Summary of the Enacted 2013-2014 Budget: Implications for Older Adults and People with Disabilities

On June 27, 2013, California Governor Edmond G. Brown, Jr., signed the 2013-14 budget. The enacted budget outlines the state's spending plan for the fiscal year beginning on July 1, 2013 and ending June 30, 2014. The budget includes program modifications that impact the health and human services delivery system serving older adults and people with disabilities.

Background and Updated Budget Picture

The final budget outlines fiscal year 2013-14 expenditures of approximately $96.3 billion, revenues of $98 billion, and a $1 billion reserve.[1] Despite there being no new reductions to health and human services programs, the budget neglects to restore many of the previously-implemented reductions to programs serving older adults and people with disabilities.

Items Impacting Older Adults and People with Disabilities

The following budget items impact older adults and people with disabilities, as well as the broader long-term services and supports (LTSS) service delivery system.

Revisions to the Coordinated Care Initiative

Background: Last year's state budget established the Coordinated Care Initiative (CCI) with the goal of "transforming California's Medi-Cal delivery system to better serve the state's low-income older adults and persons with disabilities" (p. 1).[2] The CCI outlines changes to the medical care and LTSS systems serving these individuals and specifies various requirements related to the Dual Eligible Integration Demonstration (renamed "Cal MediConnect").[3,4] The main components of the CCI include: 1) provisions of Cal MediConnect; 2) mandatory enrollment of dual eligible individuals (individuals eligible for both Medicare and Medi- Cal) into Medi-Cal managed care,[*] and 3) integration of Medi-Cal-funded LTSS into Medi-Cal managed care.[5] The CCI is slated for implementation in eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). California received federal approval for Cal MediConnect on March 27, 2013.[6,7]

[*]Previous state law (Steinberg, SB 208, Chapter 714, Statutes of 2010) required that Medi-Cal-only seniors and persons with disabilities be enrolled into managed care health plans. While the CCI provides dual eligibles who reside in the eight Demonstration counties with the ability to opt out of the Demonstration for purposes of Medicare coverage, these individuals will be mandated to enroll in a Medi-Cal managed care plan for coverage of Medi-Cal benefits. Therefore, in order to access any Medi-Cal covered service, such as LTSS, dual eligibles residing in the eight counties will need to enroll in a Medi-Cal managed care health plan.

January Budget Proposal: The governor's initial proposed 2013-14 budget outlined a revised timeline for CCI implementation, delaying Cal MediConnect enrollment from March 2013 to September 2013.[8] This revised date also applied to the inclusion of LTSS as a Medi-Cal managed care benefit for beneficiaries residing in the eight counties, as well as the mandatory enrollment of dual eligible individuals into Medi-Cal. At that time, enrollment in Los Angeles County was proposed to be phased-in over an 18-month period, beginning no sooner than September 2013. Enrollment in San Mateo County was proposed to occur all at once in September 2013. Finally, in the remaining six counties (Alameda, Orange, Riverside, San Bernardino, San Diego, and Santa Clara), enrollment was proposed to occur over a twelve-month period, beginning no sooner than September 2013.[9]

May Revision: The governor's May Revision outlined a new implementation date and enrollment approach for the CCI, which includes: Cal MediConnect; mandatory enrollment into Medi-Cal managed care for dual eligible beneficiaries; and the inclusion of LTSS as a Medi-Cal managed care benefit.

Enacting Legislation, "CCI Trailer Bill": The Budget "Trailer Bills" outline the statutory authority through which to implement components of the budget. For the CCI, the Trailer Bill Language (TBL) includes significant policy elements that impact the program and its implementation, as follows:[10]

- **De-Linking of CCI Components:** The TBL "de-links" the three components of the CCI, which are: 1) establishment of Cal MediConnect; 2) mandatory enrollment of dual eligibles into Medi-Cal managed care; and 3) implementation of Medi-Cal managed LTSS. This separation in statute permits the three components of the CCI to proceed independently.

- **"Poison Pill" Provision:**
  - Initial Determination: The TBL permits the Department of Finance (DOF) to determine, at least 30 days prior to enrolling beneficiaries in the CCI, whether the overall CCI program will lead to net General Fund (GF) savings. Should DOF determine that the CCI will not generate net GF savings, all components of the CCI will be suspended immediately and the CCI shall become inoperative July 1, 2014.

  - Annual Determination: Assuming the CCI is implemented, the DOF will estimate by January 10th of each year after implementation the amount of net GF savings associated with the CCI. If the DOF determines that the CCI will not generate net GF savings, the CCI will become inoperative January 1 of the following calendar year.

  - If the CCI beomes inoperative: If the CCI becomes inoperative, then Department of Health Care Services (DHCS) will be responsible for providing notifications to affected parties.

- **D-SNP Policy Revised:** The CCI TBL provides a one-year extension for California's Medicare Dual Eligible Special Needs Plans (D-SNPs)[†] to operate without passively enrolling beneficiaries into Cal MediConnect. Previously, the state had considered mandating that D-SNP enrollees be passively enrolled into Cal MediConnect at the start of the enrollment process. The TBL changed this policy and mandates that beneficiaries already enrolled in D-SNPs can remain in their current plan for the calendar year 2014. After that time, the state will reconsider this policy.

- **Stakeholder Process:** The TBL requires that, commencing August 1, 2013, DHCS convene stakeholders on a quarterly basis to evaluate the CCI's progress and make recommendations to DHCS and the Legislature.

- **Risk Corridors:** The TBL outlines risk corridors for Medi-Cal managed care plans in regard to provision of managed LTSS. These risk corridors are established to ensure that the managed care plans and the state are both protected from substantial overpayments or underpayments. These risk corridors do not impact those outlined in the Cal MediConnect program for the Medicare-covered services.[6]

Enacted Budget: Under the enacted budget, beneficiaries in the eight CCI counties will enroll into Medi-Cal managed care plans no sooner than January 1, 2014. Los Angeles County will phase-in beneficiaries over 12 months, subject to further discussions with the federal government. San Mateo County will enroll beneficiaries in January 2014. All remaining counties (Alameda, Orange, Riverside, San Bernardino, San Diego and Santa Clara) will pursue a phased-in enrollment process over a 12-month period.[11] The budget projects GF savings of $119.6 million in 2013-14 for CCI implementation, which is attributed to the increase in the state's Managed Care Organization Tax (see item below).

Across-the-Board Reductions to In-Home Supportive Services (IHSS)

Background: The IHSS program provides in-home personal care assistance to low-income adults who are over 65 years of age, 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.

January Budget Proposal: The January budget assumed implementation of a 20 percent across-the-board reduction in authorized service hours for specified IHSS recipients. This reduction was originally triggered by lower than expected 2011-12 revenues, pursuant to the enacted 2011-12 budget (Chapter 41, Statutes of 2011). This "trigger cut" was halted by a federal court in response to litigation filed against the state. The January proposed budget assumed success in litigation such that the reduction would have taken effect in November 2013, following resolution of *Oster v. Lightbourne* in the U.S. District Court, California Northern District.[12]

May Revision: In March 2013, the Administration reached a settlement with plaintiffs with respect to the specified IHSS litigation filed against the state. The May Revision reflected the settlement terms requiring that the IHSS 20 percent across-the-board reduction be replaced by an 8 percent across-the-board reduction effective July 1, 2013, and a 7 percent across-the-board reduction annually thereafter. The 7 percent reduction is in place of the 8 percent reduction, and not in addition to it.

Authorizing Legislation: For the IHSS settlement terms to be implemented, authorizing legislation was needed to repeal the reductions enacted in prior years and replace with the terms of the settlement. Senate Bill 67 (Committee on Budget and Fiscal Review) codifies the terms of the settlement agreement reached between the state and plaintiffs resolving outstanding lawsuits affecting IHSS.[13]

Enacted Budget: The enacted budget includes savings of $176.4 million GF in 2013-14 as a result of the IHSS settlement provisions.

[†] D-SNPs enroll beneficiaries who are entitled to both Medicare and Medicaid (Medi-Cal in California) and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

IHSS and the Statewide Authority

Background: Prior to the CCI, local IHSS public authorities maintained responsibility for performing a number of functions including acting as the employer of record for IHSS workers, maintaining provider registries, offering training for consumers and providers, and other functions. The CCI established the California IHSS Authority (referred to as the "Statewide Authority") as the employer of record, for purposes of collective bargaining for IHSS providers in accordance with certain procedures. The establishment of the Statewide Authority will transfer collective bargaining authority from the county level to the state level; local public authorities will retain all other functions. The CCI only authorizes the shift in collective bargaining for the eight CCI counties.[5]

Enacted Budget: The enacted budget includes $259,000 GF and four positions within the Department of Social Services (DSS) to staff the Statewide Authority, which is responsible for collective bargaining with unions representing individual IHSS providers in CCI counties. The state anticipates that the Statewide Authority will convene before the first county completes its transition into mandatory managed care for LTSS.[11]

Restoration of Adult Dental Benefits

Background: In 2009, the enacted budget eliminated the Denti-Cal Adult Dental Services benefit due to the state's fiscal crisis. Since that time, the only available adult dental benefits have been those categorized as "federally required adult dental services" (FRADS), as well as dental services to pregnant women and nursing home patients. Generally, FRADS primarily involves the removal of teeth and treating the affected area.[14]

Legislature Partial Restoration of Benefits: The Legislature voted to restore partial Medi-Cal Adult Dental Benefits effective May 1, 2014. This partial restoration includes preventive/diagnostic services, restoration services, and full mouth dentures.[15]

Enacted Budget: The enacted budget includes $16.9 million GF to provide preventative adult dental benefits beginning May 1, 2014 through June 30, 2014. Thereafter, annual costs are estimated to be $85.6 million GF.[11]

Restoration of Enteral Nutrition Medi-Cal Benefit

Background: In 2011, due to the state's fiscal crisis, the enacted budget eliminated coverage of enteral nutrition products when taken orally. For individuals who require tube-feeding, Medi-Cal will cover enteral nutrition products.[16]

Legislature Restoration of Coverage: The Legislature voted to restore enteral nutrition benefits starting May 1, 2014.[15]

Enacted Budget: The enacted budget funds the Medi-Cal enteral nutrition benefit beginning May 1, 2014 through June 30, 2014 for $1.7 million GF. Thereafter, annual costs are estimated to be $14.3 million GF.

Mental Health Grants

The enacted budget includes $142.5 million GF for one-time grants in order to "strengthen local capacity" for providing crisis stabilization and treatment to individuals with mental illness.[11] Specifically:

- The California Health Facilities Financing Authority will offer one-time grants to local entities to add 25 Mobile Crisis Support Teams, approximately 2,000 beds in Crisis Residential Treatment Programs, and additional Crisis Stabilization Units over the next two years.
- The Mental Health Oversight and Accountability Commission will award grants to local entities for approximately 600 triage personnel over the next two years. These personnel support high-need individuals in accessing medical care, substance disorder treatment, and other services.

Managed Care Organization Tax

Background: A "provider tax," sometimes termed a "fee" or "assessment," authorizes the collection of revenue from specified categories of providers. In most states, it is used as a mechanism to generate new in-state funds and match them with federal funds so that the state gets additional federal Medicaid dollars.[17] In 2009, the Legislature passed the Gross Premiums Tax, which assesses a tax on the total operating revenue of Medi-Cal managed care plans.[18] Subsequent legislation has extended the sunset date for this tax, most recently extending the statute through June 30, 2012.[19] A proposal to extend the tax further was not approved during the 2012-2013 budget period.

January Budget Proposal: The governor proposed to permanently reauthorize the Gross Premiums Tax on Medi-Cal Managed Care plans.

May Revision: The governor proposed a permanent Managed Care Organization (MCO) Tax on health plans. Under this proposal, in 2012-13, the tax rate would be retroactively applied and equal to the current Gross Premiums Tax rate. In 2013-14 and beyond, the tax rate would equal the state sales tax rate.

Enacted Budget: The enacted budget reauthorizes the MCO Tax through 2015-16. In 2012-13, the tax rate will be equal to the gross premiums tax (2.35 percent) to generate $128.1 million GF savings. The 2012-13 year revenues will be directed to support the Healthy Families Program. In 2013-14 through 2015-16, the rate will be equal to the state sales and use tax rate (3.9375 percent). Half of these total funds will draw down federal matching funds and reimburse Medi-Cal managed care plans for the incurred taxes. The other half of the funds will offset GF expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles. The MCO tax is estimated to generate GF savings of $166.4 in 2012-13 and $340.3 million GF in 2013-14.[11]

Managed Care Savings

January Budget Proposal: The governor included a "Managed Care Efficiencies" proposal to identify new ways to improve the efficiency of the health care delivery system and develop payment systems that promote high quality health outcomes in managed care.

May Revision: The governor withdrew the "Managed Care Efficiencies" proposal.

Enacted Budget: The legislature agreed to withdraw the "Managed Care Efficiencies" proposal.

Annual Medi-Cal Managed Care Open Enrollment

Background: Under current law, Medi-Cal beneficiaries may change health plans once per month or up to 12 times per year.

January Proposal: The governor proposed that Medi-Cal beneficiaries be permitted to change plans one time per year during an annual open enrollment period.

Enacted Budget: The Legislature rejected the Governor's proposal to establish an annual enrollment period for Medi-Cal, and therefore this proposal is not included in the enacted budget.[15]

Implementation of Medi-Cal Provider Rate Cuts

Background: The 2011-12 enacted budget (AB 97, Chapter 3, Statutes of 2011) reduced provider payments for physicians, pharmacy, clinics, medical transportation, home health, family health programs, certain hospitals, and skilled nursing facilities by 10 percent.[20] These reductions were subject to federal approval, which was provided in October 2011. Meanwhile, advocates brought forth a lawsuit challenging the reductions, in *California Medical Association, et. al., v. Toby Douglas, et. al.* In January 2012, the U.S. District Court tentatively blocked the cut, saying it could cause irreparable harm to beneficiaries.[21] However, in December 2012, a three-judge appeals court panel of the 9th Circuit Court of Appeals ruled that the federal government has authority to decide whether California and other states can reduce Medicaid rates while still adhering to program regulations.[22]

January Proposal: The proposed budget assumed that the state would proceed with the previously-authorized Medi-Cal provider reductions, effective March 2013 for a GF savings of $261 million in 2012-13 and GF savings of $431 million in 2013-14.[23]

Related Legislation: Assembly Bill 900 (Alejo) would eliminate the Medi-Cal reductions that were adopted as part of the 2011-12 budget, for specified providers. As recently amended, this legislation would eliminate the Medi-Cal reductions only as applied to nursing facilities and a sub-category of nursing facilities referred to as "distinct-part" nursing facilities (DP-NFs). All other Medi-Cal provider rate reductions would remain in effect.

Enacted Budget: The enacted budget maintains the 10 percent reduction as part of the 2013-14 budget. However, legislation to restore the rate reduction to NFs and DP-NFs continues to proceed through the policy process as part of the current 2013-14 legislative session.

Health Care Reform Implementation and Medicaid Expansion

Background: The Affordable Care Act (ACA) created opportunities to increase access to private and public health care coverage through various programmatic, regulatory, and tax incentive mechanisms. Included in the ACA is the optional expansion of Medicaid coverage at the state level (Medi-Cal in California).[24] Medi-Cal currently provides health care services at no or low cost to approximately eight million low-income individuals including families with children, seniors, persons with disabilities, children in foster care, and pregnant women. Eligibility for Medi-Cal varies depending on the coverage group. Single, childless adults currently are not eligible for Medi-Cal unless they meet qualifications for eligibility under the aged/blind/disabled category. Adults not eligible for Medi-Cal can receive services through county indigent health services programs, although these services are limited.

January Budget Proposal:

- **Long-Term Care (LTC) Benefit Carve-Out:** The governor's January proposal carved out long-term care services from the Medi-Cal expansion benefit package.

- **State vs. County Approach:** The governor's January budget proposed to expand coverage to all legally-residing Californians with incomes under 138% of FPL, or around $15,000 in annual income for an individual.[25] The January budget outlined two options for implementing this expansion: a state-based expansion or a county-based expansion. A state-based expansion approach would build upon the existing state-administered Medi-Cal program and managed care delivery system. The state would offer a standardized, statewide benefit package. A county-based approach would also offer a standardized benefit package and would build upon the existing Low-Income Health Program and/or county indigent health care services program as the basis for operating the Medicaid expansion. Under a county-operated Medicaid expansion, the counties would act as the fiscal and operational entity responsible for the expansion. The May Revision retracted the county-based approach, and instead proceeded with a state-based approach to implementation of Medi-Cal optional expansion.[26]

May Revision:

- **LTC Benefit Inclusion:** Medi-Cal LTC services are now included in the benefit package for the expansion population, provided that the federal government allows California to apply the existing Medi-Cal LTC asset test to these LTC services for the expansion population.

- **Human Services Realignment:** The May Revision assumed that the counties would generate savings through implementation of Medi-Cal expansion based on decreased expenditures for indigent health care. Based on these assumptions, the governor proposed to transfer the funding of specified human services programs (including Cal Works and Cal Fresh) from the state to counties. The May Revision proposed that a mechanism/funding formula be established to determine the amount of county savings generated that would be redirected to support human services programs. The May Revision estimated that $300 million (total funds) would be shifted from local health programs to local human services programs in 2013-14, $900 million in 2014-15, and $1.3 billion in 2015-16 and 2016-17, with specifics based on the established funding formula.

- **Substance Use Disorders Enhanced Benefit Package:** The May Revision proposed that counties be given the discretion to offer an "enhanced benefit package" for substance use disorders to existing and newly-eligible Medi-Cal beneficiaries.

Enacted Budget: The enacted budget includes approximately $1.5 billion federal funds and $21 million GF to implement the Medi-Cal expansion, as provided under the federal Affordable Care Act.[11,15] The legislature rejected the governor's human services realignment proposal as outlined in the May Revision. Instead, the enacted budget outlines a fiscal mechanism for the state to capture county savings that result from the Medi-Cal expansion, and creates a mechanism for shared savings between the state and counties.[1] In addition, the substance use disorders benefit will be a required benefit in all Medi-Cal managed care plans, instead of an option for counties (as was originally proposed by the governor in the May Revision).[27] The Medi-Cal benefit package and all eligibility issues are outlined in legislation through SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez).[27,28] Savings are estimated at approximately $300 million GF in 2013-14, thereby transferring this amount from counties to the state in 2013-14. The actual amount to be transferred from counties to the state may be adjusted after the actual savings from the first year of ACA implementation are calculated.

Department of Developmental Services

Background: The Department of Developmental Services (DDS) serves approximately 256,000 individuals with developmental disabilities in the community and 1,569 individuals in state-operated facilities.

Enacted Budget: Among other items, the enacted budget includes an increase of $32.2 million GF to restore previously-implemented cuts totaling 1.25 percent to regional center operations and provider payments. The budget also includes an increase of $5.7 million GF in 2012-13 and $11.9 million GF in 2013-14 to backfill the sequester reduction to the Social Services Block Grant, which is used in part to fund services provided by regional centers.[29]

State-Level Agency Reorganization

Background: The 2012-2013 budget required a plan for reorganizing and transferring administrative and programmatic functions performed by the Department of Alcohol and Drug Programs (DADP). DADP's functions are to be transferred to other state departments effective July 1, 2013.[30]

January Budget: The January budget proposed to transfer all substance use disorder programs from DADP to DHCS to improve coordination and delivery of services.[29] The budget also proposed to transfer mental health licensing and quality improvement functions from the Department of Social Services to DHCS, further consolidating and streamlining the licensing and certification functions for these programs within a single department.

Enacted Budget: The budget authorizes and provides legislative authority to complete the elimination of the Department of Alcohol and Drug Programs, transferring substance use disorder programs to DHCS and the Office of Problem Gambling to the Department of Public Health.[11] The budget also transfers mental health licensing and quality improvement functions from DSS to DHCS.

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