

California's Proposed 2012-13 Budget: Impact on California's Seniors and People with Disabilities

On January 5, 2012, California Governor Edmund G. Brown, Jr., released his proposed budget, outlining his spending plan for the fiscal year beginning on July 1, 2012 and ending June 30, 2013. The proposed budget includes initiatives and program reductions that impact California's seniors and people with disabilities.

Understanding the Problem

The governor estimates the General Fund budget deficit at \$9.2 billion through the period ending June 30, 2013. Of this estimated deficit, \$4.1 billion is attributed to the current 2011-12 fiscal year, and \$5.1 billion is attributed to the 2012-13 fiscal year.^{1,2} In contrast, at this time last year, the Governor's proposed 2011-12 budget projected a shortfall of approximately \$25.4 billion.³

The 2012-2013 Proposed Budget

The governor's proposed budget projects expenditures totaling \$92.6 billion General Fund in 2012-13, including \$10.3 billion in cuts and revenues in order to balance the budget and build a \$1.1 billion reserve. In his budget, the governor assumes that voters will approve his tax initiative in the November 2012 election, which would temporarily increase both the personal income tax on the highest income bracket and the sales tax by one-half percent. In total, the tax initiative would provide \$4.4 billion in revenues to the General Fund. If the tax initiative fails to gain voter approval, then \$5.4 billion in additional cuts would be triggered in 2012-13, including cuts to education, parks and other programs, with the greatest impact on K-14 education at \$4.8 billion in reductions.^{1,2,4} There are no trigger cuts proposed to health and human services programs.

Budget Proposals Impacting Older Adults and People With Disabilities

Integrate Medical Care and Long-Term Services and Supports for "Dual Eligibles"

The governor proposes to enroll all persons eligible for both Medicare and Medi-Cal ("dual eligibles") into managed care plans. The proposal would be phased in over a three-year period starting January 1, 2013. In

this proposal, managed care plans would be given a blended payment of federal, state, and county funds to deliver a range of Medicare and Medi-Cal-covered medical services and long-term services and supports, including In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS, replacing the Adult Day Health Care Program), nursing facility services, and others. The proposal indicates that county-administered behavioral health services would be coordinated with the range of Medicare and Medi-Cal benefits when necessary.¹ This proposal builds on the Dual Eligible Pilot Project (www.calduals.org), which is currently under development through the Department of Health Care Services. Authorizing legislation will be needed to expand this project statewide, as statute currently limits the number of pilot sites to four counties, as outlined in SB 208 (Steinberg, Chapter 714, Statutes of 2010).

Eligible Population: Individuals who are eligible for Medicare and Medi-Cal would be mandated to enroll in one of the selected Medi-Cal managed care plans. Beneficiaries with developmental disabilities who are clients of the regional center system would be required to enroll in one of the Medi-Cal managed care plans, but would continue to receive services provided as part of the Home- and Community-Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD) and other long-term services and supports through the regional center system.¹

Dual Eligible Enrollment Timeline: Starting in 2013, all dual eligibles would transition into a Medi-Cal managed care plan that would also provide long-term supports and services, if managed care is available in their county, as follows:

- The state would select eight to ten Medi-Cal managed care counties deemed to have the capacity to integrate the range of Medi-Cal and Medicare benefits, including medical care services and long-term services and supports. The governor's proposal specifies that approximately 800,000 of California's 1.2 million dual eligible beneficiaries reside in these eight to ten counties (specific counties are not identified).
- The remaining counties that operate Medi-Cal managed care plans would enroll all dual eligibles starting in 2013, and would begin to integrate Medicare benefits in 2014, if they are deemed capable. Therefore, until the Medi-Cal managed care plans are deemed to have the capacity to integrate Medicare benefits, these plans would initially be responsible for providing the range of Medi-Cal covered medical and long-term services and supports.¹

Long-Term Services and Supports Benefit Integration Timeline: In year one, IHSS, other Medi-Cal-funded home- and community-based services, and Medi-Cal-funded nursing facility care would become managed care benefits. The proposal indicates that in this first year, the IHSS program would operate as it does currently, with the exception that all authorized IHSS benefits would be included in managed care plan rates. Over time, managed care plans would take on increasing responsibility for home- and community-based services, including IHSS. At the time of publication, additional details and specifications about the parameters of this proposal have not been released.¹

Medi-Cal Only Individuals: In November 2010, California obtained federal approval for a Section 1115 Medicaid waiver authorizing, among other provisions, mandatory enrollment into managed care plans for seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only (not Medicare) in 16 counties.^{5,6} At present, these managed care plans for SPDs are responsible

for providing Medi-Cal-covered medical services, with Medi-Cal long-term services and supports “carved out.” Under the governor’s proposal, managed care plans serving Medi-Cal-only SPDs would integrate long-term services and supports into the range of benefits offered, consistent with the services integrated under Medi-Cal managed care dual eligible plans. Behavioral health services would be coordinated with counties, consistent with the Medi-Cal managed care dual eligible plans.

Policy Considerations: The governor’s proposal recognizes that integrating the range of acute care services and long-term services and supports through Medi-Cal managed care plans raises important issues that would need to be considered in the program design including, but not limited to: (1) consumer protections for medical care and long-term services and supports within managed care; (2) development of a uniform assessment tool for home- and community-based services; and (3) consumer choice and protection when selecting an IHSS provider. The Administration has indicated that it would consult with consumers and other stakeholders in this effort. Additional issues to consider related to the state-county relationship in financing and delivering services include determining the collective bargaining structure for IHSS providers, and the long-term county financial responsibility for IHSS and other health care programs. The Administration indicates that it would work with counties and stakeholders to address these overarching issues by developing legislation that would be necessary to implement this budget proposal.¹

Projected Savings: The governor’s proposed budget assumes that as these beneficiaries transition from fee-for-service to managed care, the state would generate savings due to a reduction in hospital and nursing facility costs. However, because of the manner in which Medi-Cal is budgeted, there would be a delay in realizing these savings. To accelerate these savings into 2012-13, the proposed budget modifies the payment approach, including a payment deferral for all providers. Together, the governor’s budget assumes this proposal would generate savings of approximately \$678.8 million General Fund in 2012-13 and \$1 billion General Fund in 2013-14.¹

Medi-Cal Managed Care Expansion

California currently operates three delivery models of Medi-Cal managed care in 30 counties across the state: County Organized Health Systems (COHS), the Two Plan Model, and Geographic Managed Care.^{6,*} The governor proposes to expand Medi-Cal managed care statewide into the remaining counties that currently only operate as fee-for-service, beginning in June 2013. Medi-Cal beneficiaries residing in these counties would complete their transition to Medi-Cal managed care plans in 2014-15. The governor’s budget assumes that this expansion would result in a General Fund savings of \$2.7 million in 2012-13 and \$8.8 million in 2013-14.¹

* COHS currently serve about 885,000 beneficiaries through six health plans in 14 counties. In the COHS counties, DHCS contracts with a health plan created by the County Board of Supervisors. The County administers the health plan, and all Medi-Cal beneficiaries residing in that county are enrolled in the COHS health plan. Two-Plan Models serve about three million beneficiaries in 14 counties. In most Two-Plan model counties, there is a “Local Initiative” (LI) and a “commercial plan” (CP). DHCS contracts with both plans. Local stakeholders are able to give input when the LI is created, and it is designed to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. Geographic Managed Care (GMC) models serve approximately 450,000 beneficiaries in two counties: Sacramento and San Diego. In GMC counties, DHCS contracts with several commercial plans.

Other Medi-Cal Proposals

Limits on Medi-Cal Managed Care Open Enrollment

Under current law, Medi-Cal beneficiaries may change plans once per month or up to 12 times per year. The governor proposes to mandate that Medi-Cal beneficiaries may only change plans one time per year during an annual open enrollment period, for a General Fund savings of \$3.6 million in 2012-13 and \$6 million in 2013-14.¹

Nursing Facility Rate Adjustment

The governor's proposed budget includes funding to restore the 10 percent provider rate reduction (an increase of \$171.2 million General Fund spending), and also includes supplemental payments (an increase of \$245.6 million General Fund spending) for nursing facilities. The governor also proposes to permanently extend the rate methodology and nursing facility fee initially established by Chapter 875, Statutes of 2004 (AB 1629).¹

Other Proposed Program Reductions

In-Home Supportive Services (IHSS) Cuts

Eliminate Domestic and Related Services for Specified Individuals: Domestic and related services provided under the IHSS program include housework, grocery shopping, meal preparation and cleanup, laundry, and other shopping and errands. Under this proposal, IHSS beneficiaries residing in a shared living arrangement will not be eligible for domestic and related services that can be provided by other household members, with specified exceptions. This proposal is estimated to provide General Fund savings of \$163.8 million in 2012-13 and is estimated to impact approximately 254,000 IHSS recipients beginning July 1, 2012.¹

20 Percent Reduction in IHSS Service Hours: The governor's budget assumes savings from a partial-year implementation of a 20 percent reduction in authorized service hours for all IHSS recipients, with specified exceptions. This reduction was triggered by lower than expected 2011-12 revenues, pursuant to the enacted 2011-12 budget (Chapter 41, Statutes of 2011). To date, this "trigger cut" has been temporarily halted by a federal court in response to litigation filed against the state. As a result, the state currently is prevented from implementing this reduction. However, the governor's budget assumes success in litigation such that the reduction can take effect in April 2012 for a General Fund savings of \$50.7 million for 2011-12, and \$222 million for 2012-13, following resolution of *Oster v. Lightbourne* in the U.S. District Court, California Northern District. The budget also includes a set-aside of equivalent General Fund dollars in case of a ruling against the state.² The 20 percent reduction would be in addition to the 3.6 percent across-the-board reduction in hours enacted in February 2011 as part of the 2010-2011 budget. However, on July 1, 2012, the 3.6 percent reduction would sunset and the 20 percent reduction would remain, assuming the court rules in favor of the state.

Repeal Medication Dispensing Machine Pilot Project: Originally enacted as part of the 2011-12 budget, the governor proposes to repeal the Medication Dispensing Machine Pilot Project that

utilizes an automated medication dispensing machine with associated telephonic reporting service for monitoring and assisting Medi-Cal recipients with taking prescribed medications. Current law also requires the Department of Social Services to implement an across-the-board reduction in authorized hours for IHSS recipients beginning October 1, 2012, to the extent the pilot project and/or alternative savings proposals enacted by the Legislature do not achieve a combined net annual General Fund savings of \$140 million. The proposed budget assumes neither savings from the pilot project nor savings from the associated across-the-board reduction, and proposes to repeal the associated statutory requirements.^{1,2,4}

Eliminate Funding for California's Caregiver Resource Centers

The governor proposes to eliminate funding for California's Caregiver Resource Center program. Caregiver Resource Centers (CRCs) provide information and referral, short-term counseling, respite care, education, training and support to families and caregivers of persons with Alzheimer's disease, stroke, Parkinson's disease, and other disorders at 11 centers throughout the state.⁷ In the 2009-10 budget, state funding for the program was decreased by approximately 66 percent, or \$7.6 million, down from \$10.5 million General Fund.⁸ Prior to these cuts, approximately 16,800 caregivers were served across the state in 2006-07.⁸ The governor's proposal would eliminate total funding for the program, for a savings of \$2.9 million General Fund in 2012-13.¹

Department of Developmental Services Cuts

The Department of Developmental Services (DDS) serves approximately 256,000 individuals with developmental disabilities in the community and 1,500 individuals in state-operated facilities. The governor's proposed budget includes a decrease of \$200 million General Fund for DDS. To achieve these savings, DDS is considering extending the 4.25 percent provider and regional center operations payment reductions, reductions in the developmental center budget, and other potential savings options. DDS will engage stakeholders to discuss savings proposals.¹

State-Level Administrative Changes

Consolidate Behavioral Health Programs

Consistent with the enacted 2011-12 budget, the governor's proposed budget provides the plan for completing the elimination of the Departments of Mental Health (DMH) and Alcohol and Drug Programs (DADP). With the elimination of DMH and DADP, community mental health programs and the remaining non-drug-related Medi-Cal programs will be shifted to other state entities. Under the new arrangement, the Department of Health Care Services will assume responsibility for the administration of various Mental Health Services Act programs, financial oversight of Mental Health Services Act funds, administration of federal Substance Abuse and Mental Health Services Administration discretionary and block grants, and others. The governor's proposed budget outlines a number of other responsibilities that will be shifted to other state entities.¹

Create New Department of State Hospitals

The governor's proposed budget establishes a new Department of State Hospitals (DSH). State

hospitals operated by DSH will provide long-term care and services to individuals with mental illness. The budget includes \$1.3 billion General Fund spending in 2012-13 for support of the new Department.¹

Realignment

The enacted 2011-12 budget moved or “realigned” a range of government services to local jurisdictions, referred to as the “2011 realignment.” This included the realignment of various programs to counties, including Adult Protective Services, mental health services, public safety programs, and others. These services are to be funded through two sources – a state special fund sales tax of 1.0625 percent totaling \$5.1 billion and \$462.1 million in Vehicle License Fees (VLF). The governor’s proposed 2012-13 budget outlines a permanent funding structure for 2011 Realignment for both base and growth funding that seeks to provide local entities with a reliable and stable funding source for these programs.¹

What’s Next In The Budget Process

The governor’s proposed budget requires approval by the Senate and the Assembly. The Legislature will deliberate the governor’s proposed budget through a series of budget subcommittee hearings in each house, from March through May.

In May, the governor will release an updated revenue forecast, referred to as the “May Revision,” which accounts for changes in revenues and proposed changes to the governor’s January budget. Each subcommittee votes on its respective issue area(s) in the budget and submits a report to the full budget committee for a vote. Next, the budget bill is sent to the full membership of the Senate and Assembly for vote. From the floor, each house’s budget bill is referred to a joint budget conference committee where differences between the houses can be resolved. The conference committee votes on the proposed version, which, if passed, is sent to the floor of each house simultaneously.

By law, the Legislature must approve the budget by June 15 in time for the governor to sign it by July 1. The provisions of California’s Proposition 25 lower the vote requirement for approving the budget from two-thirds to a majority (50 percent plus one) of each house of the Legislature, and require a forfeit in pay to Legislators if the budget is not enacted by the June 15 deadline.⁹ Finally, the governor has the authority to “blue pencil” (reduce or eliminate) any appropriation contained in the budget.¹⁰

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