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 $142 billion ($31 billion General Fund and $111 billion other funds) for these programs. Figure HHS-01 displays expenditures for each major program area and Figure HHS-02 displays program caseload.

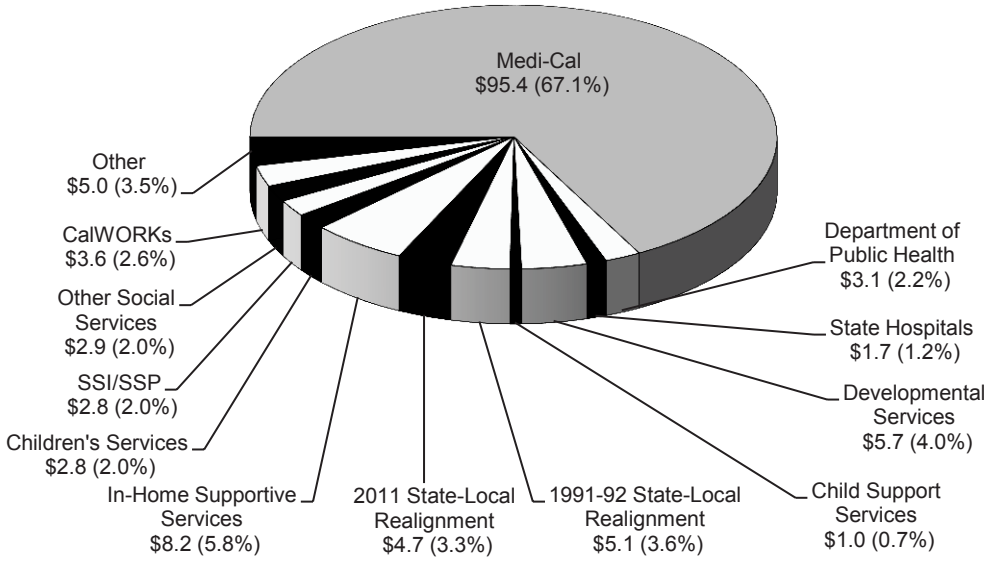
California continues its implementation of federal health care reform, which has enabled millions of Californians to obtain health care coverage. Many Californians now have access to affordable, quality health insurance coverage through Covered California, the new health insurance marketplace. By law, health coverage cannot be dropped or denied because of pre-existing conditions or illness. California also expanded Medi-Cal to cover childless adults and parent/caretaker relatives with incomes up to 138 percent of the federal poverty level, and expanded Medi-Cal mental health and substance use disorder benefits.

Figure HHS-01

Health and Human Services Proposed 2015-16 Funding[1]

All Funds

(Dollars in Billions)



[1] Totals $142.2 billion for support, local assistance, and capital outlay. This figure includes reimbursements of $14.3 billion and excludes $5.1 million in Proposition 98 funding in the Department of Developmental Services budget and county funds that do not flow through the state budget.

Figure HHS-02

Major Health and Human Services Program Caseloads

	2014-15 Revised	2015-16 Estimate	Change
Medi-Cal enrollees	11,972,700	12,221,500	248,800
California Children's Services (CCS) [a]	16,062	16,303	241
CalWORKs	543,557	533,335	-10,222
CalFresh households	1,847,942	2,007,309	159,367
SSI/SSP (support for aged, blind, and disabled)	1,302,668	1,310,977	8,309
Child Welfare Services [b]	136,172	135,669	-503
Foster Care	43,843	43,798	-45
Adoption Assistance	84,647	84,748	101
In-Home Supportive Services	446,053	462,648	16,595
Regional Centers for persons with developmental disabilities	278,593	288,317	9,724
State Hospitals [c]	6,892	6,953	61
Developmental Centers [d]	1,112	1,010	-102
Vocational Rehabilitation	26,736	26,736	0

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

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

c Represents the year-end population. Includes population at Vacaville and Salinas Valley Psychiatric Programs.

d Represents average in-center population.

Federal Actions Cause Increased State Costs and Significant Fiscal Uncertainty

There have been numerous recent federal actions in the health and human services area that have increased state costs or created substantial fiscal uncertainty for California. These actions include:

Increased State Costs

- Recent federal guidance indicates that California's tax on managed care organizations is inconsistent with federal Medicaid regulations and will not be allowed after its expiration in 2016. The tax offsets $1.1 billion in General Fund expenditures in 2015-16. The Administration is proposing a new managed care tax to comply with federal guidelines.

- The Department of Labor issued regulations requiring overtime, travel time between recipients and wait time related to doctor's visits be paid to In-Home Supportive Services workers. These costs total approximately $315 million General Fund in 2015-16. In late December, a federal district court ruled that a portion of the regulations exceeded the Department of Labor's authority and delayed implementation of the regulations. Under state law, the state's implementation of overtime is also delayed pending further action by the federal court.

- The Centers for Medicare and Medicaid Services required states to provide Behavioral Health Treatment as a required Medi-Cal benefit. This benefit is estimated to cost California over $150 million General Fund annually.

Fiscal Uncertainty

- California was assessed a repayment of $50 million by the Administration for Children and Families (ACF) for a noncompliance issue from 2000 to 2001. The penalty was based on a finding that relative caregivers were not subject to the same criminal background checks as non-relative homes. At the time of the audit, the state was substantially in compliance and the state has been in full compliance with the federal rule for many years. The state has appealed this issue and the ACF is considering the appeal.

- The U.S. Department of Agriculture implemented spending targets for state CalFresh administrative expenditures. California's target for federal fiscal year 2015 is approximately $800 million; however, CalFresh expenditures are estimated to exceed this amount based on updated caseload projections. If other states do not spend less than their expenditure targets, or the federal government does not provide additional funding, California would have to backfill the difference with General Fund or reduce funding for the program. These targets create potential state costs of $180 million in 2014-15 and $90 million in 2015-16.

- The federal government, through the state Department of Public Health, has determined that certain housing units at the Sonoma, Porterville and Fairview Developmental Centers are noncompliant with federal licensing and certification requirements and may be decertified, thereby becoming ineligible for federal funding. The state is spending tens of millions in order to maintain eligibility for those funds and come into compliance with federal requirements; however, approximately $95 million in federal funds remains at risk.

- The President announced several executive actions in November intended to allow certain undocumented immigrants to pass a criminal background check and pay taxes in order to temporarily stay in the U.S. without fear of deportation. These individuals may be recognized as having Permanent Residence Under Color of Law status due to their deferred action status, and/or because the federal government does not intend to deport them. This status potentially qualifies individuals for state-funded full-scope Medi-Cal, In-Home Supportive Services, and Cash Assistance Program for Immigrants. At this time, there is a great deal of uncertainty about the scope, timing and effect of these actions. Consequently, the Budget does not assume any higher costs from these individuals, but covering eligible immigrants under these programs could cost hundreds of millions of dollars annually.

The Administration will be working with its federal partners to relieve the fiscal impact on the state from these federal actions.

High-Cost Drugs

Several new Hepatitis C drugs have recently been approved by the Federal Food and Drug Administration that provide a cure for the disease. However, these drugs cost approximately $85,000 per treatment regimen. There are thousands of inmates in state prisons, patients in state hospitals, and participants in Medi-Cal and the AIDS Drug Assistance Program who are infected with Hepatitis C. The Budget reserves $300 million to account for the fiscal impact of these high-cost drugs. The Administration will convene

a workgroup of affected entities, including sheriffs and the Receiver, to address the state's approach regarding high-cost drug utilization policies and payment structures.

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 insurance 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 program, the Primary and Rural Health program, the Targeted Low-Income Children's Program (former Healthy Families Program) and oversees county-operated community mental health and substance use disorder programs.

Since 2012-13, total Medi-Cal benefit costs grew 10 percent annually (approximately $1.5 billion per year) to $81.3 billion in 2014-15 because of a combination of health care cost inflation, program expansions, and caseload growth. Medi-Cal General Fund spending is projected to increase 4.3 percent from $17.8 billion in 2014-15 to $18.6 billion in 2015-16. Growth in Medi-Cal General Fund expenditures has been reduced through the use of other funding sources, including the Managed Care Organization Tax (authorized in 2013-14), the Hospital Quality Assurance Fee (first authorized in 2011-12), intergovernmental transfers, and Medicaid waivers that allow claiming of federal funds for state-only health care costs.

The Budget assumes that caseload will increase approximately 2.1 percent from 2014-15 to 2015-16 (from 11.9 million to 12.2 million), largely because of the continued implementation of federal health care reform. Federal health care reform will increase the program's caseload by an estimated 1 million in 2014-15 and 1.1 million in 2015-16. In the short term, the state will receive 100 percent federal funding for non-disabled childless adults with income up to 138 percent of the federal poverty level (FPL), and parent and caretaker relatives with incomes between 109 and 138 percent of FPL. With these trends, approximately 32 percent of the state's total population will be enrolled in Medi-Cal. Caseload has increased from 7.9 million in 2012-13 to 12.2 million in 2015-16.

The Federal Medical Assistance Percentage (FMAP) determines the level of federal financial support for the Medi-Cal program. The current formula relies on per capita income, which harms California since a relatively few high-wage earners skew the per capita income. California has generally had an FMAP of 50 percent (the minimum percentage authorized under federal law) since the inception of the Medicaid program in 1965. California's percentage is lower than the national average and is lower than those of neighboring states. Oregon, Nevada, and Arizona currently have percentages of 64 percent, 64 percent, and 69 percent, respectively. The state's percentage is also substantially lower than Mississippi's 74-percent FMAP percentage, currently the highest in the country.

The Medi-Cal program cost per case is lower than the national average. According to data from federal fiscal year 2011, California's cost per case of $4,468 was substantially lower than other low FMAP states such as Massachusetts ($8,717) and New York ($8,901). California's projected cost per case is $5,608 in 2015-16.

California is one of 27 states that implemented the optional expansion under federal health care reform, which expanded Medi-Cal eligibility to all parent/caretaker relatives and childless adults under 138 percent of FPL. In addition, California provides coverage for pregnant women up to 213 percent of FPL and for non-working persons with disabilities up to 138 percent of FPL; these two eligibility levels are the 9th highest in the nation.

Significant Adjustments:

- County Medi-Cal Administration—County workers conduct Medi-Cal eligibility work on behalf of the state. Medi-Cal caseload has grown significantly since implementation of the Affordable Care Act, and the system built to automate eligibility work is still not completely functional. As a result, counties require additional resources for administration of the program. The Budget includes an additional $150 million ($48.8 million General Fund) in 2014-15 for these purposes. The Administration will continue to monitor county workload to determine if additional resources are also warranted in 2015-16. In the interim, the Budget continues the increase of $240 million ($78 General Fund) in 2015-16 that counties received the last two years. Once the eligibility system stabilizes, the state will conduct time studies to inform a new Medi-Cal county administration budgeting methodology.

- Skilled Nursing Quality Assurance Fee—Current law authorizes a quality assurance fee on skilled nursing facilities until July 31, 2015 and provided for a 3-percent increase in reimbursement rates in 2013-14 and 2014-15. This fee leverages additional federal funding that offsets General Fund expenditures in these facilities. The Budget assumes continuation of this fee for five years with annual rate increases of 3.62 percent beginning in August 2015.

- Behavioral Health Treatment—In July 2014, the federal government required behavioral health treatment services be covered under Medicaid Early and Periodic Screening, Diagnosis and Treatment requirements for services delivered on or after July 1, 2014. The Budget includes costs of $190 million ($89 million General Fund) in 2014-15 and $320 million ($151 million General Fund) in 2015-16 for behavioral health treatment services for individuals with Autism Spectrum Disorder up to 21 years of age. Chapter 40, Statutes of 2014 (SB 870), requires the Department of Health Care Services to implement behavioral health treatment services, including Applied Behavioral Analysis, to the extent required by the federal government.

- Provider Rates—Chapter 3, Statutes of 2011 (AB 97), reduced most Medi-Cal provider rates by up to 10 percent. The 2014 Budget Act assumed retroactive recoupment of rate reductions for some services in fee-for-service Medi-Cal and prospective savings from rate reductions in fee-for-service and managed care. The 2014 Budget Act also exempted additional providers, including high-cost prescription drugs, specialty physician services, various distinct-part nursing facilities and nonprofit pediatric dental surgery centers. The Budget reflects an estimated $130 million annual General Fund cost for these exemptions.

- Limited Benefit Programs—Several state health programs including the Medi-Cal Access Program, California Children's Services, the Genetically Handicapped Persons Program, and Every Woman Counts currently provide health services that do not qualify as comprehensive coverage. Due to the Affordable Care Act, individuals can receive comprehensive health coverage that typically covers the services provided in these non-comprehensive programs. Consistent with a policy of encouraging comprehensive coverage, the Budget proposes to require individuals in these programs to seek comprehensive coverage offered through Covered California or Medi-Cal in order to maintain eligibility for these programs.

- Annual Open Enrollment—The Budget proposes to institute an annual 90-day time period when certain non-disabled Medi-Cal beneficiaries enrolled in managed care plans can change their health plan, similar to the Covered California open enrollment period. This proposal supports continuity of care and enables increased

care management and does not impact the ability of individuals to apply for and be enrolled in Medi-Cal coverage at any time throughout the year. This change results in General Fund savings of $1.6 million in 2015-16.

- Pediatric Palliative Care—Beginning in 2006, DHCS developed a statutorily required pediatric palliative care pilot project intended to improve the quality of life for children with life-threatening illnesses. The 11-county pilot minimizes hospitalization by allowing access to in-home palliative care. The pilot has proven successful and the Budget proposes to expand it to seven additional counties, resulting in net General Fund savings of $1.4 million in 2015-16.

Coordinated Care Initiative

Under the Coordinated Care Initiative (CCI), persons eligible for both Medicare and Medi-Cal (dual eligibles) receive medical, behavioral health, long-term supports and services, and home and community-based services coordinated through a single health plan. These changes are being pursued through a federal demonstration project known as Cal MediConnect. The CCI is also enrolling all dual eligibles in managed care plans for their Medi-Cal benefits and integrating long-term services and supports for Medi-Cal-only beneficiaries. The CCI was intended to operate in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The following changes have occurred since enactment of the 2012 Budget Act and the creation of the program:

- More than 100,000 participants were exempted, including Medicare Special Needs Plans and certain categories of Medi-Cal beneficiaries based on age or health condition.

- Passive enrollment was delayed until 2014, and Alameda County will no longer participate in the demonstration due to concerns regarding one of the health plan's readiness. Six counties have begun passive enrollment and the seventh, Orange County, will begin in July 2015.

- Medicare and Medicaid savings were intended to be shared 50-50 with the federal government; however, the federal government reduced the amount of savings California was allowed to retain to approximately 25 to 30 percent.

- To help pay for implementation, the federal government allowed a 4-percent tax on managed care organizations through June 30, 2016 which is attributable to the state's participation in the demonstration. However, recent guidance from the federal

government indicates the tax is inconsistent with federal Medicaid regulations and will not be allowed to continue.

- As of November 1, 2014, approximately 69 percent of eligible participants have opted out of the demonstration compared to initial projections of approximately 33 percent. That percentage is around 80 percent for In-Home Supportive Services (IHSS) beneficiaries, and participation varies widely by county.
- Due to revised federal Fair Labor Standards Act regulations, IHSS providers are entitled to overtime compensation. Because the CCI established a Maintenance-of-Effort funding formula for the IHSS program, the state's IHSS costs have significantly increased due to the CCI. This arrangement changed the fiscal exposure for counties from a share of non-federal costs to a cost cap based on 2011-12 expenditure levels plus annual growth of 3.5 percent. The cost cap applies to all 58 counties, not just the seven counties implementing CCI. This funding change, together with the federal government's change in overtime regulations, has significantly increased the state's costs.

Under current law, the Director of Finance is required to annually send to the Legislature a determination of whether the CCI is cost-effective. If the CCI is not cost-effective, the program would automatically cease operation. Although the Budget projects net General Fund savings for the CCI of $176.1 million in 2015-16, these savings are primarily from the tax on managed care organizations. Without the tax revenue, the CCI would have a General Fund cost of $396.8 million in 2015-16. The most recent analysis also shows that the initiative could result in net costs to the state in 2016-17 and beyond due to the factors outlined above. If these factors are not improved by January 2016, the CCI would cease operating effective January 2017.

The Administration remains committed to implementing the CCI to the extent it can continue to generate program savings. Over the course of the next year, the Administration will seek ways to improve participation, extend an allowable managed care tax, and lower state costs.

Managed Care Organization Tax

Chapter 33, Statutes of 2013 (SB 78), authorized a tax on the operating revenue of Medi-Cal managed care plans based on the state sales tax rate. Nearly half of this revenue is used for the non-federal share of supplemental payments to Medi-Cal managed care plans. The remainder of the revenue is used to fund increased capitation rates for Medi-Cal managed care plans that would otherwise be paid by the General Fund,

which offsets General Fund spending in the Medi-Cal program. The Budget includes a General Fund offset from the tax of $803 million in 2014-15 and $1.1 billion in 2015-16.

The federal government recently released guidance indicating that this tax is likely impermissible under federal Medicaid regulations because it only applies narrowly to Medi-Cal managed care plans. The current form of the tax, therefore, could not be extended.

The Administration is proposing a new managed care tax that complies with federal law. The new revenue will offset the same amount of General Fund expenditures as the current tax, as well as fund a restoration of the 7-percent across-the-board reduction to authorized IHSS hours of service. The restoration of hours is consistent with a settlement of various IHSS cases to seek a non-General Fund source of funding for these hours. The Administration will be pursuing this new managed care tax early in 2015.

Medi-Cal 1115 Waiver Renewal

California's current Medi-Cal 1115 Waiver, "Bridge to Reform", which has been fundamental to the successful implementation of the Affordable Care Act (ACA), expires in October 2015. DHCS will seek a five-year renewal of the waiver to continue to support ACA implementation, drive significant delivery system transformation, and provide for the long-term fiscal stability of the Medi-Cal program. The main objectives of the new waiver are to:

- Strengthen primary care delivery and access.
- Avoid unnecessary institutionalization and services.
- Use the Medi-Cal program to test innovative approaches to care.

These objectives are consistent with the goals of higher quality, improved health outcomes, and lower costs. DHCS is undertaking a stakeholder process to discuss several core areas targeted in the waiver renewal process, including delivery system transformation and other provider or plan incentives, safety net funding reform, workforce development, housing and supportive services for targeted populations, and shared savings with the federal government. The Budget assumes continuation of the funding available in the Bridge to Reform Waiver for designated public hospital systems; however, updates to those assumptions will occur as part of the May Revision after DHCS formally submits the waiver renewal to the federal government.

Health Care Reform Implementation

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

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

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

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

With these reforms, an estimated 3.3 million additional people will enroll in Medi-Cal and 2 million people will enroll in Covered California by the end of 2015-16. Covered California has received over $1 billion in start-up funding from the federal government, with the vast majority of the funds paying for staff, information technology systems, and marketing. Under state law, it must be self-sustaining by January 1, 2015, and will assess fees on its 10 qualified health plans to fund its operating budget.

The Budget assumes net costs of $2 billion ($943.2 million General Fund) in 2015-16 to provide for the mandatory Medi-Cal expansion. California will split these costs with the federal government. Additionally, the federal government has committed to pay 100 percent of the cost of the new adult group optional expansion for the first three years; by 2020-21, the federal share will have decreased to 90 percent and the state will pay 10 percent. The Budget assumes net costs of $14.3 billion in 2015-16 for the optional Medi-Cal expansion.

1991-92 State-Local Realignment Health Account Redirection

Under the ACA, county costs and responsibilities for indigent health care are expected to decrease as more individuals gain access to health care coverage. The state-based Medi-Cal expansion will result in indigent care costs previously paid by counties shifting to the state.

Chapter 24, Statutes of 2013 (AB 85), modifies 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect savings counties will experience from the implementation of federal health care reform effective January 1, 2014. County savings are estimated to be $724.9 million in 2014-15 and $698.2 million in 2015-16, and these savings will be redirected to counties for CalWORKs expenditures. This redirection mechanism frees up General Fund resources to pay for rising Medi-Cal costs. The estimates for 2015-16 will be updated in the May Revision using updated data from the counties.

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

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

Based on current revenue estimates, the Child Poverty and Family Supplemental Support Subaccount is projected to receive $170.3 million in base and growth funds in 2014-15, plus an additional $67.1 million in carryover funding from the prior fiscal year. Of the total amount available ($237.4 million), $214.1 million will be used to fund the 5-percent

increase to CalWORKs grant levels that took effect on March 1, 2014 and the additional 5-percent grant increase scheduled to become effective April 1, 2015. The remaining $23.3 million will be carried over to 2015-16 to help fund the full-year costs of both grant increases, estimated to be $340.5 million. Including the carryover funding, total deposits to the Child Poverty and Family Supplemental Support Subaccount in 2015-16 are projected to be $267.2 million. The Budget includes $73.3 million General Fund to provide the remaining funding needed for the full-year costs of the grant increases.

Mental Health and Substance Use Disorder Services

California expanded the mental health and substance use disorder benefits available to those eligible for Medi-Cal. The Budget continues to reflect the costs of the expansion of benefits.

DHCS is seeking a waiver from the federal Centers for Medicare and Medicaid Services to provide better coordination of care and a continuum of care for substance use disorder treatment services, including residential treatment services which would be unavailable for most beneficiaries absent a waiver. The waiver will allow state and county officials more authority to select quality providers to provide substance abuse treatment, assessments, and case management.

Due to concerns about program integrity in the Drug Medi-Cal program, DHCS took steps to eliminate fraud and abuse in the program, including temporarily suspending the certification of hundreds of facilities providing drug treatment inconsistent with program goals, and referring many drug treatment providers to the Department of Justice for potential criminal prosecution. DHCS is still in the process of statewide recertification of active providers, and plans on completing those efforts by November 2015. The Budget extends the 21 positions and $2.2 million ($1.1 million General Fund) provided in the 2014 Budget Act to continue the current recertification efforts and implement on-site monitoring of provider operations to further fraud prevention efforts.

2011 Realignment Funding

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

2011 Realignment is funded through two sources: a state special fund sales tax of 1.0625 cents totaling $6.6 billion and $546 million in Vehicle License Fees. These funds are deposited into the Local Revenue Fund 2011 for allocation to the counties and are constitutionally guaranteed for the purposes of 2011 Realignment. Figure HHS-03 identifies the programs and funding for 2011 Realignment.

Figure HHS-03

2011 Realignment Estimate[1] - at 2015-16 Governor's Budget

	2013-14	2013-14 Growth	2014-15	2014-15 Growth	2015-16	2015-16 Growth
Law Enforcement Services	**$2,124.3**		**$2,078.3**		**$2,248.4**	
Trial Court Security Subaccount	508.0	9.8	518.1	17.0	535.1	15.2
Enhancing Law Enforcement Activities Subaccount[2]	489.9	24.6	489.9	36.2	489.9	56.2
Community Corrections Subaccount[3]	998.9	73.1	934.1	127.7	1,061.7	113.7
District Attorney and Public Defender Subaccount[3]	17.1	4.9	15.8	8.5	24.3	7.6
Juvenile Justice Subaccount	110.4	9.8	120.4	17.0	137.4	15.2
Youthful Offender Block Grant Special Account	*(104.3)*	*(9.3)*	*(113.8)*	*(16.1)*	*(129.9)*	*(14.4)*
Juvenile Reentry Grant Special Account	*(6.1)*	*(0.5)*	*(6.6)*	*(0.9)*	*(7.6)*	*(0.8)*
Growth, Law Enforcement Services	**122.2**	**122.2**	**206.4**	**206.4**	**207.9**	**207.9**
Mental Health[4]	**1,120.6**	9.1	**1,120.6**	15.8	**1,120.6**	14.1
Support Services	**2,829.4**		**3,022.0**		**3,322.3**	
Protective Services Subaccount	1,837.0	112.0	1,970.7	153.5	2,124.2	126.8
Behavioral Health Subaccount[5]	992.4	60.0	1,051.3	146.7	1,198.1	140.9
Women and Children's Residential Treatment Services	*(5.1)*	-	*(5.1)*	-	*(5.1)*	-
Growth, Support Services	**181.1**	**181.1**	**316.0**	**316.0**	**281.8**	**281.8**
Account Total and Growth	**$6,377.6**		**$6,743.3**		**$7,181.0**	
Revenue						
1.0625% Sales Tax	5,863.1		6,217.2		6,634.9	
Motor Vehicle License Fee	514.5		526.1		546.1	
Revenue Total	**$6,377.6**		**$6,743.3**		**$7,181.0**	

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] Dollars in millions.

[2] Allocation is capped at $489.9 million. Growth will not add to subsequent fiscal year's subaccount base allocations.

[3] 2013-14 and 2014-15 growth is not added to subsequent fiscal year's subaccount base allocations.

[4] Growth does not add to base.

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

The Administration, in consultation with county partners and stakeholders, is continuing to develop an allocation for funds in the 2011 Realignment Behavioral Health Services Growth Special Account. From 2013-14 revenues, the Account has $60.0 million. The first priority for growth funds is federal entitlement programs: Medi-Cal Specialty Mental Health, including those required by Early Periodic Screening, Diagnosis, and Treatment, and Drug Medi-Cal.

Existing law also requires DHCS, in collaboration with stakeholders, to create a Performance Outcomes System to track outcomes of Medi-Cal Specialty Mental Health Services for children and youth. DHCS continues to work with stakeholders to identify key components of the system and finalize the outcome measures that will be prioritized for data collection.

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 $3.1 billion ($124.4 million General Fund) in 2015-16 for the Department.

Significant Adjustment:

- Licensing and Certification—To meet mandated state and federal licensing and certification workload and implement quality improvement projects within the Licensing and Certification Program, the Budget includes an additional $21.8 million in special funds and 237 positions for 2015-16. In addition, the Budget includes $9.5 million in special funds to augment the Los Angeles County contract to allow the County to complete high-priority federal and state workload as well as $378,000 in special funds and three state positions to provide on-site oversight, training, and quality improvement activities in Los Angeles County.

Department of State Hospitals

The Department of State Hospitals (DSH) administers the state mental health hospital system, the Forensic Conditional Release Program, the Sex Offender Commitment Program, and the evaluation and treatment of judicially and civilly committed patients. The Budget includes $1.7 billion ($1.6 billion General Fund) in 2015-16 for support of DSH. The patient population is projected to reach a total of 6,953 in 2015-16.

Significant Adjustment:

- Not Guilty by Reason of Insanity Involuntary Medication Authorization—The Budget includes $3.2 million General Fund and 14.4 limited-term positions to support a new involuntary medication authorization process for the Not Guilty by Reason of Insanity commitments in the state hospitals. In response to a recent court decision (*Greenshields*), the Department proposes to use the same process for these patients as the Department uses for Mentally Disordered Offender and Sexually Violent Predator involuntary medication orders.

Incompetent to Stand Trial Waitlist

The incompetent to stand trial (IST) waitlist continues to increase despite DSH adding 196 IST beds systemwide since 2013 and implementing several measures to more efficiently place and move patients within the system. In addition, based on the success of the Restoration of Competency program in San Bernardino County, DSH is working to expand the Restoration of Competency program by 55 beds as directed in the 2014 Budget Act. Despite these efforts, DSH currently has over 400 IST patients waiting to be admitted, up from approximately 150 in 2012. The waitlist for admissions into the Department of Developmental Services' Secure Treatment Program in Porterville is also growing—the current waitlist is approximately 59 consumers, some of whom have been waiting close to a year.

DSH and the Department of Developmental Services continue to ascertain why the number of referrals is increasing. In the meantime, both departments have received increased pressure from the judicial system on the admissions of IST defendants. These pressures have resulted in a multitude of court orders, ongoing litigation, and the potential for being ordered to pay for the costs of housing defendants in jail, as well as being ordered to increase capacity.

In addition to adding capacity in the state system, DSH is also exploring options to increase capacity through partnerships with local governments and the private sector. These options include:

- Collaborating with counties to establish contract-based treatment programs located within secure county or private facilities.
- Releasing a Request for Information to community-based mental health treatment providers/facilities in response to Chapter 734, Statutes of 2014 (AB 2190), which

allowed for IST commitments to be placed in the community for treatment before the previous 180-day prohibition.

In recognition of the need to mitigate the waitlist issue, the Department also has the following proposals in the Budget that make use of existing facility space. (Also see the Department of Developmental Services section for an additional related proposal.)

Significant Adjustments:

- Activate Atascadero beds—The Budget includes $8.6 million General Fund and 75.1 positions to activate an additional 55 beds at Atascadero State Hospital.
- Activate Coalinga beds—The Budget contains $8.7 million General Fund and 74.6 positions in the budget year to activate 50 beds at Coalinga State Hospital to treat *Coleman* patients (currently treated at Atascadero), and use the vacated beds at Atascadero for IST commitments.
- Expand Secure Treatment Area at Metropolitan State Hospital—The Budget proposes $1.9 million General Fund for plans to increase the secure bed capacity at Metropolitan State Hospital. Total project costs are approximately $32 million, while ongoing staffing costs are estimated to be $48 million. The project will add approximately 200 new IST treatment beds and 32 skilled nursing facility beds, and IST defendants would have priority placement in the new bed capacity.

Department of Developmental Services

The Department of Developmental Services (DDS) provides consumers with developmental disabilities a variety of services and supports that allow them to live and work independently or in supported environments. California is the only state providing developmental services as an individual entitlement. DDS serves approximately 288,000 individuals with developmental disabilities in the community and 1,100 individuals in state-operated developmental centers (DCs). For 2015-16, the Budget includes $5.7 billion ($3.3 billion General Fund) for support of the Department.

Significant Adjustments:

- Porterville Incompetent to Stand Trial Bed Expansion—The Budget proposes $9 million General Fund and 92.3 positions in 2014-15 and $18.1 million General Fund and 184.5 positions in 2015-16 to increase the Porterville Secure Treatment Program by 32 beds by the end of 2014-15. The new beds are needed to accommodate the

increasing number of clients who need to be restored to competency in order to stand trial.

- Certification Issues—The Budget includes $21.4 million ($11.6 million General Fund) and 179.5 positions for costs related to the ongoing implementation of Program Improvement Plans at the Sonoma, Fairview, and Porterville Developmental Centers. The federal government, through the state Department of Public Health, has determined that certain units at the Sonoma Developmental Center are noncompliant with federal licensing and certification requirements and should be decertified, thereby becoming ineligible for federal funding. This ruling is being appealed, but if the appeal is not successful the state will have to backfill approximately $33 million in lost federal funds in 2014-15, growing to $43 million in 2015-16. In addition, the Porterville and Fairview Developmental Centers are implementing federally required Program Improvement Plans to maintain annual eligibility for approximately $50 million in federal funds.

Department of Social Services

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

The Budget includes $20.3 billion ($7.2 billion General Fund) for DSS, an increase of $244.7 million General Fund from the revised 2014-15 budget, primarily due to an increase in IHSS expenditures.

Significant Adjustments:

- Community Care Licensing—Following last year's actions to improve the underlying structure of the Community Care Licensing program, the Budget includes $3 million General Fund and 28.5 positions to address a backlog of complaint cases and expand training and technical assistance. Beginning in January 2017, DSS will begin increasing inspection frequency to every three years for all facilities, every two years by 2018 for all facility types except child care, and annually by 2019 for adult day care and residential care facilities for the elderly. Ongoing staffing costs would be approximately $14 million.

- Interagency Child Abuse and Neglect (ICAN) Investigation Reports Grants—The Budget includes $4 million General Fund to support an optional grant program for counties to report instances of suspected child abuse or neglect to local law enforcement agencies. For additional information on ICAN, see the Local Government Chapter.
- State Utility Assistance Subsidy—The Budget includes $9.2 million General Fund to provide a state-funded energy assistance subsidy for CalFresh recipients to comply with federal changes regarding the minimum energy assistance benefit that must be received by a household in order to access the standard utility allowance. This program increases household monthly food payments by an average of $62 for over 320,000 families.

Continuum of Care Reform

The Budget includes $9.6 million ($7 million General Fund) to begin implementing the Continuum of Care Reform. This reform effort builds upon past collaborative system improvements, including the development of preventive services to help keep children safely in their homes, kinship guardian programs to help increase long-term family care for children, extended foster care supports through age 20, and wraparound and increased mental health services to help support successful reunifications.

In 2012, in response to a desire to reduce the number of foster youth residing in congregate care for extended periods of time, the Legislature directed DSS to develop a report identifying recommendations to improve the foster care system. This report is being released concurrently with the Governor's Budget. The report contains 19 interdependent recommendations, two of which require action in the budget year: increasing the availability of home-based family care through recruitment and retention efforts, and bolstering the social worker capacity of foster family agencies to provide services in home-based family care placements. Implementation will require a multi-year effort with continuing consultation with policymakers, counties, youth and practitioners.

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 billion (state, local, and federal funds) in 2015-16. The amount budgeted includes $5.8 billion for CalWORKs program expenditures and $1.2 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, California Community Colleges child care and education services, and the Department of Child Support Services.

Average monthly CalWORKs caseload is estimated to be about 529,000 families in 2015-16, a 0.6-percent decrease from the 2014 Budget Act projection.

Significant Adjustments:

- Maximum Aid Payment Levels—The 2014 Budget Act increases Maximum Aid Payment levels by 5 percent, effective April 1, 2015. This increase, combined with the prior 5-percent increase in 2014 is estimated to cost approximately $340.5 million in 2015-16. The increase will be funded by 1991-92 Realignment growth funds deposited in the Child Poverty and Family Supplemental Support Subaccount (see the Health Care Reform Implementation section within Department of Health Care Services), as well as a $73.3 million General Fund augmentation. Subsequent grant increases will be based on analysis of revenue and caseload estimates in future years.

In-Home Supportive Services

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

The Budget includes $8.2 billion ($2.5 billion General Fund) for the IHSS program in 2015-16, a 14.4-percent increase over the revised 2014-15 level. Average monthly caseload in this program is estimated to be 463,000 recipients in 2015-16, a 0.3-percent decrease from the 2014 Budget Act projection.

Implementation of the U.S. Department of Labor regulations that require overtime pay for domestic workers effective January 1, 2015, is estimated to cost $403.5 million

($182.6 million General Fund) in 2014-15 and $707.6 million ($314.3 million General Fund) annually thereafter. Chapters 29 and 488, Statutes of 2014 (SB 855 and SB 873), limit providers to a 66-hour workweek, less the current 7-percent reduction in service hours (or a 61-hour workweek). IHSS providers who work for multiple recipients will be paid for their travel time between recipients, up to 7 hours per week. In late December 2014, a federal district court ruled that a portion of the regulations exceeded the Department of Labor's authority and delayed the implementation of the regulations. Under state law, the state's implementation of overtime is also delayed pending further action by the federal court.

The Budget proposes to restore the current 7-percent across-the-board reduction in service hours with proceeds from the new tax on managed care organizations effective July 1, 2015. The cost to restore the 7-percent reduction is estimated to be $483.1 million in 2015-16. For additional information on the tax, refer to the Department of Health Care Services section.

Supplemental Security Income/State Supplementary Payment

The federal SSI program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. In California, the SSI payment is augmented with an SSP grant. These cash grants assist recipients with basic needs and living expenses. The federal Social Security Administration (SSA) administers the SSI/SSP program, making eligibility determinations, grant computations, 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 $2.8 billion General Fund for the SSI/SSP program. This represents a 1-percent increase ($29 million) over the revised 2014-15 budget. The average monthly caseload in this program is estimated to be 1.3 million recipients in 2015-16, a slight increase over the 2014-15 projected level. The SSI/SSP caseload consists of 71-percent disabled persons, 27-percent aged, and 2-percent blind.

Effective January 2015, maximum SSI/SSP grant levels are $881 per month for individuals and $1,483 per month for couples. SSA applies an annual cost-of-living adjustment to the SSI portion of the grant equivalent to the year-over-year increase in the Consumer Price Index (CPI). The current CPI growth factors are 1.7 percent for 2015 and a projected 1.5 percent for 2016. Maximum SSI/SSP monthly grant levels will

increase by $11 and $16 for individuals and couples, respectively, effective January 2016. CAPI benefits are equivalent to SSI/SSP benefits, less $10 per month for individuals and $20 per month for couples.