 (Chapter 367, Statutes of 2015).

6. California Department of Social Services. Detail tables cost comparisons. 2016; http://www.cdss.ca.gov/cdssweb/entres/localassistanceest/Jan2016/DetailTables.pdf. Accessed January 12, 2016.

7. California Department of Social Services. Budget change proposal;in-home supportive services (IHSS) case management, information and payrolling system (CMIPS), maintenance and operations (M&O). 2016; http://web1a.esd.dof.ca.gov/Documents/bcp/1617/FY1617_ORG5180_BCP541.pdf. Accessed January 12, 2016.

8. Assembly Budget Subcommittee No. 1 on Health and Human Services. Agenda - part 1; Assembly Budget Subcommittee No. 1 on Health and Human Services. 2016; http://abgt.assembly.ca.gov/sites/abgt.assembly.ca.gov/files/May%2018%20Assembly%20Sub.%201%20May%20Revise%20Agenda%20%28NV%29.pdf. Accessed May 18, 2016.

9. Senate Bill 1008 (Chapter 33, Statutes of 2012).

10. Senate Bill 1036 (Chapter 45, Statutes of 2012).

11. The SCAN Foundation. California's coordinated care initiative: October 2015 update. 2015; http://www.thescanfoundation.org/californias-coordinated-care-initiative-october-2015-update. Accessed January 12, 2016.

12. Centers for Medicare & Medicaid Services. Financial alignment extension memo. 2015; https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAExtensionMemo071615.pdf. Accessed January 14, 2016.

13. California Department of Health Care Services. DHCS submits non-binding letter to CMS. 2015; http://www.calduals.org/2015/08/27/dhcs-submits-non-binding-letter-to-cms/. Accessed January 14, 2016.

14. California Department of Finance. Governor's budget summary, 2016-17. 2016; http://www.ebudget.ca.gov/2016-17/pdf/BudgetSummary/FullBudgetSummary.pdf. Accessed January 11, 2016.

15. California Health and Human Services. Budget change proposal - use, disclosure & protection of specially protected health information (0530-400-BPC-BR-2016-MR). 2016; http://web1a.esd.dof.ca.gov/Documents/bcp/1617/FY1617_ORG0530_BCP817.pdf. Accessed May 18, 2016.

16. California Department of Social Services. California Department of Social Services 2016 May revision, local assistance, executive summary. 2016; http://www.cdss.ca.gov/cdssweb/entres/localassistanceest/May2016/ExecutiveSummary.pdf. Accessed May 18, 2016.

17. Senate Bill 67 (Chapter 4, Statutes of 2013).

18. California Department of Finance. California 2015-16 state budget. 2015; http://www.dof.ca.gov/documents/FullBudgetSummary-2015.pdf. Accessed June 28, 2015.

19. Senate Bill 97 (Chapter 11, Statutes of 2015).

20. California Department of Health Care Services. Budget change proposal; statewide transitions plan - long term care waivers. 2016; http://web1a.esd.dof.ca.gov/Documents/bcp/1617/FY1617_ORG4260_BCP608.pdf. Accessed January 12, 2016.

21. California Department of Aging. Budget change proposal - community-based adult services (CBAS) branch request for additional staffing to comply with state and federal mandates 2016; http://web1a.esd.dof.ca.gov/Documents/bcp/1617/FY1617_ORG4170_BCP568.pdf. Accessed January 13, 2016.

22. California Department of Health Care Services. HCBS statewide transition plan. 2016; http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx. Accessed January 12, 2016.

23. California Department of Finance. 2015-16 governor's budget summary. 2015; http://www.ebudget.ca.gov/2015-16/pdf/BudgetSummary/FullBudgetSummary.pdf. Accessed October 13, 2015.

24. State of California Executive Department. A proclamation by the governor of the state of California. 2015; http://gov.ca.gov/docs/6.16.15_Health_Care_Special_Session.pdf. Accessed October 14, 2015.

25. California State Senate Committee on Budget & Fiscal Review. Summary of the governor's proposed 2016-17 budget. 2016; http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/QuickS/SummaryGovernorProposed2016-17Budget.pdf. Accessed May 18, 2016.

26. Centers for Medicare & Medicaid Services. California Medi-Cal 2020 demonstration special terms and conditions. 2015; http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf. Accessed January 12, 2016.

27. Department of Health and Human Services. Medicaid and children's health insurance program (CHIP) programs; Medicaid managed care, CHIP delivered in managed care, and revisions related to third party liability. In: Services CfMM, ed. 42 CFR Parts 431, 433, 438, 440, 457 and 495. Federal Register2016.

28. California Department of Health Care Services. Budget change proposal - federal managed care regulations staffing resources (4260-402-BCP-BR-2016-MR). 2016; http://web1a.esd.dof.ca.gov/Documents/bcp/1617/FY1617_ORG4260_BCP874.pdf. Accessed May 17, 2016.

29. California Department of Developmental Services. CMS home and community-based services (HCBS) regulations. 2016; http://www.dds.ca.gov/HCBS/. Accessed January 12, 2016.

30. California State Senate. How the budget process works (taken from "The Budget Process", prepared by the Senate Rules Committee). http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/BWORKINGS.PDF. Accessed January 12, 2016.