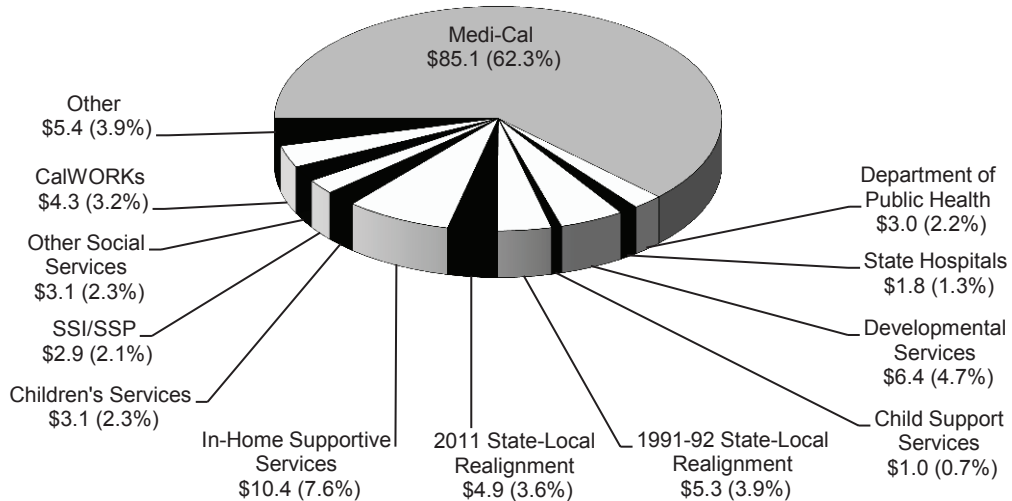


HEALTH AND HUMAN SERVICES

The Health and Human Services Agency oversees departments and other state entities that provide health and social services to California’s vulnerable and at-risk residents. The Budget includes \$136 billion (\$34 billion General Fund and \$102 billion other funds) for these programs. Figure HHS-01 displays expenditures for each major program area and Figure HHS-02 displays program caseload.

Figure HHS-01
Health and Human Services Proposed 2016-17 Funding¹
All Funds
 (Dollars in Billions)



¹ Totals \$136.6 billion for support, local assistance, and capital outlay. This figure includes reimbursements of \$15.9 billion and excludes \$5 million in Proposition 98 funding in the Department of Developmental Services budget and county funds that do not flow through the state budget.

Figure HHS-02

Major Health and Human Services Program Caseloads

	2015-16 Revised	2016-17 Estimate	Change
Medi-Cal	13,276,300	13,478,400	202,100
California Children's Services (CCS) ^a	14,820	13,113	-1,707
CalWORKs	507,615	496,558	-11,057
CalFresh	1,916,132	2,043,270	127,138
SSI/SSP (support for aged, blind, and disabled)	1,301,167	1,311,082	9,915
Child Welfare Services ^b	142,063	143,172	1,109
Foster Care	45,071	45,702	631
Adoption Assistance	84,812	84,844	32
In-Home Supportive Services	463,537	489,775	26,238
Regional Centers	290,496	302,419	11,923
State Hospitals ^c	7,313	7,323	10
Developmental Centers ^d	1,011	847	-164
Vocational Rehabilitation	27,686	27,686	0

a Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS clients.

b Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one service area.

c Represents the year-end population.

d Represents average in-center population as of January 31 each year.

California continues its implementation of federal health care reform, which has enabled millions of Californians to obtain health care coverage. Many Californians now have access to affordable, quality health care coverage through Covered California. California also expanded Medi-Cal to cover childless adults and parent/caretaker relatives with incomes up to 138 percent of the federal poverty level, and expanded Medi-Cal mental health and substance use disorder benefits.

FEDERAL ACTIONS CONTINUE TO INCREASE STATE COSTS

Several federal actions over the last few years have directly increased state costs. These increased costs are reflected in the Budget as follows:

- Chapter 31, Statutes of 2014 (SB 857), shifted pregnant women on Medi-Cal with "pregnancy-only" Medi-Cal benefits who are between 138 and 213 percent of the federal poverty level to Covered California to ensure comprehensive coverage, with the state paying the cost for premiums and cost-sharing. The proposal was expected to save more than \$100 million in General Fund costs annually when fully implemented. The state sought a waiver to implement these changes, but the

waiver was not approved because the federal government now considers Medi-Cal pregnancy-only coverage to be comprehensive coverage.

- The federal government requires that states provide Behavioral Health Treatment as a required benefit under Medi-Cal. This benefit will cost approximately \$91 million General Fund in the budget year.
- The federal Department of Labor issued regulations entitling home care providers to payment for overtime, travel time between recipients, and wait time related to doctor visits. The federal rules affect all home care workers, including the following state-funded programs: In-Home Supportive Services, Waiver Personal Care Services, and Developmental Services. These regulations will lead to over \$440 million annually in additional state costs.

There have also been recent federal actions in the health and human services area that have created substantial fiscal uncertainty for California. The impact of these actions is currently unknown, but could cost the state billions of dollars annually.

- In June 2015, the federal government released a proposed regulation pertaining to Medicaid managed care programs. There are several components of the proposed regulation that could negatively impact California's Medicaid managed care program and result in General Fund costs potentially in the billions of dollars annually. The federal government has indicated it intends to finalize the regulation in the first half of 2016.
- In 2011, the federal government published a proposed regulation regarding Medicaid fee-for-service access standards and monitoring and issued the final regulation in October 2015. The final regulation is significantly improved from the initial proposal, but there are still costly provisions for states seeking to provide timely access to services and setting fee-for-service payment policies.
- The federal government recently indicated it would be implementing a change in how California has historically claimed Disproportionate Share Hospital funding for public safety net hospitals and that the change would likely be applied retroactively. This change could result in tens of millions in lost revenue to public safety net hospitals and associated General Fund costs over the next two years.
- California and the federal government reached an agreement on the Section 1115 Waiver renewal that begins January 1, 2016. While the exact magnitude is

unknown, the Waiver reduced funding for public hospitals and will result in negative General Fund impacts over the next few years.

- The federal government, through the state Department of Public Health, determined that the state's developmental centers are noncompliant with federal regulations and should be decertified, thereby becoming ineligible for federal funding. The state entered into a settlement agreement for the decertified units at the Sonoma Developmental Center to keep federal funds available until either July 1, 2016 or July 1, 2017, depending on the state's continued compliance with the agreement. Discussions are ongoing over the decertification of the Porterville and Fairview Developmental Centers. The state must make substantial progress in closing all of the developmental centers outside the secured treatment area at Porterville to maintain federal funds. Delays could cost the state hundreds of millions if the federal government decertifies the centers.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal, California's Medicaid program, is administered by the Department of Health Care Services (DHCS). Medi-Cal is a public health care coverage program that provides comprehensive health care services at no or low cost for low-income individuals. The federal government mandates basic services, including: physician services; family nurse practitioner services; nursing facility services; hospital inpatient and outpatient services; laboratory and radiology services; family planning; and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits such as outpatient drugs, home and community-based services, and medical equipment. DHCS also operates the California Children's Services and the Primary and Rural Health programs, and oversees county-operated community mental health and substance use disorder programs.

Since 2012-13, total Medi-Cal benefit costs grew at an average of 22 percent annually to \$87.9 billion in 2015-16 because of a combination of health care cost inflation, program expansions, and caseload growth. Medi-Cal General Fund spending is projected to increase 8 percent from \$17.7 billion in 2015-16 to \$19.1 billion in 2016-17.

The Budget assumes that caseload will increase approximately 8.1 percent from 2014-15 to 2015-16 and 1.5 percent from 2015-16 to 2016-17. Recent caseload trends reflect a larger increase in the current fiscal year (727,000), with more typical growth (62,000) by

2016-17. With these trends, over a third of the state's total population will be enrolled in Medi-Cal, with total caseload expected to be 13.5 million in 2016-17.

Compared to other states, California is providing higher levels of Medicaid services while receiving lower federal reimbursements and maintaining lower-than-average costs per case. The Federal Medical Assistance Percentage (FMAP) determines the level of federal financial support for the Medi-Cal program. California has generally had an FMAP of 50 percent (the minimum percentage authorized under federal law) since the inception of the Medicaid program in 1965. California's FMAP percentage is lower than the national average and is lower than those of neighboring states. Oregon, Nevada, and Arizona currently have FMAP percentages of 64 percent, 65 percent, and 69 percent, respectively. The state's FMAP percentage is also substantially lower than Mississippi's 74 percent FMAP percentage, currently the highest in the country.

Furthermore, the Medi-Cal program cost per case is lower than the national average (28th out of 50 states plus the District of Columbia). According to data from federal fiscal year 2011, California's cost per case of \$6,108 was lower than the national average of \$6,502. The highest cost per case state is Massachusetts (\$11,091) and the lowest is Nevada (\$4,010).

California is one of 31 states (including the District of Columbia) that implemented the optional expansion under federal health care reform, which expanded Medi-Cal eligibility to all parent/caretaker relatives and childless adults under 138 percent of the federal poverty level (FPL). In addition, California provides coverage for pregnant women up to 322 percent of FPL (which is the highest of any Medicaid program in the nation), and 138 percent of FPL for parents and caretaker relatives (4th highest in the nation).

Significant Adjustments:

- Extension of Full-Scope Medi-Cal Coverage to Undocumented Children—Chapter 18, Statutes of 2015 (SB 75), expands full-scope Medi-Cal benefits to undocumented children under 19 years of age. The Budget includes \$182 million (\$145 million General Fund) to provide full-scope benefits to 170,000 children. The provision of this benefit is scheduled to begin by May 1, 2016.
- County Medi-Cal Administration—County workers conduct Medi-Cal eligibility work on behalf of the state. Medi-Cal caseload continues to grow significantly post implementation of the Affordable Care Act, and the system built to automate eligibility determinations is not yet completely functional. The Budget provides

counties an additional \$169.9 million (\$57 million General Fund) in 2016-17 and the following year to administer the program. Once the eligibility system is stabilized, the state will conduct time studies to inform a new Medi-Cal county administration budgeting methodology.

HEALTH CARE REFORM IMPLEMENTATION

In 2013, California implemented significant portions of the Affordable Care Act. Covered California, the state's insurance marketplace, has provided affordable health insurance, including plans subsidized with federally funded tax subsidies and products for small businesses, beginning January 1, 2014.

In addition, the Medi-Cal program was expanded in two ways:

- The mandatory expansion simplified eligibility, enrollment, and retention rules, making it easier to get on and stay on the program.
- The optional expansion extended eligibility to adults without children, and parent and caretaker relatives with incomes up to 138 percent of the federal poverty level.

Significant reforms in the individual and small group insurance markets also took effect January 1, 2014. Most health plans and insurers in California are required to cover the 10 essential health benefits required by federal law: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric oral and vision care.

With these reforms, the Medi-Cal caseload will increase from 7.9 million in 2012-13 to a projected 13.5 million in 2016-17, covering over a third of the state's population. In addition, 1.5 million people will be enrolled in Covered California by the end of 2015-16. Covered California is now a self-sustaining entity primarily through the fees it assesses on qualified health plans to fund its operating budget.

The Budget assumes net costs of \$4 billion (\$1.9 billion General Fund) in 2016-17 for the cost of the mandatory Medi-Cal expansion. Additionally, the federal government will pay 100 percent of the cost of the optional expansion for the first three years. Beginning in 2017, the state assumes a 5-percent share for the optional expansion population. By 2020-21, the federal share will have decreased to 90 percent and the state will pay

10 percent. The Budget assumes costs of \$13.7 billion (\$551.5 million General Fund) in 2016-17 for the state's share of costs for the optional Medi-Cal expansion.

1991-92 STATE-LOCAL REALIGNMENT HEALTH ACCOUNT REDIRECTION

Under the Affordable Care Act, county costs and responsibilities for indigent health care are decreasing as more individuals gain access to health care coverage. The state-based Medi-Cal expansion has resulted in indigent care costs previously paid by counties shifting to the state, contributing to significant increases in state costs.

Chapter 24, Statutes of 2013 (AB 85), modified the 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect savings counties are experiencing from the implementation of federal health care reform. The net savings are redirected for county CalWORKs expenditures, which saves the state General Fund on the CalWORKs program. County savings are estimated to be \$741.9 million in 2015-16 and \$564.5 million in 2016-17. However, actual county savings in 2013-14 were \$151.7 million lower than estimated and the Budget assumes reimbursement of this amount to counties in 2016-17. The estimates for 2016-17 will be updated in the May Revision using more current data from the counties. As mentioned earlier in this Chapter, the 1115 Waiver and other actions pending by the federal government may further impact the savings reported by counties.

LRF sales tax revenues are first allocated to base funding to the subaccounts (Mental Health, Health, Social Services, and CalWORKs) within the fund. Any sales tax revenues deposited into the LRF in excess of base funding are distributed through various growth formulas. These growth funds are first distributed to fund cost increases in social services programs, followed by County Medical Services Program growth pursuant to a statutory formula. Any remaining growth funds, or general growth, are distributed to each of the subaccounts within the LRF.

AB 85 established two new subaccounts within the LRF beginning in 2013-14: (1) the Family Support Subaccount, which receives sales tax funds redirected from the Health Subaccount, as noted above, and then redistributes to counties in lieu of General Fund for the CalWORKs program, and (2) the Child Poverty and Family Supplemental Support Subaccount, which receives base and growth revenues dedicated solely towards funding increases to CalWORKs grant levels. Additionally, under AB 85, the Health Subaccount receives a fixed 18.5 percent of general growth funds, while the Mental Health Subaccount continues to receive general growth without any changes to the original

statutory formula. The Child Poverty and Family Supplemental Support Subaccount receives any remaining general growth funds.

Based on current revenue estimates, the Child Poverty and Family Supplemental Support Subaccount is projected to receive \$241.5 million in base and growth funds in 2015-16, plus an additional \$69.5 million in carryover funding from the prior fiscal year. These funds will be used to fund the two 5-percent increases to CalWORKs grant levels that took effect on March 1, 2014 and April 1, 2015, which are estimated to cost \$326 million in 2015-16 and \$319.8 million in 2016-17. Total deposits to the Child Poverty and Family Supplemental Support Subaccount in 2016-17 are projected to be \$302.4 million. The Budget includes \$15 million General Fund in 2015-16 and \$17.4 million General Fund in 2016-17 to provide the remaining funding needed for the grant increases.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

California expanded the mental health and substance use disorder benefits available to those eligible for Medi-Cal as part of its implementation of the Affordable Care Act. The Budget includes the costs of the expansion of these benefits.

DHCS sought a waiver from the federal Centers for Medicare and Medicaid Services to provide better coordination and a continuum of care for substance use disorder treatment services, including residential treatment services which would be unavailable for most beneficiaries absent a waiver. The waiver amendment, which was approved in August 2015 and is included in the Medi-Cal 2020 Waiver, will allow state and county officials more authority to select quality providers to provide substance use disorder treatment, assessments, and case management. To participate in the waiver, counties which must opt in by submitting an implementation plan to DHCS, which expects over 50 counties to begin participating by the end of the budget year. The Budget includes \$90.9 million (\$32.5 million General Fund) for residential treatment services expanded under the new waiver.

Existing law also requires DHCS, in collaboration with stakeholders, to create a Performance Outcomes System to track outcomes of Medi-Cal Specialty Mental Health Services for children and youth. DHCS continues to work with stakeholders to identify key components of the system and finalize the outcome measures that will be prioritized for data collection. The Budget includes \$11.9 million General Fund for implementation of this system, including county collection of assessment data and related training to better report on participant outcomes.

MANAGED CARE ORGANIZATION TAX

Chapter 33, Statutes of 2013 (SB 78), authorized a tax on the operating revenue of Medi-Cal managed care plans based on the state sales tax rate. This tax offset General Fund spending in the Medi-Cal program by approximately \$1 billion annually. The federal government released guidance in 2014 indicating that the current tax is impermissible under federal Medicaid regulations. California's current tax expires at the end of 2015-16.

The 2015 Governor's Budget proposed to amend the scope of the tax in order to: comply with federal requirements by broadening the tax to apply to nearly all managed care plans; continue to offset General Fund expenditures in the Medi-Cal program by \$1 billion annually; and restore the 7-percent reduction in hours for recipients of In-Home Supportive Services. The 2015 Budget Act restored the 7-percent reduction in the In-Home Supportive Services program for one year using General Fund dollars, but the Administration's proposed tax extension has not been passed by the Legislature. The Governor called a special session in June 2015 to address the proposed tax.

Calendar year 2017 is the first year that the state will share the costs of the optional expansion population under federal health care reform. To serve the 3.4 million residents now receiving coverage, the Budget allocates \$740 million General Fund for the state's 5-percent share of costs (on a half-year basis). These costs will eventually reach \$1.8 billion General Fund annually by 2020-21. The managed care organization tax remains a critical component of maintaining Medi-Cal program funding that allows for the coverage of the expanded population and for future provider rate increases.

The Budget proposes a tax reform package to extend a federally allowable managed care organization tax. The Budget also assumes that revenues from the tax be placed in a special fund and be used to restore the 7-percent reduction to the In-Home Supportive Services (\$236 million annually). Finally, the Budget assumes the tax is in place for three years starting in 2016-17.

COORDINATED CARE INITIATIVE

Under the Coordinated Care Initiative (CCI), persons eligible for both Medicare and Medi-Cal (dual eligibles) receive medical, behavioral health, long-term supports and services, and home and community-based services coordinated through a single health plan. The coordination of care for dual eligibles has the potential to reduce costs and improve care over the long term. These changes are being implemented through a

federal demonstration project known as Cal MediConnect. The CCI is also mandatorily enrolling most other dual eligibles in managed care plans for their Medi-Cal benefits only and integrating long-term services and supports for Medi-Cal-only beneficiaries. The CCI was intended to operate in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Under CCI, the state is in the process of starting to collectively bargain with In-Home Supportive Services (IHSS) workers in the counties that have implemented the CCI. The CCI also includes a new IHSS maintenance of effort for counties that replaces the old county share of cost.

The following changes have occurred since creation of the program:

- More than 100,000 participants were exempted, including Medicare Special Needs Plans and certain categories of Medi-Cal beneficiaries based on age or health condition.
- Implementation was delayed until 2014, and Alameda County will no longer participate in the demonstration. Passive enrollment is now complete in six of the seven demonstration counties, with passive enrollment in Orange County still in progress.
- Medicare and Medicaid savings were intended to be shared 50-50 with the federal government. However, the federal government reduced the amount of savings California was allowed to retain to approximately 25 to 30 percent.
- To help pay for Cal MediConnect implementation, the federal government allowed a 4-percent tax on managed care organizations through June 30, 2016. However, the federal government has indicated the tax is inconsistent with federal Medicaid regulations and will not be allowed to continue without major modifications.
- As of November 1, 2015, approximately 69 percent of eligible participants have opted out of, or disenrolled from, the demonstration compared to initial projections of approximately 33 percent. The opt-out rate is around 83 percent for IHSS beneficiaries, and participation varies widely by county.
- Due to revised federal Fair Labor Standards Act regulations, IHSS providers are entitled to overtime compensation. Because the CCI replaced the county share of cost with a cost cap based on 2011-12 expenditure levels plus annual growth of 3.5 percent, the overtime rule has significantly increased the state's IHSS costs. The cost cap applies to all 58 counties, not just the seven counties implementing CCI.

Under current law, the Director of Finance is required to annually send to the Legislature a determination of whether the CCI is cost-effective. If the CCI is not cost-effective, the program would automatically cease operation in the following fiscal year. If the managed care tax is not extended, the Budget projects net General Fund costs for the CCI of approximately \$130 million in 2016-17 and beyond due to the factors outlined above.

The Administration proposes to continue to implement the CCI in 2016. Over the course of the next year, the Administration will seek ways to improve participation in the program and extend an allowable managed care organization tax. If the tax is not extended and participation is not improved by January 2017, the CCI would cease operating effective January 2018.

MEDI-CAL 1115 WAIVER RENEWAL

Throughout 2015, California negotiated with the federal government to renew the Medi-Cal Section 1115 “Bridge to Reform” Waiver, which was fundamental to the successful implementation of the Affordable Care Act. California subsequently received approval for the Waiver renewal, called Medi-Cal 2020, effective January 1, 2016 through December 31, 2020. The total initial federal funding in the renewal is \$6.2 billion over five years, with the potential for additional funding in the global payment program outlined below.

Medi-Cal 2020 will enable California to continue the delivery system transformation of public hospital systems begun under the Bridge to Reform Waiver. It will also implement new efforts to further improve services across the Medi-Cal program, including in the Medi-Cal dental program and in the treatment of high-risk, vulnerable populations.

The agreement includes the following core elements:

- A delivery system transformation and alignment incentive program for designated public hospitals and district/municipal hospitals that totals \$3.3 billion.
- A global payment program for designated public hospitals for services to the remaining uninsured. The program transitions around \$1 billion in current federal Disproportionate Share Hospital funding annually along with federal uncompensated care funding (initially \$276 million) into a value-based system aimed at improving care for the remaining uninsured.

- A whole person care pilot program that would integrate care for high-risk, vulnerable populations in a county-based, voluntary program. The funding for this program would be up to \$1.5 billion.
- A dental transformation incentive program totaling \$750 million.

In addition to these programs outlined above, the federal government requires as a condition of the waiver an independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries and independent studies of uncompensated care and hospital financing.

2011 REALIGNMENT FUNDING

In an effort to provide services more efficiently and effectively, 2011 Realignment shifted responsibility and dedicated funding for public safety services to local governments. In addition, community mental health programs previously funded in 1991-92 State-Local Realignment are now funded primarily by revenue dedicated for 2011 Realignment.

2011 Realignment is funded through two sources: a state special fund sales tax of 1.0625 cents totaling \$6.9 billion, and \$589.2 million in Vehicle License Fees. These funds are deposited into the Local Revenue Fund 2011 for allocation to the counties and are constitutionally guaranteed for the purposes of 2011 Realignment. Figure HHS-03 identifies the programs and funding for 2011 Realignment.

The Administration, in consultation with county partners and stakeholders, is continuing to develop an allocation for 2014-15 funds in the 2011 Realignment Behavioral Health Services Growth Special Account. From 2014-15 revenues, the Account has \$117 million. The first priority for growth funds is federal entitlement programs including Medi-Cal Specialty Mental Health (including those required by Early Periodic Screening, Diagnosis, and Treatment) and Drug Medi-Cal.

Figure HHS-03
2011 Realignment Estimate at 2016-17 Governor's Budget
(Dollars in Millions)

	2014-15	2014-15 Growth	2015-16	2015-16 Growth	2016-17	2016-17 Growth
Law Enforcement Services	\$2,078.3		\$2,289.1		\$2,418.2	
Trial Court Security Subaccount	518.1	14.5	532.5	12.9	545.4	13.8
Enhancing Law Enforcement Activities	489.9	57.8	489.9	80.5	489.9	99.3
Community Corrections Subaccount	934.1	173.4	1,107.5	96.8	1,204.3	103.4
District Attorney and Public Defender	15.8	8.5	24.3	6.5	30.8	6.9
Juvenile Justice Subaccount	120.4	14.5	134.9	12.9	147.8	13.8
<i>Youthful Offender Block Grant Special Account</i>	(113.8)	(13.7)	(127.5)	(12.2)	(139.6)	(13.0)
<i>Juvenile Reentry Grant Special Account</i>	(6.6)	(0.8)	(7.4)	(0.7)	(8.2)	(0.8)
Growth, Law Enforcement Services		268.7		209.6		237.2
Mental Health²	1,120.6	13.4	1,120.6	12.0	1,120.6	12.8
Support Services	3,022.1		3,277.6		3,505.2	
Protective Services Subaccount	1,970.7	138.5	2,109.2	107.8	2,217.0	115.2
Behavioral Health Subaccount ³	1,051.4	117.0	1,168.4	119.8	1,288.2	128.0
<i>Women and Children's Residential Treatment Services</i>	(5.1)	-	(5.1)	-	(5.1)	-
Growth, Support Services		268.9		239.6		256.0
Account Total and Growth	\$6,758.6		\$7,136.5		\$7,537.2	
Revenue						
1.0625% Sales Tax	6,210.9		6,566.1		6,948.0	
Motor Vehicle License Fee	547.7		570.4		589.2	
Revenue Total	\$6,758.6		\$7,136.5		\$7,537.2	

This chart reflects estimates of the 2011 Realignment subaccount and growth allocations based on current revenue forecasts and in accordance with the formulas outlined in Chapter 40, Statutes of 2012 (SB 1020).

¹ Base Allocation is capped at \$489.9 million. Growth does not add to the base.

² Base Allocation is capped at \$1,120.6 million. Growth does not add to the base.

³ The Early and Periodic Screening, Diagnosis, and Treatment and Drug Medi-Cal programs within the Behavioral Health Subaccount do not yet have a permanent base.

DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services (DSS) serves, aids, and protects needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. The Department's major programs include CalWORKs, CalFresh, In-Home Supportive Services (IHSS), Supplemental Security Income/State Supplementary Payment (SSI/SSP), Child Welfare Services, Community Care Licensing, and Disability Determination. The Budget includes \$23.8 billion (\$8 billion General Fund) for DSS in 2016-17.

Significant Adjustments:

- **Continuum of Care Reform Resources**—The Budget includes \$94.9 million (\$60.9 million General Fund) for DSS, DHCS, county child welfare agencies, and county probation departments to continue the implementation of the Continuum of Care reforms codified in Chapter 773, Statutes of 2015 (AB 403). The reforms emphasize home-based family care, improve access to services without having to change out-of-home placements to get those services, and increase the role of children, youth, and families in assessment and case planning. The measure establishes a core practice model to govern all services, whether delivered by a county or licensed provider organization, and provides medically necessary mental health services to children and youth in foster care regardless of their placement setting.
- **CalFresh Assistance and Training**—The Budget includes five positions and \$804,000 (\$261,000 General Fund) for DSS to provide technical assistance and training to the 19 largest counties on effective business processes for enrolling and retaining families in the CalFresh Program. Their work will be coordinated with Medi-Cal and the Department of Public Health’s Women, Infants and Children program to provide appropriate nutrition assistance for young children.

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS

The CalWORKs program, California’s version of the federal Temporary Assistance for Needy Families (TANF) program, provides temporary cash assistance to low-income families with children to meet basic needs. It also provides welfare-to-work services so that families may become self-sufficient. Eligibility requirements and benefit levels are established by the state. Counties have flexibility in program design, services, and funding to meet local needs.

Total TANF expenditures are \$7.5 billion (state, local, and federal funds) in 2016-17. The amount budgeted includes \$5.4 billion for CalWORKs program expenditures and \$2.1 billion in other programs. Other programs primarily include expenditures for Cal Grants, Department of Education child care, Child Welfare Services, Foster Care, Department of Developmental Services programs, the Statewide Automated Welfare System, Work Incentive Nutritional Supplement, California Community Colleges child care and education services, and the Department of Child Support Services.

Average monthly CalWORKs caseload is estimated to be about 497,000 families in 2016-17, a 5.5-percent decrease from the 2015 Budget Act projection. Due to an improving economy, caseload has decreased every year from a peak of 587,000 in 2010-11.

IN-HOME SUPPORTIVE SERVICES

The IHSS program provides domestic and related services such as housework, transportation, and personal care services to eligible low-income aged, blind, and disabled persons. These services are provided to assist individuals to remain safely in their homes and prevent institutionalization. The IHSS program is also a key component of the CCI. IHSS has been incorporated into the managed care delivery system in the seven CCI counties, along with a range of long-term services and supports. For additional information on CCI, refer to the Department of Health Care Services section.

The Budget includes \$9.2 billion (\$3 billion General Fund) for the IHSS program in 2016-17, an 8.4-percent increase over the revised 2015-16 level. Average monthly caseload in this program is estimated to be 490,000 recipients in 2016-17, a 4.9-percent increase from the 2015 Budget Act projection. General Fund costs in this program have doubled since 2010-11, while caseload has increased 12 percent.

The Budget proposes to restore the current 7-percent across-the-board reduction in service hours with proceeds from the managed care organization tax effective July 1, 2016. The cost to restore the 7-percent reduction is estimated to be \$236 million in 2016-17. For additional information on the tax, refer to the Department of Health Care Services section.

Implementation of the U.S. Department of Labor regulations that require overtime pay for domestic workers is estimated to cost \$700.4 million (\$331.3 million General Fund) in 2015-16 and \$942 million (\$443.8 million General Fund) annually thereafter. Chapters 29 and 488, Statutes of 2014 (SB 855 and SB 873), limit providers to a 66-hour workweek. Providers who work for multiple recipients will be paid for their travel time between recipients, up to 7 hours per week.

In late December 2014, a federal district court ruled that a portion of the overtime pay regulations exceeded the Department of Labor's authority and voided the regulations. In August 2015, however, a U.S. Court of Appeals upheld the regulations. The ruling was appealed to the U.S. Supreme Court, but in October 2015, the Supreme Court denied the plaintiff's request for a motion to stay the appellate court's decision. The Court has not yet decided whether to consider the case.

To allow for an orderly transition, minimize confusion, and permit time for IHSS automation changes, implementation of the federal overtime rules for IHSS providers is anticipated to begin February 1, 2016. Increased rates to cover these costs for developmental services providers became effective December 1, 2015.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT

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. In California, the SSI payment is augmented with an SSP grant. These cash grants assist recipients with basic needs and living expenses. The federal Social Security Administration (SSA) administers the SSI/SSP program, making eligibility determinations, computing grants, and issuing combined monthly checks to recipients. The state-only Cash Assistance Program for Immigrants (CAPI) provides monthly cash benefits to aged, blind, and disabled legal non-citizens who are ineligible for SSI/SSP due solely to their immigration status.

The Budget includes \$2.9 billion General Fund for the SSI/SSP program. This represents a 2.8-percent increase (\$76.8 million) over the revised 2015-16 budget. The average monthly caseload in this program is estimated to be 1.3 million recipients in 2016-17, a slight increase over the 2015-16 projected level. The SSI/SSP caseload consists of 71-percent disabled persons, 28-percent aged, and 1-percent blind.

SSA applies an annual cost-of-living adjustment 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. The Budget also includes \$40.7 million General Fund for a cost-of-living increase to the SSP portion of the grant equivalent to the increase in the California Necessities Index, which is estimated to be 2.96 percent. The increase would be effective January 1, 2017 and represents the first state-provided cost-of-living increase since 2006.

Effective January 2016, maximum SSI/SSP grant levels are \$889 per month for individuals and \$1,496 per month for couples. Under the Budget, maximum SSI/SSP monthly grant levels will increase by \$17 and \$31 for individuals and couples, respectively, effective January 2017. CAPI benefits are equivalent to SSI/SSP benefits, less \$10 per month for individuals and \$20 per month for couples.

DEPARTMENT OF STATE HOSPITALS

The Department of State Hospitals (DSH) administers the state mental health hospital system, the Forensic Conditional Release Program, the Sex Offender Commitment Program, and the evaluation and treatment of judicially and civilly committed patients. The Budget includes \$1.8 billion (\$1.7 billion General Fund) in 2016-17 for support of DSH. The patient population is projected to reach a total of 7,323 in 2016-17.

Significant Adjustments:

- Unified Hospital Communications and Public Address System—The Budget proposes \$6.5 million General Fund and 2 positions in 2016-17 to replace the aged public address systems and local area networks at the Coalinga and Patton hospitals.
- Sonoma Jail-Based Competency Treatment Beds—The Budget includes \$500,000 General Fund in 2015-16 and \$1.5 million General Fund in 2016-17 for DSH to contract with Sonoma County for 10 beds in its jail facility. With this request, DSH will support a total of 158 restoration of competency beds to serve incompetent to stand trial patients outside of the state hospitals, at a cost of approximately \$20 million General Fund annually.

DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) provides individuals with developmental disabilities a variety of services that allow them to live and work independently or in supported environments. California is the only state that provides developmental services as an individual entitlement. The state is in the process of closing all the state-operated developmental centers, except for the secure treatment area at the Porterville Developmental Center. By the end of 2016-17, DDS estimates it will serve approximately 302,000 individuals with developmental disabilities in the community and 847 individuals in state-operated developmental centers. For 2016-17, the Budget includes \$6.4 billion (\$3.8 billion General Fund) for support of developmental services.

DEVELOPMENTAL CENTER CLOSURES

DDS carries out its responsibilities through 21 community-based, non-profit corporations known as “regional centers” and three state-operated developmental centers. The Administration announced in 2015 the planned closure for the three remaining developmental centers: Sonoma, Fairview and the general treatment area of Porterville.

To assist in the development of community resources for placement of current developmental center residents, the Budget includes \$146.6 million (\$127.2 million General Fund). This amount includes \$78.8 million General Fund specifically for Sonoma (\$24.5 million), Fairview (\$29.7 million), and Porterville (\$24.6 million).

As part of the developmental center closure activities, the Budget also includes \$18 million (\$12 million General Fund) to resolve open workers’ compensation claims, inventory and archive clinical and historical records, execute an independent monitoring

contract as stipulated by the federal government, and relocate residents and their personal belongings.

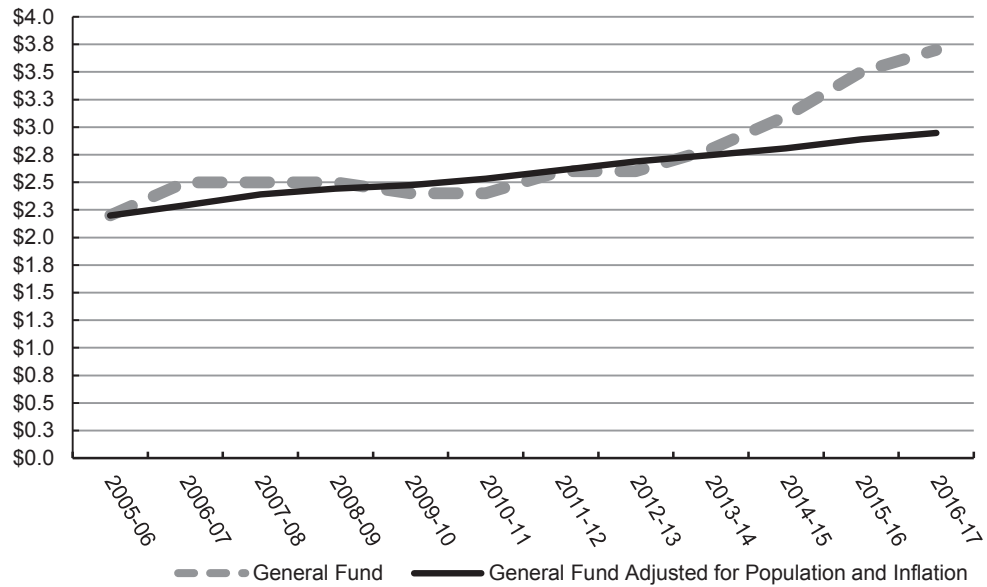
REGIONAL CENTER SERVICES

The regional center system is projected to serve more than 300,000 individuals with developmental disabilities and their families in the budget year. Regional centers provide intake, assessment, eligibility determination, resource development, and case management services. The centers also work with the thousands of businesses and individuals providing developmental services in the community.

The shift of the remaining consumers from developmental centers to the community, which will be complete by 2021 (with the exception of the secure treatment program at Porterville and the Canyon Springs facility), increases the urgency to improve the state’s oversight role, identify service cost drivers, and implement efforts that support the efficient delivery of quality services.

Since 2013-14, as shown in Figure HHS-04, regional center costs have grown from \$2.5 billion General Fund to \$3.1 billion General Fund in 2015-16. This represents a 24-percent increase despite a freeze on provider rates. Caseload growth over the same

Figure HHS-04
Department of Developmental Services
Budgeted Expenditures vs. Inflation & Population Growth
 (Dollars in Billions)



period has been only 5.7 percent. Not all of the causes of this increase are known, although increases in autism services, an aging population, individuals transitioning from the developmental centers into the community, and individuals moving from their family homes into supported living arrangements, are all contributing to the increase. To improve the oversight and understanding of the regional center system, the Budget includes targeted resources to improve the data systems and research capacity of DDS. The Budget includes \$1.9 million (\$1.3 million General Fund) and 14 positions for audit functions and to create a new fiscal and research unit that will help develop accurate, reliable, and data-driven programmatic information and service trends that can improve the administration of the regional center system.

Provider rates throughout the developmental services system have become a complex and layered patchwork over time. Many rates have been frozen for years, although rates have been increased recently for state and federal mandates such as minimum wage increases and overtime. The core staffing formula used to adjust regional center budgets based on the number of consumers served has not been adjusted for the majority of classifications since 1991. Under the Home and Community-Based Services Waiver, the federal government is mandating many changes to the delivery of services in the community. In recognition of these demands, the Budget includes \$80 million (\$50 million General Fund) for the following targeted investments in the developmental services system:

- Establish 4-bed Alternative Residential Model homes rate—\$46 million (\$26 million General Fund). The rates for these homes are old and were originally based on a 6-bed model, so providers have two fewer beds from which to derive revenue while maintaining the same overhead. The smaller 4-bed model is increasingly used by regional centers. A large portion of regional center clients living outside their family home live in Alternative Residential Model homes.
- Case Managers—\$17 million (\$12 million General Fund). The federal government mandates a maximum caseload for each case manager employed by a regional center. These ratios were eroded during the recession to preserve direct services to regional center consumers and will be improved by the funding provided in the Budget.
- Compliance with Home and Community-Based Services Waiver requirements—\$15 million (\$11 million General Fund). The Department will target rate increases to providers to transition services like segregated day programs and

sheltered workshops to models that are more integrated in the community and consistent with the Home and Community-Based Services Waiver.

The Administration will also continue its work with the developmental services community to develop data-driven solutions to the issues facing regional centers and providers. Any additional targeted spending proposals are expected to be funded from the proposed extension of the managed care organization tax.

DEPARTMENT OF PUBLIC HEALTH

The Department of Public Health is charged with protecting and promoting the health and well-being of the people in California. The Budget includes \$3 billion (\$134 million General Fund) in 2016-17 for the Department.

Significant Adjustments:

- **Timely Outbreak Detection and Disease Prevention**—The Budget includes \$1.6 million General Fund and 14 positions to enhance state laboratory capacity to address communicable diseases through increased disease surveillance and testing.
- **Implementation of the Medical Marijuana Regulation and Safety Act**—The Budget contains \$457,000 in 2015-16 and \$3.4 million and 14 positions in 2016-17 for the Department to begin its regulatory responsibilities associated with the Act. For additional information on the Act, see the Statewide Issues Chapter.