Summary of the Enacted 2017-18 Budget: Impact on California's Older Adults and People with Disabilities

Fact Sheet • July 2017

On June 27, 2017, California Governor Edmund G. Brown, Jr. signed California's 2017-18 budget. The enacted budget outlines the state's spending plan for the fiscal year beginning on July 1, 2017 and ending June 30, 2018. The budget includes program modifications that impact the health and human services delivery system serving older adults and people with disabilities.

The Enacted Budget reflects General Fund (GF) resources of $127.5 billion and anticipated expenditures of $125.1 billion.

Overview

California's enacted budget includes total resources of $127.5 billion General Fund (GF) and total expenditures of $125.1 billion GF (an increase of $3.7 billion over the revised 2016-17 level), along with $8.5 billion in the Budget Stabilization Account.* This fact sheet addresses items impacting older adults and people with disabilities included in the 2017-18 budget. Significant changes include:

- Elimination of CCI while extending certain core components;
- A new In-Home Supportive Services (IHSS) funding model;
- Funding to counties to mitigate the cost of IHSS funding model changes;
- Elimination of IHSS Statewide Authority;
- Discontinuation of universal assessment tool development; and
- Restoration of Medi-Cal dental and vision benefits for adults.[2]

In-Home Supportive Services (IHSS)

Background: The IHSS program provides in-home personal care assistance to low-income adults who are either age 65 years and 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 531,000 recipients in 2017-18, an 8.2 percent increase from 2016-17.[3]

Federal enforcement of new regulations under the Fair Labor Standards Act (FLSA) requires 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 training.[4] In implementing the new regulations, the 2016-17 budget prohibited an IHSS provider from working more than 66 hours within a work week. Certain providers are exempt from state limits on overtime usage, including live-in family care providers who, as of January 31, 2016, reside in the home of and provide services

* The Budget Stabilization Account is often referred to as the "Rainy Day Fund," in accordance with Proposition 2, the voter-approved Constitutional amendment.[1]

to two or more disabled minor or adult children or grandchildren. The 2016-17 budget specified that additional exemptions would be considered on a case-by-case basis for recipients with extraordinary circumstances.[5]

Proposed Budget: It included $10.6 billion ($3.2 billion GF) for the IHSS program in 2017-18, a 6.5 percent increase over the revised 2016-17 level.[6]

May Revision: It decreased the IHSS budget by $22.5 million GF in 2016-17 and $80.8 million GF in 2017-18, due primarily to a projected decrease in costs associated with IHSS provider travel time and medical accompaniment wait time.[7]

Enacted Budget: It provides $11.7 billion ($3.5 billion GF) for the IHSS program in 2017-18, including $1.9 million GF in 2017-18 for increased costs associated with overtime exemptions for IHSS providers. The budget also outlines exemptions to the FLSA overtime provisions. It requires counties to notify recipients whose providers may be eligible for an exemption, and supply written notification to the provider and recipients of approval or denial of an exemption.[8,9]

Coordinated Care Initiative & Related IHSS Impact

Background: Enacted as part of California's 2012-13 budget, the Coordinated Care Initiative (CCI) changed how medical care and long-term services and supports (LTSS) are provided for low-income older adults and people with disabilities who qualify for Medi-Cal and those who are dually eligible (Medicare-Medi-Cal beneficiaries) by providing care coordination and integration through Medi-Cal managed care plans in participating counties. The governor's original proposal, as outlined in the proposed 2012-13 budget, laid the groundwork for statewide implementation of CCI.[10] Further, in the initial May 2012 CMC proposal submitted to the Centers for Medicare & Medicaid Services (CMS), the state reiterated its initial intent to expand CCI statewide–four counties in 2013, eight counties in 2014, and statewide in 2015.[11] However, the enacted 2012-13 budget only provided authority to implement CCI in eight counties, without reference to potential statewide implementation.[12,13] CCI was launched in June 2014 and became fully operational a year later in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).[14]

Table 1: Changes to CCI Addressed in the 2017-18 Budget Process

Component	Coordinated Care Initiative (as enacted)[3]	Governor's 2017-18 Proposed Budget[3]	2017-18 May Revision[7]	2017-18 Enacted Budget[2]
Mandatory Medi-Cal Managed Care	Dual enrollees in seven counties must enroll in a managed care plan for Medi-Cal services	Ends, as part of CCI, effective January 1, 2018 Proposes extension through 2019	No changes from proposed budget	No changes from proposed budget
Managed LTSS	Access to certain Medi-Cal LTSS is through managed care in seven counties. Health plans' capitation rates include costs for: • In-Home Supportive Services (IHSS) • Multipurpose Senior Services Program (MSSP) • Community-Based Adult Services (CBAS) • Nursing Facility Services	Ends, as part of CCI, effective January 1, 2018 Proposes extension through 2019 without IHSS	No changes from proposed budget	No changes from proposed budget
Cal MediConnect	Dual enrollees in seven counties have benefits between Medicare and Medi-Cal coordinated. Health plans integrate medical and LTSS services, including: • IHSS • MSSP • CBAS • Nursing Facility Services	Ends, as part of CCI, effective January 1, 2018 Proposes extension through 2019 without IHSS	No changes from proposed budget	No changes from proposed budget
Universal Assessment	State is required to develop and pilot a universal assessment tool to ensure access to needed LTSS	Requirement eliminated immediately	No changes from proposed budget	No changes from proposed budget
Statewide Authority	State takes responsibility for negotiating IHSS worker wages and benefits in seven counties	Counties resume responsibility for negotiating IHSS worker wages and benefits, effective January 2018	No changes from proposed budget	No changes from proposed budget

Component	Coordinated Care Initiative (as enacted)[3]	Governor's 2017-18 Proposed Budget[3]	2017-18 May Revision[7]	2017-18 Enacted Budget[2]
IHSS Funding	All counties held to their 2011-12 IHSS expenditure levels with marginal increases annually (maintenance of effort [MOE] funding model)	Counties resume responsibility for 35 percent of non-federal costs (share of cost funding model)	Reverts back to the MOE funding model, with: • New base for county costs • Phased- in annual inflation	Same MOE funding model proposed in May Revision, with changes to share of cost related to locally negotiated wages

Program Components of CCI:

1. Cal MediConnect (CMC): California's Financial Alignment Initiative with CMS, providing dually eligible individuals the option to enroll in one managed care plan responsible for the provision of Medicare and Medi-Cal benefits;[15]

2. Mandatory enrollment in Medi-Cal Managed Care: Dually eligible individuals are required to enroll in a managed care plan for Medi-Cal services; and[15]

3. Managed long-term services and supports (MLTSS): Medi-Cal funded LTSS are accessed through a managed care plan, including IHSS, Community-Based Adult Services (CBAS), and the Multipurpose Senior Services Program (MSSP) as well as nursing facility care.[15]

CCI State-level Initiatives:

1. IHSS Statewide Authority: The state assumed responsibility for negotiating for IHSS worker wages and benefits in the seven counties;[14] and

2. Universal assessment (UA): The state is required to develop and test a UA tool and process in at least two of the seven counties to ensure access to needed LTSS.[14]

Operational Provisions:

1. Medicare shared savings: CMC includes an agreement between the federal government and state to share savings achieved in Medicare expenditures;[16]

2. IHSS financing: CCI includes an IHSS funding formula establishing a maintenance of effort (MOE) agreement for sharing the specific costs in the IHSS program between the state and all 58 counties;[14] and

3. LTSS as managed care benefit: Participating Medi-Cal managed care plans in the seven counties receive capitated rates to cover specified LTSS.[14]

4. MSSP transition to managed care benefit: CCI statute includes requirements to transition MSSP[†] from a federal waiver to a managed care benefit in the seven CCI counties beginning January 1, 2015, or after 19 months of MSSP beneficiary enrollment into managed care. The enacted 2015-16 budget extended the MSSP transition deadline to December 31, 2017, and allowed earlier transition in a county/region when MSSP sites and managed care plans mutually agree on the early transition.[16,17]

Department of Finance Savings Determination: State law requires that the Director of Finance determine if the CCI is cost-effective on an annual basis. The law further states that if not cost effective, CCI would cease operation in the following fiscal year.[14]

Proposed Budget: The Director of Finance completed the annual assessment of CCI and determined it was no longer cost-effective, thereby discontinuing the demonstration in the budget year (January 1, 2018). The termination of CCI meant the removal of, or significant changes to, the following components:

- Removal of IHSS benefits from Medi-Cal managed care plan capitation rates: The proposed budget removed IHSS payments from Medi-Cal managed care plan rates, effective January 1, 2018. This change is anticipated to have no direct impact on IHSS benefits, services for consumers, or workers' wages.[3]

- Removal of IHSS from CMC and MLTSS: The proposed budget removed the IHSS program from CMC and MLTSS in the seven CCI counties, effective January 1, 2018. The

[†] The MSSP program is a 1915(c) Medicaid waiver program, providing care management to high-need older adults by connecting them with community-based services to help them remain in their homes.

Administration will encourage, but not require, Medi-Cal managed care plans to collaborate with IHSS county social workers for care coordination.[3]

- Elimination of Statewide Authority responsible for negotiating IHSS workers' wages and benefits in the seven CCI counties: Per the proposed budget, the seven CCI counties would re-assume responsibility for the collective bargaining process, as was the arrangement prior to CCI.[3,6]

- Re-establishment of the IHSS share of cost funding formula: The proposed budget terminated the CCI's IHSS MOE financing arrangement and reinstated the state-county share of cost arrangement for IHSS in all 58 counties. With the share of cost, counties would have resumed responsibility to cover 35 percent of the non-federal portion of IHSS program costs. The share of cost financing arrangement would have yielded approximately $626 million in state GF savings with a corresponding shift of these costs to counties, resulting in "financial hardship and cash-flow problems" for the counties.[3,18]

- Discontinuation of the UA tool: The proposed budget halted efforts to establish a UA tool.[6] (See "Universal Assessment" section for more information).

- MSSP transition delay: The proposed budget included to further delay of the full transition of the MSSP waiver into managed care plans for another two years.[6]

While the Director of Finance reported that CCI was no longer cost-effective,[19] the proposed budget estimated $20 million GF savings attributed to the CMC program.[6,20] As such, the following program components in the seven CCI counties were proposed to continue through December 31, 2019:

- CMC operation extended: Dually eligible individuals would continue to have the option to enroll, with Medicare and Medi-Cal services organized through one managed care plan.[3]

- Mandatory enrollment in Medi-Cal managed care: Dually eligible individuals residing in the seven counties would continue to be required to enroll in a managed care plan.[3]

- MLTSS: Medi-Cal-only and dually eligible individuals in the seven counties would continue to access CBAS[‡], MSSP, and nursing facility care through managed care plans. Managed care plans would no longer include IHSS, but will be encouraged to work with counties to coordinate care.[3]

May Revision: It maintained the changes to CCI proposed in January, with the following adjustments to two IHSS-related components:

- Elimination of Statewide Authority responsible for negotiating IHSS workers' wages and benefits in the seven CCI counties: The May Revision continued dissolution of the Statewide Authority, and proposed to modify the state's portion of IHSS wage and benefit costs.[7]

- Re-establishment of the IHSS share of cost funding formula: The May Revision established a new MOE financing arrangement, with a new base for county costs and a phased-in annual inflation factor.[7] To mitigate the financial impact to the counties and assist with the transition to the revised funding arrangement, the May Revision proposed the following:

    - GF assistance: Provided counties with $400 million GF in 2017-18, $330 million in 2018-19, $200 million in 2019-20, and $150 million in 2020-21 and ongoing.[7]

    - Redirect Vehicle License Fee growth: Redirected all Vehicle License Fee growth for three years from the Health, County Medical Services Program (CMSP), and Mental Health Subaccounts to the Social Services Subaccount, which includes IHSS. In the fourth and fifth years, 50 percent of this Vehicle License Fee growth will be redirected to the Social Services Subaccount.[7]

    - Share of cost cap: The state's portion of IHSS wage and benefit costs will be capped at $1.10 above the hourly state minimum wage, in accordance with specified details.[7]

    - Inflation factor: Established a new base for county costs of IHSS in 2017-18 that includes services and administrative costs. An annual inflation factor, as specified by the Administration, would be phased in and applied to the base.[7]

[‡] CBAS is a Medi-Cal managed care plan benefit in all 58 counties.

- Loan option for counties: Proposed that counties experiencing financial hardship due to the increased IHSS costs could apply to the Department of Finance for a low interest loan.[7]

Enacted Budget: It maintains the changes to CCI proposed in January. CCI will be formally eliminated as of January 1, 2018, with certain components re-established and continuing for an additional two years. The enacted budget also builds on adjustments to IHSS and MSSP proposed throughout the budget process:[§]

- Elimination of Statewide Authority responsible for negotiating IHSS workers' wages and benefits in the seven CCI counties: It eliminates the Statewide Authority, returning collective bargaining to counties. Beginning July 1, 2017, if a county does not conclude bargaining with its IHSS workers within nine months, the union may appeal to the Public Employment Relations Board.[21]

- Re-establishment of the IHSS share of cost funding formula: It maintains the MOE structure proposed in the May Revision with changes to the share of cost formula related to locally negotiated wages. The budget also provides a one-time increase of $37 million for county administrative costs, and calls for the state and counties to work together to update the methodology for setting county administrative cost limits in the future. In addition, the Department of Finance, in consultation with the California State Association of Counties and other affected parties, is required to re-examine 1991 realignment as part of its development of the 2019-20 budget.[2,21,22]

- MSSP transition delay: The MSSP transition will occur no sooner than December 31, 2019, or on the date managed care health plans and MSSP providers satisfy the readiness criteria, whichever is earlier. The Department of Health Care Services (DHCS), managed care health plans, and MSSP providers are to collaborate on development of standards that create an integrated, person-centered care management and care coordination model that works within the context of managed care, exploring which portions of the MSSP model are adaptable while maintaining the model's integrity and efficacy.[23]

[§] See the Legislative Analyst's Office report, The 2017-18 Budget: California Spending Plan (Preliminary), for details of the IHSS changes related to the discontinuance of CCI .

Other CCI Provisions

Program for All Inclusive Care for the Elderly

Background: The Program of All-Inclusive Care for the Elderly (PACE) is an integrated care program for Medi-Cal beneficiaries who are 55 and older, certified by the state to need nursing home level of care, and are able to live safely in the community with support. The program serves dual eligibles and non-dual eligibles in 12 counties, including six of the seven CCI counties, and operates as a provider-based plan that specializes in serving older adults and persons with disabilities who have higher care needs and require coordinated care to continue living as independently as possible. The initial authorization for the CCI recognizes PACE as an option for beneficiaries who are eligible for enrollment in Cal MediConnect. PACE plans are required to be presented as a Cal MediConnect enrollment option in the CCI counties and included in all enrollment materials and outreach programs. However, PACE has not been offered as an enrollment option for beneficiaries required to enroll in a Medi-Cal managed care plan for receipt of specified LTSS.

Enacted Budget: It requires that DHCS inform individuals in the seven CCI counties that must enroll in MLTSS of their right to be assessed for and choose PACE.[23]

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. CCI authorizing statute required the Departments of Health Care Services, Aging, and Social Services to consult with stakeholders to develop a UA process, including the development of a UA tool for IHSS, CBAS, and MSSP. The process sought to facilitate better care coordination, enhance consumer choices, and reduce administrative inefficiencies.[24] In prior budgets, resources were set aside for development, piloting, and evaluation of the UA tool in 2-4 CCI counties.

Proposed Budget: The termination of CCI eliminated the UA effort, resulting in GF savings of $500,000 for the Department of Social Services budget.[25]

May Revision: It maintained elimination of the UA effort.

Enacted Budget: It maintains elimination of the UA effort.[3]

Optional Medi-Cal Benefits: Dental and Vision

Background: Dental and vision benefits are optional services under Medi-Cal, meaning the state is not required to fund these services as part of the Medi-Cal program. Prior to 2008, California included dental and vision care as part of the Medi-Cal benefits package for adults as well as children, but both were cut during the Great Recession. In 2014, the state returned limited dental services through Denti-Cal.

Enacted Budget: Restores Medi-Cal funded dental and vision services as follows:

- Dental benefit: It includes $34.7 million GF in 2017-18 and $72.9 million GF in subsequent years to restore full dental benefits for Medi-Cal eligible adults, effective January 1, 2018.[2,9]
- Vision benefit: It includes statutory changes to restore optometric and optical services for Medi-Cal eligible adults, effective January 1, 2020, if the Legislature includes funding in budget.[2,9]

Developmental Disabilities

Background: Governed by the Lanterman Developmental Disabilities Act and the Early Intervention Services Act, California's developmental disabilities service system consists of both Regional Centers and state-operated facilities. Regional Centers provide or coordinate services that include diagnosis and assessment, care monitoring, advocacy for the protection of legal, civil, and service rights, as well as training and education for individuals and their families. The state-operated facilities consist of three developmental centers and one community facility that provide 24-hour habilitation and treatment services for residents with developmental disabilities. The Administration announced in 2015 the planned closure of the three remaining developmental centers: Sonoma, Fairview, and the general treatment area of Porterville. The secure treatment program at Porterville will remain while the Department of Developmental Services (DDS) works to develop new models of care that provide community-based residential and support services to individuals in the program.[3]

Proposed Budget:

- Developmental center closures: The proposed budget included $450 million ($330 million

GF) for developmental center operations, an $80 million decrease over the updated 2016-17 budget. In addition, the proposed budget included $505,000 GF for costs related to developmental center closures, as well as $597,000 ($544,000 GF) and four staff positions for increased oversight of new community housing projects to support individuals moving out of the state developmental centers.[26]

- Minimum wage: The proposed budget included an increase of $72 million ($48 million GF) to cover the increase in the state minimum hourly wage.[26]

May Revision: It maintained the provisions outlined in January, and provided $7.5 million GF in 2017-18 to establish acute crisis facilities in the community, as well as two, 24-hour mobile acute crisis teams to provide in-home treatment and stabilization services. The Administration proposed to establish intensive transition and support services, including wraparound residential services, through individual evaluations, assessments, and treatment recommendations.[7]

Enacted Budget: In addition to the provisions outlined in both January and May, the enacted budget includes $5.6 million GF in 2017-18 to remove the 90 hour, per quarter limit for home respite services effective January 1, 2018. It also includes statutory changes that allows DDS to provide grant funding directly to community-based organizations to promote equity and reduce disparities when purchasing services for their population.[2,27]

Housing and Disability Advocacy Program

Background: Enacted as part of the "No Place Like Home" Initiative in the 2016-17 budget, the Housing and Disability Advocacy Program sought to provide matching funds for local governments to connect homeless and at-risk individuals to Supplemental Security Income (SSI) and other benefits.[28]

Proposed Budget: It halted implementation of the Housing and Disability Advocacy Program, citing "fiscal constraints," for savings of $45 million GF.[3]

May Revision: It maintained program stoppage proposed in January.[7]

Enacted Budget: It includes one-time funding of $45 million GF to extend the Housing and Disability Advocacy Program for one year.[2]

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

Background: The federal SSI program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. The federal Social Security Administration (SSA) administers the SSI/SSP program, making eligibility determinations, grant computations, and issuing combined monthly checks to recipients. In California, the SSI payment is augmented with an SSP grant. The average monthly caseload is estimated to be 1.3 million recipients in 2017-18 (54.8 percent people with disabilities, 44.3 percent older adults, and 0.9 percent people who are blind). 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 factors are 0.3 percent for 2017 and 2.6 percent for 2018. In the 2016-17 fiscal year, SSI/SSP grant levels increased to a maximum of $895.72 per month for individuals and $1,510.14 per month for couples.[3]

Proposed Budget: It included $2.9 billion GF for the SSI/SSP program, representing a 2 percent increase ($55.2 million) over the revised 2016-17 budget estimate. No policy changed for the SSP portion of the SSI/SSP grant. The budget increase reflects a higher average per person SSI/SSP payment offset by lower caseload.[3,29]

May Revision: It decreased SSI/SSP program funding by $34.1 million GF in 2016-17 and $37.3 million GF in 2017-18, based on updated caseload and average cost-per-person/couple projections.[7]

Enacted Budget: It includes $2.9 billion GF for the SSI/SSP program with no policy change for the SSP portion of individuals' SSI/SSP grant.[9]

Independent Living Centers

Background: Independent Living Centers advocate for disability rights and provide services and supports for people with disabilities to live in the community. The 2016-17 budget included a $705,000 GF augmentation to the Department of Rehabilitation for the administration of independent living services in three regions in California.[5]

Proposed Budget: It eliminated $705,000 GF in ongoing supplemental funding for the three Independent Living Centers included in the 2016-17 Budget Act.[3]

May Revision: It maintained elimination of ongoing supplemental funding.[30]

Enacted Budget: It includes $705,000 GF supplemental funding for three Independent Living Centers.[31]

Home and Community-Based Services Waivers

Nursing Facility/Acute Hospital (NF/AH) Waiver Renewal

Background: The NF/AH Waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. Services include private duty nursing, case management, and personal care services.[32] DHCS developed and released a NF/AH Waiver renewal approved by CMS in November 2016. Enhancements in the renewal application include increased waiver capacity, localized comprehensive care management, a new enrollment standard that 60 percent of enrollments are from institutional settings, a shift to an aggregate cost neutrality, and integration of the In-Home Operations Waiver.[6]

Proposed Budget: It included $9.8 million ($4.9 million GF) for the NF/AH Waiver in the DHCS budget and proposed statutory changes to align with the renewal application submitted to CMS.[6]

May Revision: It decreased funding to $8.9 million ($4.5 million GF) to reflect anticipated lower costs related to a phase-in for new enrollees.

Enacted Budget: : It includes statutory changes to align with the renewal application submitted to CMS.[23]

San Francisco Community Living Support Benefit Waiver/Assisted Living Waiver

Background: The San Francisco Community Living Support Benefit (CLSB) Waiver allows San Francisco city and county to offer community-based alternatives to residents of Laguna Honda Hospital or those at risk of institutionalization who are eligible for Medi-Cal.[33] CMS approved the CLSB Waiver for a five-year period, with an effective date of July 1, 2012. The San Francisco

Department of Public Health uses the waiver to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. Waiver services include care coordination, enhanced care coordination, community living supports, behavior assessment and planning, as well as accessibility adaptations, and home-delivered meals.[34]

Proposed Budget: It sought to integrate the CLSB into the Assisted Living Waiver (ALW) and double the existing ALW capacity in San Francisco. Individuals participating in the CLSB would have transitioned to the ALW in July 2017.[6]

May Revision: It expanded this proposal to transition people to other services, including, but not limited to, other ongoing waiver programs.[20]

Enacted Budget: It includes statutory language to integrate CLSB into the ALW, and transition people to other services, including, but not limited to, other ongoing waiver programs as previously proposed.[23]

Supplemental Funding

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

Long-Term Care Ombudsman Program: The Long-Term Care Ombudsman Program investigates and endeavors to resolve complaints made by, or on behalf of, individual residents in long-term care facilities including nursing homes, residential care facilities for the elderly, and assisted living facilities. The enacted budget includes a one-time, $1 million augmentation to the Long-Term Care Ombudsman Program, drawn from the State Health Facilities Citation Penalty Account. This funding will enable unannounced monitoring visits, complaint investigation, as well as volunteer recruitment, training, and supervision.[9]

Traumatic Brain Injury (TBI) Program: In coordination with consumers and their families, seven service providers throughout California provide a coordinated post-acute care service model for persons with TBI, including supported living, community reintegration, and vocational supportive services. The enacted budget included an $800,000 augmentation to the TBI Fund from the State Penalty Fund. This funding will maintain services to Californians with traumatic brain injury.[9]

California Senior Legislature: The California Senior Legislature (CSL) was established in 1980 to provide model legislation and advocate for the needs of California's older adults. The CSL is primarily funded by donations through an income tax check-off on state income tax returns. However, tax check-off contribution yields were not sufficient this year to sustain the program's operating expenses and one staff position. The enacted budget includes $375,000 GF on a one-time basis for the CSL as a relief appropriation. This funding will support its basic administrative costs, allowing the CSL to continue.[9]

References

1. 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 January 12, 2017.

2. California Department of Finance. 2017-18 California state budget. 2017; http://www.ebudget.ca.gov/FullBudgetSummary.pdf. Accessed June 29, 2017.

3. California Department of Finance. 2017-18 governor's budget summary. 2017; http://www.ebudget.ca.gov/2017-18/pdf/BudgetSummary/FullBudgetSummary.pdf. Accessed January 10, 2017.

4. 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.

5. California Department of Finance. California state budget, 2016-17. 2016; http://www.ebudget.ca.gov/2016-17/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf. Accessed July 8, 2016.

6. California Department of Health Care Services. 2017-18 governor's budget highlights Department of Health Care Services. 2017; http://www.dhcs.ca.gov/Documents/FY-2017-18_GB_Highlights_011017.pdf. Accessed January 11, 2017.

7. California Department of Finance. 2017-18 May revision. 2017; http://www.ebudget.ca.gov/2017-18/pdf/Revised/BudgetSummary/FullBudgetSummary.pdf. Accessed May 16, 2017.

8. Senate Bill 89 (Chapter 24, Statutes of 2017).

9. California Department of Finance. Entire Health and Human Services budget. 2017; http://www.ebudget.ca.gov/2017-18/pdf/Enacted/GovernorsBudget/4000.pdf. Accessed July 10, 2017.

10. California Department of Finance. Governor's budget 2012-13; proposed budget summary. 2012; http://www.ebudget.ca.gov/2012-13-EN/BudgetSummary/BSS/BSS.html. Accessed May 16, 2017.

11. State of California. Proposal to the Center for Medicare and Medicaid Innovation: coordinated care initiative: state demonstration to integrate care for dual eligible beneficiaries. 2012; http://www.calduals.org/wp-content/uploads/2012/06/CADemoProposal0531121.pdf. Accessed January 23, 2017.

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

13. California Department of Health Care Services. California bridge to reform demonstration (No. 11-W-00193/9), amendment coordinated care initiative. 2013; http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CCI_SPA-Amend_061813.pdf. Accessed January 23, 2017.

14. The SCAN Foundation. California's coordinated care initiative: background and overview. 2012; http://www.thescanfoundation.org/california%E2%80%99s-coordinated-care-initiative-background-and-overview. Accessed January 20, 2017.

References (Cont.)

15. 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, 2017.

16. Centers for Medicare and Medicaid Services, The State of California. Memorandum of understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the State of California regarding a federal-state partnership to test a capitated financial alignment model for Medicare-Medicaid enrollees, California demonstration to integrate care for dual eligible beneficiaries. 2013; https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf. Accessed January 20, 2017.

17. Senate Bill 75 (Chapter 18, Statutes of 2015).

18. Legislative Analyst's Office. The governor's May revision in-home supportive services cost-sharing proposal. 2017; http://lao.ca.gov/publications/report/3671. Accessed May 16, 2017.

19. California Department of Finance. Estimated general fund impact for the coordinated care initiative. 2017. Accessed January 13, 2017.

20. California Department of Health Care Services. May 2017 Medi-Cal estimate. 2017; http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2017_May_Estimate/M1707_Regular_PC_Tab.pdf. Accessed May 16, 2017.

21. Senate Bill 90 (Chapter 25, Statutes of 2017).

22. Legislative Analyst's Office. The 2017-18 budget: California spending plan (preliminary). 2017; http://lao.ca.gov/Publications/Report/3694. Accessed July 12, 2017.

23. Senate Bill 97 (Chapter 52, Statutes of 2017).

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

25. California Department of Social Services. Local assistance estimates for the 2017-18 governors budget. 2017; http://www.cdss.ca.gov/inforesources/Fiscal-Financial/Local-Assistance-Estimates/Local-Assistance-Estimates-for-the-2017-18-Governors-Budget. Accessed January 12, 2017.

26. Senate Committee on Budget & Fiscal Review. Summary of the governor's proposed 2017-18 budget. 2017; http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/QuickS/SummaryGovPropBudget2017_18.pdf. Accessed January 11, 2017.

27. Assembly Bill 107 (Chapter 18, Statutes of 2017).

28. Assembly Bill 1618 (Chapter 43, Statutes of 2016).

29. California Department of Social Services. California Department of Social Services 2017-18 governor's budget local assistance, executive summary. 2017; http://www.cdss.ca.gov/cdssweb/entres/localassistanceest/Jan2017/ExecutiveSummary.pdf. Accessed January 24,2017.

30. California Department of Rehabilitation. California Department of Rehabilitation FY 2017-2018 May revision highlights. 2017; http://www.rehab.cahwnet.gov/Public/Budget-Act-Highlights-2017-2018.html. Accessed July 5, 2017.

31. California Department of Rehabilitation. California Department of Rehabilitation FY 2017-2018 budget act highlights. 2017; http://www.rehab.cahwnet.gov/Public/Budget-Act-Highlights-2017-2018.html. Accessed July 5, 2017.

32. California Department of Health Care Services. In-Home Operations. 2016; http://www.dhcs.ca.gov/services/ltc/Pages/In-HomeOperations.aspx. Accessed January 12, 2017.

33. Assembly Bill 2968 (Chapter 830, Statutes of 2006).

34. California Department of Health Care Services. Community living support benefit waiver. 2016; http://www.dhcs.ca.gov/services/ltc/Pages/CLSBW.aspx. Accessed January 17, 2017.