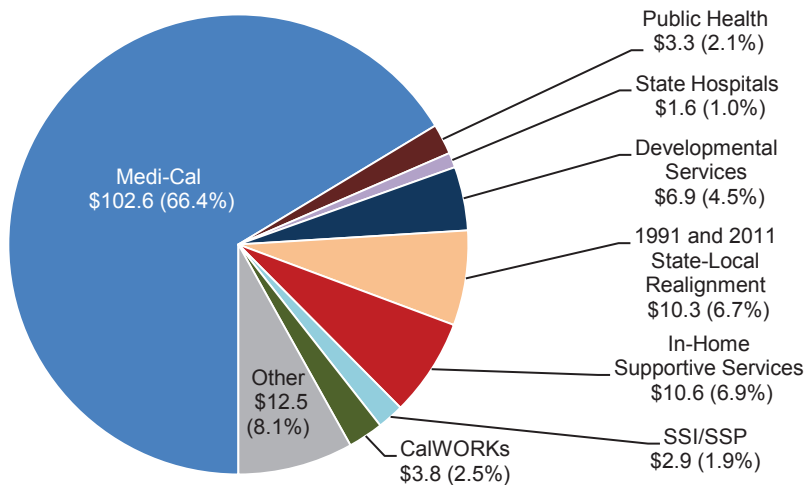


HEALTH AND HUMAN SERVICES

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 \$154.6 billion (\$34 billion General Fund and \$120.6 billion other funds) for all health and human services programs. Figure HHS-01

Figure HHS-01
Health and Human Services Proposed 2017-18 Funding^{1/}
All Funds
 (Dollars in Billions)



^{1/} Totals \$154.6 billion for support, local assistance, and capital outlay. This figure includes reimbursements of \$13.7 billion and excludes \$2.5 billion in Proposition 98 funding in the Department of Developmental Services budget and county funds that do not flow through the state budget.
 Note: Numbers may not add due to rounding.

displays expenditures for each major program area and Figure HHS-02 displays program caseload.

Figure HHS-02

Major Health and Human Services Program Caseloads

	2016-17 Revised	2017-18 Estimate	Change
Medi-Cal	14,025,500	14,281,900	256,400
California Children's Services (CCS) ^{1/}	12,803	12,557	-246
CalWORKs	463,540	459,173	-4,367
CalFresh	1,786,161	1,771,785	-14,376
SSI/SSP (support for aged, blind, and disabled)	1,282,787	1,284,131	1,344
Child Welfare Services ^{2/}	121,393	121,852	459
Foster Care	43,102	43,129	27
Adoption Assistance	85,149	85,334	185
In-Home Supportive Services	507,463	531,069	23,606
Regional Centers	303,447	317,283	13,836
State Hospitals ^{3/}	6,342	6,369	27
Developmental Centers ^{4/}	963	760	-203
Vocational Rehabilitation	28,069	28,069	0

^{1/} Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS clients.
^{2/} 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.
^{3/} Represents the year-end population, excluding psychiatric programs.
^{4/} Represents average in-center population as of January 31 each year.

HEALTH REFORM AND QUALITY OF CARE IMPROVEMENT

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

Since 2014, Covered California, the state’s health insurance marketplace, has provided individual health insurance through private plans supported by federally funded tax subsidies and products for individuals and small businesses. It is estimated that

1.4 million people will be enrolled in Covered California in 2017-18. Covered California is a self-sustaining entity funded through fees assessed on the participating health plans. Health plans and insurers in California are required to cover ten essential health benefits pursuant to the federal law.

Based on the expansion of the Medi-Cal program, caseload has increased from 7.9 million in 2012-13 to a projected 14.3 million in 2017-18, covering over one-third of the state's population. Beginning in 2017, the state assumes a 5-percent share of cost for the optional expansion population. In 2018 the cost-sharing ratio increases to 6 percent and by 2020 the state share will be 10 percent based upon current federal law. The Budget assumes costs of \$20.1 billion (\$888 million General Fund) in 2016-17 and \$18.9 billion (\$1.6 billion General Fund) in 2017-18 for the 4.1 million Californians in the optional Medi-Cal expansion.

FEDERAL UNCERTAINTY

Medicaid (Medi-Cal in California) is a federal program established more than 50 years ago and has evolved over time. The incoming presidential administration and leaders in Congress have suggested major changes to the program. Recent proposals have included reductions to federal funding for the expansion population, a block grant structure for Medicaid programs, capped per-beneficiary allotments to states, tax credits to enroll Medicaid beneficiaries in private insurance, and creation of high-deductible plans for the Medicaid program combined with health savings accounts. At this point, it is not clear what those changes will be or when they will take effect. As such, the Budget continues to reflect existing state and federal law. A complete repeal of the Affordable Care Act, without a companion replacement program, would not only affect millions of Californians' health benefits, but would also disrupt the private insurance market. As the congressional deliberations begin, the Administration stands ready to build on what has worked, support changes and efficiencies where appropriate, and play a constructive role to protect and enhance the lives and health of Californians—within the fiscal constraints facing the state.

1991 STATE-LOCAL REALIGNMENT HEALTH ACCOUNT REDIRECTION

As a result of the Affordable Care Act, county costs and responsibilities for indigent health care continue to decrease 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 due to the implementation of federal health care reform. The net savings are redirected for county CalWORKs expenditures, which reduce General Fund spending on the CalWORKs program. County savings are estimated to be \$585.9 million in 2016-17 and \$546.2 million in 2017-18. Additionally, actual expenditure data reported by counties indicates county net savings in 2014-15 were \$245.6 million higher than estimated based on the preliminary reconciliation of 2014-15, and the Budget assumes reimbursement of this amount from the counties in 2017-18. The estimates for 2017-18 will be updated in the May Revision using audited data from the counties. The General Fund savings are reflected in the CalWORKs program within the Department of Social Services' budget.

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, and then distributes those funds 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 toward funding increases to CalWORKs grant levels.

Based on current revenue estimates, the Child Poverty and Family Supplemental Support Subaccount is projected to receive base and growth funds totaling \$318.8 million in 2016-17 and \$330.6 million in 2017-18. These funds will be used to pay for the recent CalWORKs grant increases (totaling 11.43 percent since 2013-14) and repeal of the maximum family grant (MFG) rule, which became effective January 1, 2017. Together, the prior grant increases and MFG repeal are estimated to cost \$405.3 million in 2016-17 and \$528.8 million in 2017-18. The Budget includes \$86.5 million General Fund in 2016-17 and \$198.2 million General Fund in 2017-18 to provide the remaining funding needed.

COORDINATED CARE INITIATIVE

The Coordinated Care Initiative (CCI), including the Cal MediConnect demonstration project, allows persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive medical, behavioral health, long-term services and supports, and home and community-based services coordinated through a single health plan. This pilot was implemented through a federal demonstration project and currently operates in seven counties—Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The CCI also included mandatory enrollment for most other dual eligibles into Medi-Cal managed care and integrated Medi-Cal long-term services and supports,

including In-Home Supportive Services (IHSS), into managed care. As part of CCI, the state assumed bargaining responsibilities for IHSS in these seven counties. The CCI also included a new maintenance-of-effort requirement in place of the traditional county share of cost for the IHSS program for all counties.

Under current law, the Director of Finance is required to annually determine whether CCI is cost-effective. If CCI is not cost-effective, the program automatically ceases operation in the following fiscal year. Since 2015, the Administration has indicated that without changes improving participation in the program and continuation of an allowable managed care tax, CCI would not meet the statutory savings requirements. The Budget estimates CCI will no longer be cost-effective, even with the recent enactment of an allowable managed care tax. Therefore, pursuant to the provisions of current law, the program will be discontinued in 2017-18, which will have the following effects:

- Removes IHSS benefits from plan capitation rates. As part of CCI, IHSS costs were included in bundled payments to health plans, though the plans did not control this benefit.
- Eliminates the statewide authority responsible for bargaining IHSS workers' wages and benefits in the seven CCI counties. These counties would again be responsible for IHSS bargaining.
- Re-establishes the state-county share of cost arrangement for the IHSS program that existed prior to the implementation of CCI. Counties will be responsible for the payment of 35 percent of the nonfederal portion of program costs through 1991 Realignment. Based on current estimates, growth in 2017-18 realignment revenues alone will not be sufficient to cover the additional IHSS costs. Therefore, this change is likely to result in financial hardship and cash flow problems for counties. The Administration is prepared to work with counties to mitigate, to the extent possible, the impact of returning a share of the fiscal responsibility for IHSS to counties.

The net result of these changes is a General Fund reduction of \$626.2 million in 2017-18. Although CCI was not cost-effective during the initial demonstration period, the dual demonstration program provided the potential to reduce the cost of health care for the affected individuals and improve health outcomes. Therefore, based on the lessons

learned from CCI, the Budget proposes to extend the Cal MediConnect program, continue mandatory enrollment of dual eligibles, and integrate long-term services and supports (except IHSS) into managed care. Although the funding for IHSS will no longer be included in the capitation rates, plans and counties are encouraged to collaborate on care coordination. The Budget reflects savings of approximately \$20 million General Fund from the continuation of the duals demonstration as allowed under federal law through December 31, 2019.

TOBACCO TAX INCREASE (PROPOSITION 56)

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and tobacco products, effective April 1, 2017. This tax is also applicable to electronic cigarettes for the first time. The excise tax, paid by distributors selling cigarettes in California, increases by \$2 from 87 cents to \$2.87 per pack of 20 cigarettes. Proposition 56 requires backfills to Proposition 99, Proposition 10, the Breast Cancer Fund, and to state and local governments to address revenue declines that result from the additional tax.

The Proposition specifies allocations to various entities, including the University of California, Department of Justice, Department of Public Health, Board of Equalization, and State Auditor. Additionally, Proposition 56 requires 82 percent of the remaining funds be transferred to the Healthcare Treatment Fund for the Department of Health Care Services to support new growth in Medi-Cal expenditures as compared to the 2016 Budget Act. Of the remaining 18 percent, 13 percent is for the Department of Public Health and the Department of Education for tobacco prevention, and 5 percent goes to the University of California for medical research.

Figure HHS-03 reflects the allocation of Proposition 56 funding in 2017-18. Given the effective date of April 1, 2017, the Budget includes five quarters of the tax revenues for expenditure in 2017-18.

Figure HHS-03
Proposition 56 Allocations
(Dollars in Millions)

<i>Investment Category</i>	<i>Department</i>	<i>Program</i>	<i>2017-18 Amount^{1/}</i>
Enforcement	Department of Justice	Local Law Enforcement Grants ^{2/}	\$37.5
	Department of Justice	Distribution and Retail Sale Enforcement ^{2/}	\$7.5
	Board of Equalization	Distribution and Retail Sales Tax Enforcement ^{2/}	\$5.8
	Department of Public Health	Law Enforcement ^{2/}	\$7.5
Education, Prevention, and Research	University of California	Cigarette and Tobacco Products Surtax Medical Research Program	\$80.7
	University of California	Graduate Medical Education ^{2/}	\$50.0
	Department of Public Health	State Dental Program ^{2/}	\$37.5
	Department of Public Health	Tobacco Prevention and Control	\$178.5
	State Department of Education	School Programs	\$31.5
Health Care	Department of Health Care Services	Health Care Treatment	\$1,237.4
Administration and Oversight	State Auditor	Financial Audits	\$0.4
	Board of Equalization	Sales and Use Tax	\$1.1
Revenue Backfills	Proposition 99, Breast Cancer Research Fund, and Proposition 10		\$37.1
Total			\$1,712.5

^{1/} 2017-18 figures include one quarter of 2016-17 revenue and four quarters of 2017-18 revenue.
^{2/} Annual amount specified in statute.

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, Medi-Cal General Fund costs grew at an average of 5 percent annually to \$19.6 billion in 2016-17 because of a combination of health care cost inflation, program expansions, and caseload growth. Due to the passage of Proposition 56, increased General Fund health care costs in the Medi-Cal program in 2017-18 are partially funded from this tax. After accounting for Proposition 56 funds, Medi-Cal General Fund spending is projected to increase 7 percent from \$17.8 billion at the 2016 Budget Act to \$19.1 billion in 2017-18.

The Budget assumes that caseload will increase approximately 5 percent from 2015-16 to 2016-17 and 1.8 percent from 2016-17 to 2017-18. Medi-Cal is projected to cover 14.3 million people in 2017-18.

Significant Adjustments:

- **Current Year Shortfall**—The Budget includes increased expenditures in the Medi-Cal program of approximately \$1.8 billion General Fund compared to the 2016 Budget Act. The current year increase is primarily attributable to a one-time retroactive payment of drug rebates to the federal government and miscalculation of costs associated with the Coordinated Care Initiative in prior estimates.
- **Managed Care Organization 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, which is in compliance with federal Medicaid regulations. This tax funds the nonfederal share of Medi-Cal managed care rates for health care services provided to children, adults, seniors, persons with disabilities, and persons eligible for both Medi-Cal and Medicare. As a result, the Budget assumes reduced General Fund spending in the Medi-Cal program of approximately \$1.1 billion in 2016-17 and \$1.6 billion in 2017-18.
- **County Medi-Cal Administration**—County workers conduct Medi-Cal eligibility work on behalf of the state. Medi-Cal caseload continues to grow and the Budget maintains the augmentation to counties of \$655.3 million (\$217.1 million General Fund) in 2017-18, as was provided in 2016-17, to administer the program. As the eligibility system continues to achieve greater stabilization, the state is in the initial process of developing a new Medi-Cal county administration

budgeting methodology. The Budget continues to include \$1.5 million (\$731,000 General Fund) to make recommendations for a new methodology.

- Children’s Health Insurance Program (CHIP) Reauthorization—CHIP is a partnership between the federal government and states and territories to help provide low-income children, not otherwise eligible for Medi-Cal, with health insurance coverage. The Affordable Care Act (ACA) included a provision that allows the program’s federal matching assistance percentage to increase from 65 percent to 88 percent for federal fiscal years 2016 through 2019. However, the CHIP program is only authorized by the federal government through September 2017. To extend the CHIP program beyond September 2017, Congress must pass legislation. Given the uncertainties surrounding potential congressional actions, the Budget assumes the program is reauthorized, but at the non-enhanced, federal-matching percentage of 65 percent effective October 1, 2017, and includes General Fund costs of \$536.1 million to reflect this assumption.
- Full-Scope Medi-Cal Coverage for Undocumented Children—The Budget includes \$279.5 million General Fund to provide full-scope benefits to approximately 185,000 children. This amount reflects the full-year costs for this program. Chapter 18, Statutes of 2015 (SB 75), expanded full-scope Medi-Cal benefits to undocumented children under 19 years of age effective May 2016.
- Newly Qualified Immigrant Benefits and Affordability Program—Chapter 4, Statutes of 2013, First Extraordinary Session (SBx1 1), authorized transitioning coverage of these adults without children from Medi-Cal to a Qualified Health Plan in the Health Benefit Exchange, with DHCS providing premium and out-of-pocket payment assistance and wraparound benefits not covered by the Exchange plan. Because the state-only Medi-Cal program is not formally certified as meeting the minimum essential coverage requirements under the ACA, the adults continuing in state-only Medi-Cal may be subject to a tax penalty from the federal government. To ameliorate this issue, the Budget proposes that all new qualified adults eligible be included in the wrap program effective January 1, 2018. The Budget includes General Fund savings of \$48 million from transitioning coverage for these adults from Medi-Cal to an Exchange plan.
- Hospital Quality Assurance Fee Extension—On November 8, 2016, voters passed Proposition 52, which amends the state Constitution to permanently extend the existing Hospital Quality Assurance Fee as defined under Chapter 27, Statutes of 2016 (AB 1607). Under prior law, the fee was due to sunset December 31, 2017. Fees paid by private hospitals and matching federal funds are used to provide supplemental payments to private hospitals, grants to designated and non-designated public hospitals, and increased capitation payments to managed

health care plans. Revenues from the fee also fund health care coverage for children and the program's administrative expenses. The Budget assumes General Fund savings of over \$1 billion in 2017-18 from the hospital fee.

- **Proposition 56**—The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 requires 82 percent of the funds remaining after specified allocations be transferred to the Healthcare Treatment Fund to support new growth in Medi-Cal expenditures as compared to the 2016 Budget Act. The Budget includes \$1.2 billion for this purpose.
- **Major Risk Medical Insurance Fund Abolishment**—The Major Risk Medical Insurance Fund currently funds expenses related to the Major Risk Medical Insurance Program, which was originally established as a state high-risk pool. The ACA has reduced the need for the high-risk pool because individuals cannot be denied coverage based on a pre-existing health condition. The Budget abolishes the Major Risk Medical Insurance Fund and proposes to transfer the fund balance of approximately \$65 million to the Health Care Services Plans Fines and Penalties Fund. This new fund will support coverage for individuals remaining in the program and expenses related to health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program.
- **Drug Medi-Cal Organized Delivery System Pilot**—In August 2015, the federal Centers for Medicare and Medicaid Services approved the waiver necessary to begin implementation of the Drug Medi-Cal Organized Delivery System pilot program. The pilot program requires counties that opt in to the demonstration program to provide a continuum of care for substance use disorder treatment services. Counties already provide many of the required services under the current Drug Medi-Cal program, and these services will continue under the pilot program along with new services that are modeled after the American Society of Addiction Medicine criteria. A total of 6 counties are estimated to begin providing services in 2016-17 with an additional 10 counties in 2017-18. The Budget includes \$19.9 million (\$3.1 million General Fund) in 2016-17 and \$661.9 million (\$141.6 million General Fund) in 2017-18 for increased services for the pilot program.
- **Medicaid Managed Care Regulations**—The Budget includes an additional \$4.5 million General Fund to continue implementation of the federal regulations. The managed care regulations are related to beneficiary grievances, provider networks, program integrity, and financing. Some new requirements overlap with existing oversight provided by the Department of Managed Health Care. Therefore, the Budget also reflects the consolidation of these activities at DHCS. There are several components of the regulations that could negatively impact California and result in General Fund costs in the hundreds of millions of dollars annually.

2011 REALIGNMENT FUNDING

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 Realignment are now funded primarily by revenue dedicated for 2011 Realignment.

Figure HHS-04 identifies the programs and funding for 2011 Realignment, which are funded through two sources: a state special fund sales tax rate of 1.0625 percent totaling \$6.9 billion, and \$643.7 million in Vehicle License Fees.

Figure HHS-04
2011 Realignment Estimate at 2017-18 Governor's Budget
 (Dollars in Millions)

	2015-16	2015-16 Growth	2016-17	2016-17 Growth	2017-18	2017-18 Growth
Law Enforcement Services	\$2,289.1		\$2,361.2		\$2,440.1	
Trial Court Security Subaccount	532.5	7.2	539.7	7.9	547.6	10.0
Enhancing Law Enforcement Activities Subaccount ^{1/}	489.9	116.0	489.9	154.7	489.9	153.8
Community Corrections Subaccount	1,107.5	54.1	1,161.6	59.1	1,220.7	75.4
District Attorney and Public Defender Subaccount	24.3	3.6	27.9	3.9	31.9	5.0
Juvenile Justice Subaccount	134.9	7.2	142.1	7.9	150.0	10.0
<i>Youthful Offender Block Grant Special Account</i>	(127.5)	(6.8)	(134.3)	(7.5)	(141.7)	(9.4)
<i>Juvenile Reentry Grant Special Account</i>	(7.4)	(0.4)	(7.8)	(0.4)	(8.3)	(0.6)
Growth, Law Enforcement Services		188.1		233.5		254.2
Mental Health^{2/}	1,120.6	6.7	1,120.6	7.3	1,120.6	9.3
Support Services	3,277.6		3,404.9		3,543.8	
Protective Services Subaccount	2,109.2	60.3	2,169.5	65.8	2,235.3	83.9
Behavioral Health Subaccount	1,168.4	67.0	1,235.4	73.1	1,308.5	93.3
<i>Women and Children's Residential Treatment Services</i>	(5.1)	-	(5.1)	-	(5.1)	-
Growth, Support Services		134.0		146.2		186.5
Account Total and Growth	\$7,009.4		\$7,266.4		\$7,545.2	
Revenue						
1.0625% Sales Tax	\$6,403.5		\$6,621.8		\$6,901.5	
Motor Vehicle License Fee	605.9		644.6		643.7	
Revenue Total	\$7,009.4		\$7,266.4		\$7,545.2	

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.

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.

The Administration, in consultation with county partners and stakeholders, has set a base allocation for the 2011 Realignment Behavioral Health Subaccount beginning with the 2016-17 allocation. Beginning with the 2017-18 allocation, the ongoing base allocations will consist of the 2016-17 base allocation plus the subsequent growth allocations. This will serve as a “rolling base” mechanism for future allocations to the Behavioral Health Subaccount.

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, IHSS, Supplemental Security Income/State Supplementary Payment (SSI/SSP), Child Welfare Services, Community Care Licensing, and Disability Determination. The Budget includes \$23.6 billion (\$8.1 billion General Fund) for DSS in 2017-18.

Significant Adjustments:

- **Continuum of Care Reform**—The Budget includes \$217.3 million (\$163.2 million General Fund) to continue implementation of the Continuum of Care reforms outlined 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. Although significant progress has been made for the transition of foster youth beginning January 1, 2017, assumptions on caseload movement were revised to more accurately reflect the pace of implementation.
- **Child Welfare Digital Services**—The Child Welfare Services New System case management project continues to make progress, as the agile approach to software design and development adopted in November 2015 accelerates the project timeline. Rather than procuring a single, monolithic solution to replace the legacy system, a suite of digital services is being developed and integrated to deliver continually improving assistance to state and county workers, enabling effective engagement with and assistance to children and families. The Budget includes \$175.9 million

(\$88 million General Fund) to support an increase in project activity, which includes increased funding for county engagement as individual digital services are designed, developed, and implemented.

- **Minimum Wage Increase**—The Budget includes an increase in IHSS expenditures of \$56.8 million (\$26.4 million General Fund) and a decrease in CalWORKs expenditures of \$5.3 million General Fund to reflect the impact of the state minimum hourly wage from \$10.50 to \$11.00, effective January 1, 2018.
- **Continue Consolidation of Statewide Automated Welfare Systems**—The Budget includes \$38.5 million (\$7.5 million General Fund) for migration of 39 counties using the Consortium IV system to the LEADER Replacement System. The first year of funding for migration activities will be available after the county consortia negotiations are complete and the Department of Finance and the Department of Technology have reviewed and approved detailed project documents.

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 2017-18.

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 459,000 families in 2017-18, a 5.6-percent decrease from the 2016 Budget Act projection. Due to an improving economy, caseload has decreased every year from a recent peak of 587,000 in 2010-11.

Significant Adjustments:

- **Maximum Family Grant (MFG) Repeal**—The Budget includes \$224.5 million (\$198.2 million General Fund) to reflect a full year of increased grant costs resulting from the repeal of the MFG rule, effective January 1, 2017. The rule, for the purpose of calculating a household's maximum aid payment, prohibited cash aid for any child born into a CalWORKs household ten or more months after initially receiving aid.
- **County Indigent Health Savings**—The Budget includes a one-time General Fund decrease of \$265.9 million resulting from additional county savings related to federal health care reform. Actual statewide indigent health savings in 2014-15 were higher than previously estimated. Pursuant to current law, these additional county savings are redirected to the CalWORKs program to offset General Fund costs.

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 more costly institutionalization.

The Budget includes \$10.6 billion (\$3.2 billion General Fund) for the IHSS program in 2017-18, a 6.5-percent increase over the revised 2016-17 level. Average monthly caseload in this program is estimated to be 531,000 recipients in 2017-18, an 8.2-percent increase from the 2016 Budget Act projection. General Fund costs in this program have more than doubled since 2010-11, while caseload has increased 23 percent.

As outlined in the Coordinated Care Initiative (CCI) section, the authority for CCI will automatically cease and will have the following effect on the IHSS program.

Significant Adjustment:

- **IHSS Changes Related to CCI**—IHSS benefits were incorporated into the managed care delivery system in seven CCI counties, along with a range of long-term services and supports. Because CCI is no longer cost-effective and will discontinue, the IHSS maintenance-of-effort provisions are automatically repealed and the IHSS program returns to the prior state-county sharing ratios. This change results in a General Fund reduction of \$626.2 million in 2017-18. Additionally, responsibility for collective bargaining returns to counties.

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 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-percent increase (\$55.2 million) over the revised 2016-17 Budget. The average monthly caseload in this program is estimated to be 1.3 million recipients in 2017-18, a slight decrease from the 2016 Budget Act projection. The SSI/SSP caseload consists of 54.8-percent disabled persons, 44.3-percent aged, and 0.9-percent blind.

Effective January 2017, maximum SSI/SSP grant levels are \$895.72 per month for individuals and \$1,510.14 per month for couples. The current Consumer Price Index growth factors are 0.3 percent for 2017 and a projected 2.6 percent for 2018. Maximum SSI/SSP monthly grant levels will increase by \$20 and \$29 for individuals and couples, respectively, effective January 2018. CAPI benefits are equivalent to SSI/SSP benefits, less \$10 per month for individuals and \$20 per month for couples.

Significant Adjustments:

- **SSP Cost-of-Living Adjustment**—The Budget includes \$73.2 million General Fund to reflect the full-year costs of the 2.76-percent cost-of-living increase to the SSP portion of the grant, which became effective January 1, 2017.
- **Housing and Disability Advocacy Program**—Due to fiscal constraints, the Budget includes one-time savings of \$45 million General Fund in the current year from halting implementation of the Housing and Disability Advocacy Program included in the 2016 Budget Act.

DEPARTMENT OF STATE HOSPITALS

The Department of State Hospitals 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 \$1.6 billion (\$1.4 billion General Fund) in 2017-18 for support of the Department. The patient population is expected to reach 6,369 in 2017-18.

INCOMPETENT TO STAND TRIAL ADMISSIONS

The Department continues to experience a significant increase in the number of Incompetent to Stand Trial Admissions (IST) referrals from local courts, with an annual growth rate of over 10 percent since 2013-14. The Department has responded over the past several years by opening 411 additional inpatient beds and using all available bed capacity in the state hospital system. Additionally, State Hospitals has contracted with several counties to open 138 jail-based competency restoration beds, with an additional 10 beds expected to be available in early 2017. Despite these efforts, referrals continue to outpace capacity and the IST pending placement list was approximately 600 individuals in December 2016.

To address this ongoing growth, the Administration continues to work with county partners, the Judicial Council, and stakeholders to find approaches to address the increase in IST referrals, explore additional options for streamlining the IST process, and to identify other potential bed capacity through partnerships with counties. In the longer-term, up to 200 additional secured forensic beds will become available in 2018-19 when the capital outlay project to construct a security fence around an existing patient treatment building at the Metropolitan State Hospital is completed.

In addition to these efforts, the Budget proposes \$10.8 million General Fund to establish a 60-bed Admission, Evaluation, and Stabilization Center for the assessment and treatment of ISTs. The proposed Center would be located in a county jail and would admit patients from Southern California counties. Patients would receive a full evaluation upon admission to determine the degree of competency restoration required. Patients having drug-induced psychosis, presenting lower psychiatric acuity, malingering, or no longer meeting the requirements for incompetent to stand trial after the initial admission assessment will be considered short-term patients to be treated and discharged back to the referring county directly from the Center. Patients with higher psychiatric acuity will be transferred to a State Hospital for additional treatment.

State Hospitals continues to work with counties to identify other opportunities for collaboration, identify efficiencies, and reduce the costs for housing and treating IST patients. The Department is also exploring opportunities for joint-use facilities that would provide services to both State Hospital patients and appropriate jail populations.

**TRANSFER OF PSYCHIATRIC PROGRAMS TO THE CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION**

State Hospitals currently operates over 1,100 in-patient, mental-health treatment beds at three California Department of Corrections and Rehabilitation prisons: California Health Care Facility in Stockton, Salinas Valley State Prison in Soledad, and California Medical Facility in Vacaville. State Hospitals provides the in-patient services as part of a broader system of mental health care within Corrections. The Budget proposes to transfer these programs to Corrections effective July 1, 2017, and redirects \$250.4 million and 1,977.6 positions for this purpose. Transfer of these programs will streamline processes and improve timelines for inmate referrals for psychiatric inpatient treatment. Refer to the Public Safety Chapter for additional information.

DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services 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 state-operated developmental centers, except for the secure treatment area at the Porterville Developmental Center, and the Canyon Springs community facility. By the end of 2017-18, the Department estimates it will be providing services to approximately 317,000 individuals with developmental disabilities in the community. In the developmental centers, the estimated population, as of July 1, 2017, is 760 residents. The population is expected to decrease to 490 residents by June 30, 2018, as additional residents receive services through the regional centers. The Budget includes \$6.9 billion (\$4.2 billion General Fund) for support of developmental services.

DEVELOPMENTAL CENTER CLOSURES

In 2015, the Administration announced the planned closure of the three remaining developmental centers: Sonoma, Fairview and the general treatment area of Porterville. Sonoma is scheduled to close in December 2018 and no longer receives federal funding for its intermediate care facility units. On July 1, 2016, the Department entered into

settlement agreements with the federal Centers for Medicare and Medicaid Services to continue federal funding for individuals residing at Fairview and the general treatment area at Porterville. The Department's ongoing compliance with the provisions of the settlement agreements will allow the continued receipt of federal funding for intermediate care facility units at both centers. The Budget assumes federal funding will continue for both Fairview and Porterville.

The Department continues to work on developing safety-net community services for individuals transitioning from developmental centers, institutions for mental diseases, and other specialized services. New models of care that provide community-based residential and support services to individuals residing in the Porterville secure treatment program and institutions for mental diseases are being developed. The Department is also developing community residential models that will provide intensive supports; accept any individual living in the community who is in crisis and unable to remain in their current living situation; and provide residential options for children and adolescents with significant health or behavioral challenges.

REGIONAL CENTER SERVICES

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.

Significant Adjustments:

- **Community Housing Projects**—The Budget includes an increase of \$597,000 (\$554,000 General Fund) and 4 positions to provide increased oversight of community housing projects, funded through the Community Placement Plan, and to maintain focus on the development of community housing to support the developmental center closures. This housing is being developed to meet the residential placement needs of individuals transitioning from a developmental center or those who are at risk of moving to a more restrictive setting. The additional resources will allow analysis of housing proposals from developers, consistent monitoring of housing renovation/construction, and overall project monitoring.
- **Minimum Wage**—The Budget includes an increase of \$47.9 million General Fund to reflect the impact on providers of the increasing state minimum wage.

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 \$3.3 billion (\$132.2 million General Fund) in 2017-18 for the Department.

Significant Adjustments:

- Proposition 56—The Budget includes \$223.5 million and 57 positions in 2017-18 for Public Health’s dental, law enforcement, and tobacco prevention programs funded from the new revenue as outlined in Proposition 56.
- Licensing and Certification—The Budget includes \$1.1 million Licensing and Certification Program Fund in 2017-18 for the Los Angeles County contract to account for several salary increases. Los Angeles County salaries for nurse surveyors and other contracted staff are higher than state salaries, have increased in each of the past two years, and will continue to increase in 2017 and 2018. Given these continuing cost pressures, Public Health is evaluating the most effective way to provide ongoing regulatory oversight of health care facilities in Los Angeles County. Any continuation of the current relationship will require that: (1) regulatory actions be completed in a timely fashion and consistent with other areas of the state, (2) quality of evaluations be consistent with the rest of California, and (3) costs be maintained within budgeted amounts.

OTHER HEALTH AND HUMAN SERVICES

The Budget also includes the following significant adjustments given the General Fund’s condition:

- Elimination of the Health Care Workforce Augmentation—The Budget includes the reversion of \$33.4 million General Fund in 2016-17 that was intended to support health care workforce initiatives at the Office of Statewide Health Planning and Development. The Budget does not include additional funding in the future for this purpose.
- Elimination of Community Infrastructure Grants—The Budget includes the reversion of the one-time \$67.5 million General Fund augmentation included in the 2016 Budget Act for community infrastructure grants to cities and/or counties to promote public safety diversion programs and services by increasing

the number of treatment facilities for mental health, substance use disorder, and trauma-related services.

- **Children's Mental Health Crisis Services Grants**—The Budget includes the reversion of \$17 million General Fund from 2016-17 funds intended for grants to local governments to increase the number of facilities providing mental health crisis services for children and youth under the age of 21. Nearly \$11 million in Mental Health Services Act funding remains available for the program.
- **Eliminate Supplemental Funding for Three Independent Living Centers**—The Budget reflects a decrease of \$705,000 General Fund in 2017-18 to reflect elimination of ongoing funding first included in the 2016 Budget Act to provide funding support for three independent living centers. These centers already receive a larger share of federal Independent Living Discretionary Grant Program funds than other centers.