



Health and Human Services Policy Committee
Wednesday, March 9, 2016 — 10:00 a.m. – 11:00 a.m.
CSAC 1st Floor Peterson/Wall Conference Room
1100 K Street, Suite 101, Sacramento, CA 95814
Call-in: 1-800-867-2581; Passcode 7500559#

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

- 10:00 a.m. I. **Welcome and Introductions**
Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair
- 10:05 a.m. II. **Tobacco Legislation: ABX2 7, ABX2 9, ABX2 10, and ABX2 11**
ACTION ITEM
Farah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 10:20 a.m. III. **MCO Fix Update**
Farah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 10:30 a.m. IV. **Budget Update**
Farah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 10:45 a.m. V. **Homelessness Issues Update**
Farah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 11:00 a.m. VI. **Closing Comments and Adjournment**
Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

If calling in to the meeting, please place your line on MUTE. Please also DO NOT PLACE THE LINE ON HOLD. Thank you.



March 7, 2016

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500

Facsimile
916.441.5507

To: Members of the Health and Human Services Policy Committee

From: Farrah McDaid Ting, Legislative Representative
Elizabeth Marsolais, Legislative Analyst

RE: **Health Special Session Heats Up: First MCO, Now Tobacco**
-- ACTION ITEM

After a rare Leap Day show of bipartisanship on the MCO fix, Democrats and Republicans retreated to their separate camps last Thursday with a heated Assembly floor debate on a raft of anti-tobacco measures.

The Assembly ultimately passed six tobacco measures on to the Senate during the special session. Republicans vehemently opposed taking up the measures on the floor, insisting that they were not germane to the Second Extraordinary Session on Health Care. However, each bill garnered the majority vote needed and Assembly leadership then promptly adjourned the second special session.

CSAC has already taken a support position on SBX2 5 and SBX2 7:

- **SBX2 5 (Leno): CSAC Support** -- Adds e-cigarettes/vaping products to the existing definition of tobacco products.
- **SBX2 7 (Hernandez): CSAC Support** -- Increase age of sale for tobacco products from 18 years of age to 21.

The CSAC Policy Committee also considered several of the bills now in the Senate policy committee process. Policy Committee Chair Yeager asked that the committee members again review these four pieces of tobacco-related legislation as they again move through the legislative process.

For reference, the relevant CSAC policy is excerpted below:

CSAC Platform 2015-16

Chapter Six: Health Services

A. Public Health

"The county public health departments and agencies are the only health agencies with direct day-to-day responsibility for protecting the health of every person within each county. The average person does not have the means to protect him or herself against contagious and infectious diseases. Government must assume the role of health protection against contagious and infectious diseases. It must also provide services to prevent disease and disability and encourage the community to do likewise...Furthermore, counties play an integral role in chronic disease prevention through policy, system and environmental changes promoting healthier communities."

The Health and Human Services Policy Committee will review and vote on the following bills:

ABX2 10 (Bloom) -- Allows a county to impose a local tobacco tax.

Current Position: No Position

Recommended Position: Support

ABX2 10, by Assembly Member Bloom, would authorize, on and after January 1, 2017, the board of supervisors of a county or city and county to impose a tax on the privilege of distributing cigarettes and tobacco products in the county or city and county, including within an incorporated city. This bill would define "distributing" to mean making a sale of cigarettes or tobacco products in a county or city and county that has not been taxed by a cigarette or tobacco products tax ordinance of that county or city and county.

This bill would authorize the board of supervisors of a county or city and county to enter into an agreement with another county or city and county to share any startup and ongoing administrative costs of a tax imposed pursuant to that authorization. This bill also would authorize the board of supervisors of a county or city and county to contract with the State Board of Equalization to perform functions incident to the administration or operation of the cigarette and tobacco products tax ordinance of the county, with reimbursement for costs incurred, and would require the State Board of Equalization to perform those functions pursuant to that contract.

ABX2 9 (Thurmond) -- Prohibits tobacco products from school campuses.

Current Position: No Position

Recommended Position: Support

ABX2 9, by Assembly Member Tony Thurmond, would close some school tobacco regulation loopholes. The bill expands eligibility for Tobacco Use Prevention and Education (TUPE) program funding (Proposition 99) to charter schools and requires all schools to enforce a tobacco-free campus policy prohibiting the use of products containing tobacco and nicotine; prominently display "Tobacco use is prohibited" signs at all entrances to school property; and provide information about smoking cessation support programs to students and staff.

If SBX2 5 is signed into law, the provisions of ABX2 9 would also apply to vaping/e-cigarette products.

ABX2 7 (Stone) — Closes loopholes in smoke-free workplace laws, including hotel lobbies, small businesses, and break rooms.

Current Position: No Position

Recommended Position: Support

ABX2 7, by Assembly Member Mark Stone, would extend the workplace smoking prohibition to include owner-operated businesses in which the owner-operator is the only worker, expands the definition of "enclosed space" where smoking is prohibited to include covered parking lots, and reduces from 65% to 20% the amount of guestroom accommodations in a hotel, motel, or similar transient lodging establishment in which smoking is allowed.

ABX2 11 (Nazarian) -- Establishes an annual Board of Equalization tobacco licensing fee program, similar to how alcohol is licensed.

Current Position: No Position

Recommended Position: Support

ABX2 11, by Assembly Member Adrin Nazerian, would increase the retailer license fee of \$100 per location to \$265 per location and imposes a \$265 fee for the annual renewal of a tobacco retailer license. Also increases the annual distributor and wholesaler licensing fee from \$1,000 to \$1,200. Lastly, the bill requires the Board of Equalization to report back to the Legislature no later than January 1, 2019, regarding the adequacy of funding for the Cigarette and Tobacco Products Licensing Act of 2003.

Process: At the time of this writing, the Senate Public Health and Developmental Services Committee passed all four of the bills below to the Senate Appropriations Committee. These actions are occurring in the second extraordinary session on health care.

Should the CSAC Health and Human Services Policy Committee change the current position on any of the above bills, CSAC staff will generate letters reflecting the new position and lobby on the issue as needed.

Attachments:

CSAC Senate Floor Alert SBX2 5 (Leno) (March 4, 2016)

CSAC Senate Floor Alert SBX2 7 (Hernandez) (March 4, 2016)

CSAC Staff Contacts:

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110

Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

March 4, 2016

SENATE FLOOR ALERT

SB X2 5 (Leno) – Electronic Cigarettes Senate Concurrence in Assembly Amendments

The California State Association of Counties (CSAC) is pleased to SUPPORT SBX2 5, by Senator Mark Leno, which would: 1) add electronic cigarettes to the Stop Tobacco Access to Kids Enforcement (STAKE) Act; 2) make it illegal to furnish such products to minors; 3) include the STAKE Act definition for purposes of licensing and enforcement; 4) require cartridges for electronic cigarettes and solutions to be in child proof packaging; and 5) include electronic cigarettes in location restrictions for smoking cigarettes and other tobacco products.

SBX2 5 addresses the growing concern surrounding the increased use of electronic cigarettes by youth. According to the 2011-12 National Youth Tobacco Survey, adolescents who used electronic cigarettes were more likely to become established smokers and less likely to quit. Meanwhile, the Monitoring the Future study found that e-cigarette use was double that of traditional cigarette use among 8th and 10th graders; and among 12th graders, 17.1 percent used electronic cigarettes while 13.6 percent used traditional cigarettes.

Additionally, SBX2 5 also seeks to prevent poisonings by requiring child proof packaging. According to the Department of public Health's State Health Officer Report, electronic cigarette poisonings increased from 7 in 2012 to 154 in 2014; whereas 60 percent of all electronic cigarette poisoning victims were reported to be young children.

SBX2 5 seeks to keep electronic cigarettes and tobacco products in general out of the hands of minors. It is for these reasons that CSAC supports SBX2 5 and respectfully asks for your "Aye" vote on this measure. Should you have any questions about our position, please do not hesitate to contact me at 650-81110, or fmcdaid@counties.org. Thank you.

cc: Honorable Members, California State Senate
The Honorable Mark Leno, Member, California State Senate
Marjorie Swartz, Consultant, Senate Pro Tempore De León's Office
Joe Parra, Consultant, Senate Republican Caucus

March 4, 2016

SENATE FLOOR ALERT

SB X2 7 (Hernandez) – Tobacco Products: Minimum Legal Age Senate Concurrence in Assembly Amendments

The California State Association of Counties (CSAC) is pleased to SUPPORT SBX2 7, by Senator Ed Hernandez, which would raise the minimum age for access to tobacco products from 18 to 21.

SBX2 7 recognizes that many 18-year-olds still have social networks that include younger peers since this age group often still attends high school. These older peers are able to buy and supply tobacco products to their minor friends. However, by raising the minimum age to age 21, the likelihood of mixed-age minors being in the same social networks decreases, which would likely decrease the chances of the initiation age occurring before the age of 18.

California has a rich history of tobacco control, which has helped to reduce the rates of smoking and smoking--related diseases, as well as the costs of both. Because the negative effects of smoking are a well-known and costly burden to society, it is necessary to restrict young adult access to tobacco products.

Raising the minimum age to 21 would likely lead to substantial reductions in smoking prevalence among youth and reduce tobacco-related diseases. It is for these reasons that CSAC supports SBX2 7 and respectfully requests your "Aye" vote on this measure. Should you have any questions about our position, please do not hesitate to contact me at 650-8110, or fmcdaid@counties.org. Thank you.

cc: Honorable Members, California State Senate
The Honorable Ed Hernandez, Member, California State Senate
Marjorie Swartz, Consultant, Senate Pro Tempore De León's Office
Joe Parra, Consultant, Senate Republican Caucus



March 7, 2016

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500

Facsimile
916.441.5507

To: Members of the Health and Human Services Policy Committee
From: Farrah McDaid Ting, Legislative Representative
Elizabeth Marsolais, Legislative Analyst

RE: **Governor Signs MCO Fix Into Law**

Governor Brown, after more than a year of effort, signed a new Managed Care Organization (MCO) fix package into law on March 1, 2016.

MCO Fix. CSAC supported the main piece of the package—the MCO fix as outlined in SBX2 2 (Hernandez-Bonta). The tiered tax proposal is the product of months of negotiation between the Brown Administration, health plans—including local and county-run health plans—and the Legislature. It restructures the MCO tax in a way that meets federal standards. It raises between \$1.3 and \$1.7 billion annually, and will be in effect for three years, until 2019.

SBX2 2 requires all health plans to contribute funds that the state would use to draw down federal funding to create at least \$1.3 billion for Medi-Cal related services. Federal law requires the participation of all plans, which is also the reason the current MCO tax had to be scrapped, since it applied only to plans offering Medi-Cal services. In return for their participation, private health plans will receive discounts on their Gross Premium and Corporate Taxes. All plans, including local plans, are eligible for supplemental payments from the federal funds the state draws down with MCO dollars.

The new MCO structure has three tiers based on enrollment size in the base year (October 1, 2014 through September 30, 2015) and the amount of tax a plan will pay is pegged to the enrollment tiers outlined in the bill. This means that the amount that each individual plan pays will remain static for the three-year duration of the tax. This method provides certainty for both plans (costs) and the state (revenues). The bill also establishes the Health and Human Services Fund in the State Treasury and requires all MCO revenues to be deposited into that fund, and authorizes continuous appropriations from that fund for Medi-Cal related services.

Funding for Developmental Services. The second piece of the MCO fix package is ABX2 1 (Thurmond-Beall), which provides a \$300 million investment in the community-based developmental services system. It also forgives retroactive payments for rural and critical access skilled nursing facilities that are associated with general acute care hospitals.

Developmental services providers will see a 5 percent increase in rates under ABX2 1 and the state will complete a rate study to further address historically low reimbursement rates for these providers. CSAC has not taken a position on ABX2 1, since the developmental services system is operated by the state, but the Association has strongly supported relieving rural and critical access skilled nursing facilities of a budget cut that would have required them to repay payments made before 2009. Requiring these small facilities to make those payments would have jeopardized their continued operation in areas where this type of care is already rare.

Budget Piece. The third part of the package is outside of the Special Extraordinary Session on Health Care, and is instead part of the budget: AB 133. It contains four provisions requested by Republican

members of the Legislature as part of the MCO fix deal. AB 133 appropriates nearly \$520 million for the following:

- \$173 million for specified local Traffic Congestion Relief projects (\$148 million); trade corridor improvements (\$11 million); Transit and Intercity Rail Capital Program (\$9 million); and the State Highway Operations and Protection Program (\$5 million).
- \$105 million to support fire recovery and debris removal for Lake and Calaveras Counties.
- \$240 million to prefund health and dental benefit liabilities for state retirees.
- \$1.85 million to the University of California for the San Joaquin Valley Program in Medical Education (SJV PRIME) program, which provides training to medical students within San Joaquin valley clinics.

Each of these provisions was included in the Governor's January Budget proposal, and is now law.

County Impacts. Counties were key stakeholders in the MCO fix conversation and are affected in several key ways.

On a statewide level, the existing MCO tax provides implementation funding for the Coordinated Care Initiative (CCI) pilot program in seven counties. Counties strongly support the CCI to ensure better care coordination for high-risk, high-cost residents who are dually eligible for both Medicare and Medicaid. The CCI is also tied in an important way to the counties' role in the In-Home Supportive Services (IHSS) program, as the continuation of the CCI is required to preserve the county IHSS Maintenance of Effort (MOE) under 1991 Realignment. The IHSS MOE sets county IHSS costs at 2012 levels with a 3.5 percent annual inflator. Further, if the CCI succeeds in the initial seven counties, the eventual plan is to transition collective bargaining for IHSS workers from each county to the state—however there are no set timelines for this phase to occur. Without current MCO funding, the CCI is in danger of collapsing, which would then jeopardize the county IHSS MOE and possible transfer of collective bargaining.

The current MCO tax also provides funding for other Medi-Cal services throughout the state. The loss of this supplemental funding could have resulted in statewide cuts to the Medi-Cal system or county programs and services.

On a county-by-county basis, the MCO tax structure in SBX2 2 will impact counties that operate local health plans, since county health plans will not benefit from changes in the Corporate or Gross Premium Tax structures offered to private health plans under SBX2 2. Further, counties that provide local health plan coverage to county employees will experience new fiscal impacts under SBX2 2. The net impact of SBX2 2 on each county will vary, but it is clear that counties will contribute more under the new MCO structure.

CSAC Support for the MCO Fix. Preserving MCO tax funding for Medi-Cal services, including the CCI, is a CSAC priority for 2016. CSAC supported SBX2 2 as a reasonable MCO fix that meets federal requirements and preserves critical Medi-Cal funding and the CCI, at least for this year.

CSAC did not take a position on either ABX2 1 or AB 133.

Procedure. Both houses of the Legislature passed all three bills on Monday, February 29, and Governor Brown signed them into law on March 1.

The Second Extraordinary Session on Health Care remains open in the Senate. The Assembly adjourned the special session today after passing a raft of tobacco control measures.

The single other piece of legislation passed in special session last fall, ABX2 15 (Eggman) or the “End of Life Option Act,” was signed by the Governor in October. However, it cannot go into effect until 90 days after the special session adjourns in both houses.

Attachment:

CSAC Senate Floor Alert SBX2 2 (Hernandez-Bonta) (February 24, 2016)

Resources. CSAC’s Special Sessions page gathers materials and resources related to the 2015-16 special sessions on transportation and health care: <http://www.counties.org/special-sessions>

Text of SBX2 2 (Hernandez-Bonta):

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162SB2

Text of ABX2 1 (Thurmond-Beall):

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB1

Text of AB 133 (Assembly Committee on Budget):

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB133

CSAC Explanation of MCO Tax and CCI Issues (June 2015):

[http://www.counties.org/sites/main/files/file-attachments/mco and cci and the ihss moe june 2015.pdf](http://www.counties.org/sites/main/files/file-attachments/mco_and_cci_and_the_ihss_moe_june_2015.pdf)

The IHSS MOE: Frequently Asked Questions

http://www.counties.org/sites/main/files/file-attachments/ihss_labor_faq_oct_15_final.pdf

Governor’s Proclamation of Extraordinary Session

[http://gov.ca.gov/docs/6.16.15 Health Care Special Session.pdf](http://gov.ca.gov/docs/6.16.15_Health_Care_Special_Session.pdf)



® February 24, 2016

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500

Facsimile
916.441.5507

SENATE FLOOR ALERT

**RE: SBX2 2 (Hernandez-Bonta): Medi-Cal: Managed Care Organization Tax
Proposed Conference Report No. 1, February 22, 2015 -- SUPPORT**

The California State Association of Counties (CSAC) is pleased to support SBX2 2 (Hernandez Bonta) as approved in the special session Conference Committee report of February 22, 2016. This critical measure will fix the state's Managed Care Organization (MCO) tax structure and preserve more than \$1 billion in funding for Medi-Cal services in California.

SBX2 2 is the product of months of negotiations between the Brown Administration, health plans -- including local and county-run health plans -- and the Legislature to restructure the MCO tax in a way that meets federal standards. It also preserves more than \$1 billion in critical funding for Medi-Cal services throughout the state.

Counties are key stakeholders in the MCO fix conversation, and are affected in several key ways.

On a statewide level, the existing MCO tax provides implementation funding for the Coordinated Care Initiative (CCI) pilot program in seven counties, with plans to expand to all 58 in the future. Counties strongly support the CCI to ensure better care coordination for high-risk, high-cost residents who are dually eligible for both Medicare and Medicaid. The CCI also affects the counties' role in the In-Home Supportive Services (IHSS) program, as it is tied to the county IHSS Maintenance of Effort (MOE) and the eventual plan to transition collective bargaining for IHSS workers from each county to the state. If the current MCO funding for the CCI is not continued, it could jeopardize the county IHSS MOE and eventual transfer of collective bargaining.

The current MCO tax also provides funding for other Medi-Cal services throughout the state. The loss of this supplemental funding could result in statewide cuts to the Medi-Cal system or county programs and services.

On a county-by-county basis, the tax structure proposed in SBX2 2 will have fiscal consequences for counties that operate local health plans. County health plans will not benefit from changes in the Corporate or Gross Premium Tax structures under the bill. Further, counties that provide local health plan coverage to county employees will experience new fiscal impacts under SBX2 2. The net impact of SBX2 2 on each county will vary, but it is clear that counties will bear a larger proportion of the new MCO fix upon its passage.

However, due to the other circumstances mentioned above, CSAC supports efforts to develop a reasonable MCO fix that meets federal requirements and preserves critical Medi-Cal funding, including the CCI. SBX2 2 achieves these two goals.

CSAC is committed to our partnership with the state in the provision of these services, and counties will continue to work with the Legislature, Administration, and stakeholders to ensure the continued success of the MCO fix. It is for these reasons that CSAC has taken a SUPPORT position on SBX2 2. Thank you.

cc: Honorable Members, California State Senate
Nancy McFadden, Executive Secretary, Office of the Governor
Donna Campbell, Deputy Legislative Affairs Secretary, Office of the Governor
Diana Dooley, Secretary, California Health and Human Services Agency
Jennifer Kent, Director, Department of Health Care Services
Will Lightbourne, Director, Department of Social Services
Marjorie Swartz, Policy Consultant, Office of the Senate pro Tempore
Scott Bain, Consultant, Senate Health Committee
Agnes Lee, Policy Consultant, Office of the Assembly Speaker
Brendan McCarthy, Consultant, Senate Appropriations Committee
Brianna Lierman, Executive Director, Local Health Plans of California
Frank Mecca, Executive Director, County Welfare Directors Association
Jolena Voorhis, Executive Director, Urban Counties of California
Michelle Gibbons, Executive Director, County Health Executives Association of
Caliofornia
County Caucus



March 7, 2016

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500

Facsimile
916.441.5507

To: Members of the Health and Human Services Policy Committee

**From: Farrah McDaid Ting, Legislative Representative
Elizabeth Marsolais, Legislative Analyst**

RE: HHS Budget Update

Budget hearings are beginning in both houses, with budget subcommittees taking the lead to hear each of the Governor's January budget proposals as well as other ideas presented by members, advocates, and stakeholders.

Budget hearings will continue right up to the Governor's release of the May Revision Budget on or around May 15. The budget subcommittees will then reconvene to hear previous and new issues. The Legislature must pass the 2016-17 budget no later than June 15.

CSAC will be lobbying on several HHS-related budget issues up to, and through, the Governor's May Revision. They include:

AB 403 Continuum of Care Reform – The Governor signed AB 403, the Continuum of Care Reform legislation to abolish the group home system for all but the most high-need foster youth, last fall. AB 403 will require, at a minimum, funding for capacity building and new practice requirements in county child welfare services, probation, and mental health agencies.

The Governor has proposed \$96 million for foster family recruitment and probation services in his 2016-17 January budget. While the funding is welcome, it falls far short of what is needed for implementation and ongoing activities associated with AB 403— especially since the bill requires a reformed group home system just 10 short months from now.

CSAC is working with the County Welfare Directors Association, the Chief Probation Officers of California, and the County Behavioral Health Directors Association to determine county funding needs for AB 403 implementation. CSAC is also working on ongoing Proposition 30 questions surrounding AB 403 costs to affected county departments, which were realigned to counties in 2011.

Please see attached Issue Brief on AB 403/CCR.

County Medi-Cal Administration Funding – It is a CSAC 2016 priority to ensure that counties have enough administrative funding to handle the activities and workload of conducting Medi-Cal eligibility on behalf of the state.

The incredibly rapid growth in Medi-Cal caseload, coupled with technical difficulties, continues to create significant workload at the local level. The Governor's January Budget proposal for 2016-17 includes \$169 million (\$57 million General Fund) over 2015-16 levels for both 2016-17 and 2017-18 for ongoing ACA implementation at the local level. The Governor's two-year proposal will allow counties to retain and hire caseworkers and keep up with the unprecedented demand.

Further, CSAC also supports the Governor's proposal to conduct a time study to gather data on the amount of time and work county eligibility staff is contributing. This data would then be used to inform a new Medi-Cal county administration budgeting methodology.

CSAC strongly supports these proposals – see attached budget letter.

Other Issues. The budget process is just underway, so materials for specific issues are being developed. A few of the other budget issues that CSAC expects to weigh in on include:

Adult Protective Services: CSAC will join the County Welfare Directors Association to advocate for \$5 million (State General Fund) for statewide training of social work staff in the APS program.

In-Home Supportive Services Maintenance of Effort: CSAC has joined with the County Welfare Directors Association and the California Association of Public Authorities to oppose proposed trailer bill language that would raise the IHSS MOE for counties that provide IHSS services through what is known as "contract mode." Currently, only two counties are in contract mode, but the associations are opposing the precedent that the trailer bill language might set if enacted. See attached letter for more details.

In-Home Supportive Services Overtime Implementation (FLSA): CSAC has joined with a large coalition of IHSS stakeholders in asking for regulatory cleanup to assist counties with implementing new federal and state IHSS overtime rules. Asks include changing IHSS task hours from a monthly to a weekly authorization, allowing 26 equal pay periods, and paying for certain travel and wait time services in arrears to ensure the IHSS recipient is properly cared for. See attached letter for more details.

Please also note that the implementation and cost of the new federal Fair Labor and Standards Act overtime regulations remain a state cost.

Attachments:

CCR Issue Brief: Continuum of Care Reform (February 2016)

CSAC Medi-Cal Administration Budget Letter (March 2, 2016)

IHSS MOE Contract Mode Issue (March 8, 2016)

IHSS Overtime Issues (February 29, 2016)

CSAC Staff Contacts:

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110

Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

CSAC Issue Brief

Continuum of Care Group Home Reform

Background

Governor Brown signed AB 403 (Stone) in October 2015, eliminating most group homes starting in January 2017 and ushering in a foundational shift for the state's foster youth.

The goal of the bill, called "Continuum of Care Reform" (CCR), is to provide better, more appropriate care and services for foster children in home-based settings and to reduce the time spent in congregate care, or group homes. This will require investing in recruitment, training, and retention of foster care homes, changing how and where behavioral health services are provided, reclassifying the group home system, and revising overall rates for remaining high-level group home placements.

AB 403 will be a significant undertaking for all involved—the state, county departments (including child welfare services, behavioral health, and probation), group homes, foster agencies, families, and advocates. By working together and ensuring all parts of the system are ready and adequately resourced to meet the needs of children, counties believe that the Continuum of Care reforms of AB 403 will be a landmark of system-wide change to better serve vulnerable children.

In the meantime, counties will continue to meet their statutory responsibility for the health, safety, and behavioral health needs of foster and probation youth.

AB 403 will require, at a minimum, funding for capacity building and new practice requirements in county child welfare services, probation, and mental health agencies.

The Governor has proposed \$96 million for foster family recruitment and probation services in his 2016-17 January budget. While the funding is welcome, it falls far short of what is needed for implementation and ongoing activities associated with AB 403—especially since the bill requires a reformed group home system just 10 short months from now.

The state, at the very least, must adequately fund implementation activities. CSAC is working with the County Welfare Directors Association, the Chief Probation Officers of California, and the County Behavioral Health Directors Association to determine county funding needs for AB 403 implementation.

CSAC is also working on ongoing Proposition 30 questions surrounding AB 403 costs to affected county departments, which were realigned to counties in 2011.

The Department of Social Services is also working with the Legislature to craft a "clean up" bill for AB 403, AB 1997, also by Assembly Member Stone. CSAC will continue to advocate on both the fiscal and policy issues related to AB 403 implementation.

Talking Points

- The state must adequately fund implementation activities, especially given the short time allowed to fully reform the group home system.
- The \$96 million proposed by the Governor for probation and recruiting foster families falls far short of what is needed to both implement and subsequently run the new system.





March 2, 2016

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500

Facsimile
916.441.5507

The Honorable Tony Thurmond, Chair
California Assembly Budget Subcommittee No. 1
State Capitol Building, Room 5150
Sacramento, CA 95814

Re: County Medi-Cal Administration Funding

Dear Assembly Member Thurmond:

The California State Association of Counties (CSAC) appreciates the Administration's and Legislature's commitment to providing adequate funding for county administration of the Medi-Cal program. Counties have been working hard to ensure the successful implementation of the Affordable Care Act (ACA) and provide efficient and timely eligibility determinations for both new and existing Medi-Cal beneficiaries. The Governor's January Budget proposal for 2016-17 includes an increase for counties to administer the state's Medi-Cal program. CSAC strongly supports this proposal.

CSAC is grateful for the inclusion of \$169 million (\$57 million General Fund) over 2015-16 levels for both 2016-17 and 2017-18 for ongoing ACA implementation in the Governor's January budget proposal. The incredibly rapid growth in Medi-Cal caseload, coupled with technical difficulties, continues to create significant workload at the local level. The Governor's two-year proposal will allow counties to retain and hire caseworkers and keep up with the unprecedented demand.

Further, CSAC also supports the Governor's proposal to conduct a time study to gather data on the amount of time and work county eligibility staff is contributing. This data would then be used to inform a new Medi-Cal county administration budgeting methodology. County stakeholders would be included in the development of this new methodology. CSAC supports the time study proposal to provide better data on actual county costs associated with Medi-Cal eligibility. Once developed, a new budgeting methodology will stabilize the state's annual appropriations for these services and afford counties some predictability in year-to-year funding levels. For a program as important as Medi-Cal, this is a worthy effort.

Counties wish to again thank the Administration for providing additional funding for ACA implementation in the January Budget proposal and respectfully ask that your committee approve the Governor's request for \$169 million in 2016-17 and 2017-18. An "aye" vote would signal your committee's commitment to keeping California on the cutting edge of ACA implementation.

If you have additional questions about the county position on this topic, I can be reached at fmcdaid@counties.org or (916) 650-8110. Thank you.

Sincerely,

A handwritten signature in black ink that reads "Sarah M. Ting".

Farrah McDaid Ting
CSAC Legislative Representative

cc: Honorable Members, Assembly Budget Subcommittee No. 1
Agnes Lee, Office of the Assembly Speaker
Chris Woods, Office of the Assembly Speaker
Andrea Margolis, Assembly Budget Subcommittee No. 1
Cyndi Hillery, Assembly Republican Fiscal Office
Jennifer Kent, Director, Department of Health Care Services
Matt Paulin, Department of Finance
Mark Newton, Legislative Analyst's Office
Amber Didier, Legislative Analyst's Office
Frank Mecca, County Welfare Directors Association



**California State Association
of Counties**
1100 K Street, Suite 101
Sacramento, CA 95814
(916) 327-7500



**County Welfare Directors
Association of California**
925 L Street, Suite 350
Sacramento, CA 95814
(916) 443-1749



**California Association of Public
Authorities**
1127 11th Street, Suite 701
Sacramento, CA 95814
(916) 492-9111

March 3, 2016

To: The Honorable Holly Mitchell
Chair, Senate Budget Subcommittee No. 3

Honorable Members, Senate Budget Subcommittee No. 3

From: Farrah McDaid Ting, Legislative Advocate, California State Association of Counties
Frank J. Mecca, Executive Director, County Welfare Directors Association
Karen Keesler, Executive Director, California Association of Public Authorities for IHSS

Re: **Contract Mode Adjustments to IHSS MOE Trailer Bill Language – OPPOSE**

The California State Association of Counties (CSAC), the County Welfare Directors Association (CWDA), and the California Association of Public Authorities for IHSS (CAPA) are opposed to the Administration's proposed trailer bill language (TBL) that would adjust the county In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) for all increased costs of contracts in counties in the contract mode. This TBL would inappropriately shift to counties additional costs that are already covered by the IHSS MOE adjustment formula. We respectfully request that you reject or adopt a modified version of this TBL.

The IHSS MOE took effect in the 2012-13 fiscal year and changed the county contribution for IHSS Program costs. Prior to 2012-13, counties were statutorily required to cover a specified share of all nonfederal costs of the IHSS program. The IHSS MOE replaced that statutory state/county sharing ratio. It capped each county's contribution to the nonfederal costs of the IHSS program at the county's 2011-12 expenditure level and requires that the new county contribution grow annually in two ways:

- For counties that locally negotiate a wage or health benefit increase for their providers in any fiscal year, those counties' IHSS MOEs are permanently increased beginning in the fiscal year that the wage or health benefit increase takes effect for the county's share of those costs based on the previously-existing statutory state/county sharing ratios.
- Beginning in 2014-15, all counties' IHSS MOEs increase by 3.5 percent each year, except in any fiscal year in which 1991 Realignment revenues to counties declines.

The increase in the IHSS MOE for locally negotiated wage and health benefit increases ensures that counties continue to share in IHSS Program costs that are specific to IHSS and over which the county has direct control. The annual 3.5 percent inflation factor ensures that counties continue to have a share of all other IHSS costs, such as for caseload increases, increases in the costs per case, other programmatic

changes that increase costs, or other administrative costs to the IHSS Program over which the county has little or no control. The IHSS MOE does not permit the county IHSS MOE to decline in any fiscal year from the prior year.

The IHSS MOE was established in conjunction with the Coordinated of Care Initiative (CCI) and the shift of collective bargaining in the IHSS Program from counties that have fully implemented the CCI to the state. The IHSS MOE ensures that the costs resulting from any state-negotiated changes to the wage or health benefits of IHSS providers, over which counties have no control, are not shifted to the counties. The IHSS MOE was applied to all counties, and not just the original eight counties in the CCI, because eventually all counties are intended to participate in the CCI and shift IHSS collective bargaining to the Statewide Public Authority. . It is also administratively very difficult, if not impossible with our current systems, to maintain different state/county cost sharing ratios for different counties within the same program.

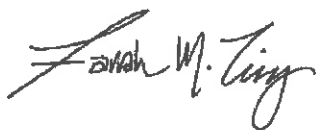
The IHSS statutes allow counties to contract with another agency to make available IHSS providers to ensure that the county can fulfill the statutory mandate that all authorized services are provided to every eligible IHSS participant. This is called "contract mode," and statute is specific about what costs can be covered by these contracts. IHSS providers employed by the contractor are required to be paid consistently with other non-contract IHSS providers in the county. The contract costs also cover costs of the contractor over which the county, and the contractor itself in many cases, have no control, such as taxes, insurance costs, and the costs of state and federal changes to the program. The statute permits the contract to cover the actual, documented expenditures of the contractor and any reasonable costs over which the contractor has no control.

There are currently only two counties that participate in this "contract mode," San Francisco and San Mateo, and in even in those counties, contract providers are used to provide services to only a minority of consumers. The use of non-contract IHSS providers is the vastly preferred method of providing IHSS services to consumers, as it provides consumers more choice and control in who their providers are. However, for some high need, difficult-to-serve consumers or consumers with no provider choices, contract providers are the only means to keep these IHSS consumers living safely in their own homes and out of more costly institutional care.

The Administration's proposed TBL would adjust a "contract mode" county's IHSS MOE for ALL increases in the cost of the contract, not just those cost increases associated with locally negotiated provider wage or health benefit increases. The contract costs that are not associated with provider wages and health benefits are comparable to other IHSS costs that are already covered by the 3.5 percent inflation factor and do not result in the calculation of a separate IHSS MOE adjustment in addition to that 3.5 percent. The proposed TBL is inconsistent with the existing statutory framework for how counties' IHSS MOEs are to grow over time. That framework for growth was part of the original IHSS MOE agreement between the Administration and counties when the IHSS MOE was put into place. The proposed TBL would, in effect, result in a county being charged twice for those contract cost increases that are beyond provider wages and health benefits, once as a part of the 3.5 percent inflation adjustment and again in the separately calculated IHSS MOE adjustment.

CSAC and CWDA are not opposed to TBL that would clarify that county IHSS MOEs should be increased for the county's share of contract provider wage or health benefit increases resulting from local negotiations, consistent with the IHSS MOE adjustment made for locally negotiated wage or health benefit increases for all other IHSS providers. The proposed TBL is currently much broader than that. Therefore, we respectfully request that you either reject the proposed TBL or adopt a modified version that is consistent with current law.

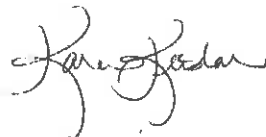
CSAC-CWDA-CAPA Budget Letter:
Contract Mode Adjustments to IHSS MOE Trailer Bill Language -- OPPOSE
March 3, 2016



Sincerely,
Farrah McDaid Ting
CSAC Legislative Representative
fmcdaid@counties.org
(916) 650-8110



Frank Mecca
CWDA Executive Director
fmecca@cwda.org
(916) 443-1749



Karen Keeslar
CAPA Executive Director
(916) 492-9111

cc: Jennifer Troia, Office of the Senate President Pro Tempore
Craig Cornett, Office of the Senate President Pro Tempore
Theresa Pena, Senate Budget Subcommittee No. 3
Chantele Denny, Senate Republican Fiscal
Will Lightbourne, Department of Social Services
Robert Smith, Department of Social Services
Michael Wilkening, Health and Human Services Agency
Matt Paulin, Department of Finance
Jay Kapoor, Department of Finance
Mark Newton, Legislative Analyst's Office
Ginni Bella Navarre, Legislative Analyst's Office
Callie Freitag, Legislative Analyst's Office
County Caucus



Making FLSA Work in IHSS: Improving Outcomes for All

The current policy places undue pressure on In-Home Support Services (IHSS) consumers and providers to navigate a complex myriad of new rules and procedures for overtime and travel time. Despite our collective efforts to educate IHSS consumers and providers on the new rules, we believe the current rules are unmanageable and a set up for failure. Several aspects of implementation are simply too cumbersome to properly implement. This places IHSS consumers in jeopardy of losing their providers and worse, potentially risks their health and safety.

To prevent unintended and undesired harmful consequences to IHSS consumers, we have identified several issues with the current implementation of Fair Labor Standards Act (FLSA) rules in the IHSS program as well as changes necessary to enable both IHSS consumers and providers to comply with FLSA requirements. We believe changes are needed to simplify and streamline the implementation and believe in the process, this will increase efficiency, decrease administrative burdens, and prevent unintentional harm to consumers and providers.

HISTORY: In 2013, the United States Department of Labor (DOL) published the Final Rule on the application of the FLSA to domestic service workers. That Final Rule essentially requires that personal care workers be afforded the same minimum wage and overtime protections as most other workers in the country. California implemented SB 855 and SB 873 (2014) to ensure the IHSS program conforms to the new federal ruling. However, for reasons stated below, implementing these new requirements is proving to be extraordinarily cumbersome and confusing to both IHSS recipients and providers. There is a grace period until May 1, 2016, at which time providers who do not follow all the rules will start to receive violations, which can lead to eventual suspension from the program.

ANALYSIS: Providers now submit timesheets twice per month, once by the 15th of the month, and again at the end of the month. SB 855 added W&I Code Section 12300.4 to specify that IHSS providers are not permitted to work more than 66 authorized hours within a workweek. The 66 hours is derived by dividing 283 – the maximum IHSS monthly hours – by 4.33, the average number of weeks per month throughout the year, and rounding up to the next whole number. SB 855 also created a “weekly authorized number of hours” of IHSS that a consumer may receive: the consumer’s monthly assessed hours divided by 4.33.

State law defines the workweek for purposes of FLSA calculations as the period beginning at 12:00 a.m. on Sunday and including the next consecutive 168 hours, terminating at 11:59 p.m. the following Saturday.

Problems with the SB 855 calculation of weekly authorized hours:

The “divide by 4.33” formula dictated in SB 855 was problematic and has been discarded by CDSS. This is due to the fact that some months have 28, 29, 30 or 31 days, which means that a consumer’s weekly authorized hours would fluctuate month by month. For example, a consumer authorized for 87 hours per month would see his/her hours fluctuate: 20.3 hours/week

(30-day month) and 19.7 hours/week (31-day month). To simplify the calculation of compensable hours, CDSS has substituted a “divide by 4” maximum weekly hours formula.

CDSS’s alternative is still too complicated and hard to comply with, leading to unintentional violations and extra administrative workload:

County social workers currently assess service hours by the week, then convert this into a monthly total. FLSA now requires an *additional* step of converting back to a weekly amount.

Although dividing by 4 is better than the original formula, this solution still falls short because:

- Consumers may falsely assume that they are able to use their maximum weekly hours every week and thus could run out of hours before the end of each month, or claim hours beyond their monthly authorization. For example, a consumer with 25 maximum weekly hours, who uses 25 hours per week from March 1-March 28, will have used her monthly maximum of 100 with three days still to go in the month.
- Some weeks span two months, with a different calculation needed for each month, making it difficult if not impossible to calculate properly.
- If, because of the complexity of the calculations, a provider works more hours than authorized, she will incur violations. Multiple violations may result in a consumer potentially losing his/her provider.

Unintended consequence: Consumers may lose authorized services and be unsafe:

The new rules prohibit providers with one consumer from working more than 70.75 hours and workers with multiple consumers from exceeding the 66 hourly cap per week regardless of the number of recipients they serve.

Providers who work lots of hours for single or multiple clients may be prevented from doing so, and those clients will be forced to find alternative providers. The State estimates that 50,000-60,000 IHSS clients have multiple providers and may be potentially impacted by this policy, and that at least 10,000 additional providers will need to be recruited, screened and hired. Providers are not interchangeable: they must be able to do the work the particular consumer requires, at the consumer’s home, at the time the consumer needs. Some of the consumers who have to find new providers are children, whose parent has been the sole caregiver.

We do not believe that sufficient new appropriate and available providers will be in place by May 1, 2016, particularly for high-risk consumers and for consumers living in more rural counties.

To partially mitigate this concern, DSS will allow providers (who are in the program as of January 31, 2016) to work up to 90 hours per week only if he/she is a live-in provider of two or more consumers and the provider is a parent, grandparent, step-parent, adoptive parent, or legal guardian. The problems:

- Providers enrolling after January 31, 2016 are excluded from this policy.
- There is no exemption for spouses, siblings, adults caring for their parents or anyone else.
- DSS is proposing to provide an individual exemption process for additional providers, but has not yet convened the workgroup to establish this process. It is unclear when and how these exceptions will be implemented and how consumers and provider will know about their availability.

- Meanwhile, consumers will be making decisions based on the information they have. For example, an adult taking care of two parents, for whom there is no other caregiver, may decided to place both parents in nursing homes (at great cost to their personal rights and health and to the taxpayers).
- There is no flexibility allowing a parent or anybody else to care for two or more consumers beyond 90 hours per week, even if the alternative is institutionalization or the consumer going without care because of the unavailability of a suitable additional provider.

Unintended consequence: consumers with high needs lose service because wait time is deducted from their total hours:

Prior to FLSA, IHSS staff assessed for medical accompaniment and factored this into the monthly authorization. FLSA and State Policy now require compensation for the time that providers are “engaged to wait” during medical appointments. The FLSA wait time is a new compensable service, for which reimbursement should be handled similarly to the new travel time payments. If, as CDSS proposes, wait time is deducted from the consumers’ hours, consumers who are at or near the caps for IHSS services and their providers would be unable to use paid wait time without taking away from other authorized services.

PROPOSED SOLUTIONS:

1. **Expand the Grace Period.** Extend the grace period to September 1, 2016, before consequences for violating overtime and travel time limits become effective.
2. **Ensure that consumers can continue to receive services to remain safely at home:**
A small number of IHSS providers care for more than one consumer with highly specialized needs; the overtime limit means that they cannot continue to provide that care if the consumers’ combined hours exceed 66 per week. These providers are parents with more than one child with disabilities, an adult caring for two parents with dementia; an adult caring for a spouse and a child, both with disabilities. There may not be a suitable additional provider available to avoid an overtime situation. When no other provider is available, the consumer cannot receive the services which were authorized as needed for safety in their homes.

The California Department of Social Services (CDSS) has recognized this issue and is attempting to address this administratively. Statutory protections are needed to allow for situations when a provider can work above the CDSS cap of 66 hours/week in certain, limited situations, including:

- Providers who are the parent, step-parent, grandparent or legal guardian of two or more children (including providers approved after Jan 31, 2016);
- Spouses, domestic partners, adult children caring for parents, adult siblings, and adult grandchildren, when no other suitable provider is available; and
- Individual consumer situations when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient’s health (including physical, psychiatric or emotional) or safety would be at risk.

In addition, statute should allow some providers to work over 90 hours/week in limited

situations based on individual consumer needs when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient's health (including physical, psychiatric or emotional) or safety would be at risk.

3. **Align IHSS Authorized Hours with FLSA Policy through the following changes:**
 - a) **Create 26 equal two-week pay periods, independent of calendar months.** Pay providers on a bi-weekly basis rather than semi-monthly to better conform to the state definition of a workweek and eliminate any confusion about how many weekly hours are authorized.
 - b) **Eliminate the conversion of the weekly authorization to a monthly authorization.** Currently the vast majority of IHSS services are already assessed weekly and then are converted to monthly by multiplying by 4.33, which is confusing now to consumers and providers. The only services authorized monthly by IHSS are Domestic Services (which 95% of recipients receive), which could be adjusted [see (c)].
 - c) **Change any IHSS service task hours from monthly to weekly authorization.** For example: Domestic Services are currently authorized at 6 hours per month. Converting this figure to a weekly authorization results in 1.4 hours per week or 1 hour and 24 minutes, which is confusing to consumers and providers. To reduce the confusion, increase the weekly authorization to 1.5 hours per week, or 1 hour and 30 minutes. This would very marginally increase the domestic service hours but would significantly reduce the confusion to consumers and providers.
 - d) **Flexibility to Adjust Hours based on Client Needs.** Retain the flexibility which allows consumers to shift hours without obtaining county approval, when no new overtime is created.
 - e) **Provide Equitable Caps. CDSS has created two different OT caps for IHSS providers:** Providers with one consumer may be compensated for hours worked up to 70.75 hours a week while providers with multiple consumers have a lower cap of 66 hours a week. This is unfair to consumers and creates new challenges for Public Authorities to recruit registry providers because workers who agree to work for multiple clients would be subject to the lower cap. This policy should be revised to allow all providers – even those with multiple consumers - to receive compensation up to the 70.75-hour weekly cap.
4. **Pay for Certain Services in Arrears to Align with FLSA:** FLSA requires payment for travel time between consumers on the same day and SB 855 allows travel time to be paid in arrears after the travel is incurred, up to 7 hours per week. The travel time is not taken from the consumers' authorized hours, it is an addition. FLSA also now requires payment for wait time at medical appointments. However, wait time is deducted from authorized hours. Therefore, consumers with the highest need, who are already at or near the 195/238 monthly authorization cap are prevented from actually claiming this new service. This puts them in jeopardy of either not having their provider to assist them at medical appointments, or if the provider claims those wait time hours, they do so at the cost of not

providing other needed services. It is also difficult to accurately predict wait time since doctor's appointments can vary.

In addition, other services occur infrequently, at irregular intervals, or cannot be easily assessed for time until after the tasks are rendered. For example: yard hazard abatement, ice/snow removal, heavy cleaning and teaching and demonstration, are services that occur infrequently but are often critical in maintaining the safety of the recipient in their home and community, and should be paid in arrears.

5. **Permit Waiver Clients to Access Public Authority Registry Services:** Currently Public Authorities are only allowed to provide access to registry services to IHSS consumers. Yet, consumers of Waiver Personal Care Services (WPCS) are excluded from registry services, even though WPCS consumers use IHSS-like services (and often use both IHSS and WPCS services) and are also subject to the new FLSA rules. This proposal would simply allow WPCS consumers to also contact the registry to help them identify in-home providers.

POSSIBLE FISCAL EFFECTS: The following are potential fiscal effects:

1. Increase in service costs from additional overtime paid during extended grace period.
2. Likely administrative cost savings to implement the exemption process, as consumers' needs will be met without disruption, thereby reducing costs to recruit and enroll new providers.
3. Increase in service costs due to the increase in domestic hours (from 1.4 to 1.5 hours/week), calculating one-time services such as heavy cleaning and yard abatement outside of the 70.75-hour cap, compensating medical accompaniment (including wait time) outside of the current service hour caps, and implementing an expanded exemption process.
4. One-time costs to make changes to CMIPS, create new timesheets and forms and instructions for counties, consumers and providers.
5. Offsetting administrative savings from reduced workload as a result of improvements to the FLSA process.

###



March 7, 2016

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500

Facsimile
916.441.5507

To: Members of the Health and Human Services Policy Committee

From: Farrah McDaid Ting, Legislative Representative
Elizabeth Marsolais, Legislative Analyst

RE: Homelessness Issues Update

Homeless issues are heating up at both the state and local levels. However, California's counties have been grappling with the issues for decades.

Overview. From urban to rural, each of California's 58 counties provide essential services for people experiencing homelessness, including poverty-reduction programs, physical and behavioral health services, public safety and affordable housing.

- **Poverty:** Counties are key partners with the state in administering many of the critical poverty-reduction programs, such as CalWORKs and CalFresh benefits and Medi-Cal health eligibility. These poverty programs provide essential support to people experiencing homelessness while they work towards self-sufficiency.
- **Behavioral Health Services:** Counties operate the county mental health plans and provide substance use disorder services. These services help to stabilize individuals as they exit homelessness, and help increase the likelihood that they will remain housed.
- **Public Safety:** County and city public safety systems have an intimate knowledge of their local homeless population due to frequent contacts, and often act as valuable partners in the effort to identify and assist homeless individuals.
- **Zoning and Siting:** Counties are also responsible for appropriate zoning and general planning, and have an important role in creating and supporting affordable housing options. Counties are also often providers of temporary housing solutions for the homeless, especially those struggling with mental health or substance use disorder issues and people recently released from state prison or local jails.

The Senate "No Place Like Home" Proposal. In January, Senate leaders released their "No Place Like Home" proposal. Senate President pro Tempore Kevin de León and former Senator Darrell Steinberg crafted the plan to redirect a portion of Mental Health Services Act (MHSA, or Proposition 63) funding from counties to help securitize up to \$2 billion in affordable housing bonds. Under the proposal, cities and counties would compete with each other for the housing bond funds. The proposal also urges an increase in the state's Supplemental Security Income/State Supplementary Payment (SSI/SSP) rates, which provide monthly funding to those who are aged, blind, or disabled. Further, the proposal affirms support for the existing Housing Support Program, which is administered by counties within the CalWORKs program, and a new "Bringing Families Home" program to provide family housing.

CSAC has not yet developed a position on the "No Place Like Home" proposal, as details beyond what is attached to this memo – three pages in all – are not yet available.

CSAC Efforts. CSAC is undertaking a number of efforts on the issue, including:

- **Collaboration:** Because homelessness is a local issue that crosses county and city boundaries, CSAC will be forming a joint task force on Homeless Issues with the League of California Cities. The task force is in the initial planning stages, and more information will be released as it becomes available.

CSAC is also working with the County Behavioral Health Directors (CBHDA) and the County Welfare Directors Association (CWDA) on developing a position on the No Place Like Home proposal. While the proposed diversion of MHSA funding is worrisome, the human services-related elements of the plan (more support for the Housing Support Program, etc.) have significant potential and are supported by human services directors. Please see CBHDA's Housing Principles document, attached.

- **Education:** The CSAC Institute for Excellence in County Government will present an Emerging Issues course on homelessness on April 14 in Sacramento. To register, visit the Institute page at <http://www.counties.org/csac-institute-excellence-county-government>

CSAC will also organize a workshop on homeless issues during the 2016 CSAC Legislative Conference, May 18-19 in Sacramento. Details on the workshop will be provided as they become available.

- **Engagement:** CSAC will continue to engage with the Senate and other stakeholders to ensure the county voice is part of the process and any final package. The Senate Budget and Fiscal Review Committee held an informational hearing titled "Challenges and Opportunities: Homelessness in California's Local Communities" on February 25, hearing testimony from a variety of state and national experts on the issue, including Yolo County Supervisor Oscar Villegas on behalf of CSAC.

CSAC will continue to work with the League of California Cities on the joint task force and issues of mutual interest.

Attachments:

Senate's No Place Like Home Proposal (January 4, 2016)

CBHDA's Housing Principles (February 11, 2016)

CSAC Staff Contacts:

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110

Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Senate President pro Tempore Kevin de León Press Release:

Senate Announces “No Place Like Home” Initiative To Tackle Homelessness in California

Monday, January 4, 2016

California Senate Legislative Package to Prevent and Address Homelessness in our Local Communities

LOS ANGELES — To assist local communities in preventing and addressing homelessness, a bipartisan coalition of members from the California State Senate introduced a strategic and first-of-its kind “No Place like Home” initiative at a press conference at The Star Apartments on Skid Row in Los Angeles on Monday. This unprecedented policy framework amounting to over \$2 billion in support builds on years of research and best practices and is guided by the core belief that no individual or family in California should ever experience the uncertainty and pain of living without a home.

“This bipartisan legislative package will help secure progress in tackling homelessness and provide a key to health and hope for many Californians who have no place to go.” said Senate President pro Tempore Kevin de León (D-Los Angeles). “Coming off the holiday season, I can think of no better way to start the legislative session than in Skid Row focused on lifting those without voices in our political process.”

“This is a tipping-point moment for mental health, homelessness, and Proposition 63 in California.” Said former Senate leader Darrell Steinberg, co-author of Proposition 63 (2004) – The Mental Health Services Act – and founder The Steinberg Institute. “Thanks to the leadership of this Senate, we have a historic opportunity to help local communities forge systemic long-term solutions, making a real difference in the lives of thousands of forgotten Californians.”

The Senate proposal is crafted with the understanding that fighting modern homelessness – with long-term solutions, not short-term Band-Aids – requires a localized approach sustained by a strategic statewide commitment.

The proposals will empower local governments with additional resources and flexibility to better serve homeless individuals and families, increase access to affordable housing, address the effects of income inequality and, and extend proven programs for homeless who are either disabled or in need of mental-health assistance.

California has the nation’s largest homeless population while ranking as the seventh largest economy of the world at the same time. The 114,000 total homeless people who live across our state make up 22 percent of the nation’s homeless population, with Los Angeles holding the dubious ranking of the homeless capital of the country with nearly 42,000 homeless residents.

The Senate legislative package on homelessness re-purposes Proposition 63 (2004) – The Mental Health Services Act – bond money and creatively leverages billions of additional dollars from other local, state, and federal funding to achieve the following goals:

Housing:

- 2 billion bond to construct permanent supportive housing for chronically homeless persons with mental illness.
- \$200 million, over 4 years, to provide supportive housing in the shorter-term, rent subsidies, while the permanent housing is constructed or rehabilitated.
- Support for two special housing programs that will assist families:

The “Bringing Families Home” pilot project, a county matching grant program to reduce homelessness among families that are part of the child welfare system.

The CalWORKs Housing Support Program, which provides housing and support services for CalWORKs families in danger of homelessness.

Income support and outreach:

- An increase in Supplemental Security Income/State Supplementary Payment (SSI/SSP) program grants which provide income support for the aged, blind, and disabled poor who cannot work.

Rates of homelessness are higher for persons with disabilities who cannot work; SSI/SSP is intended to help them make ends meet, and a large portion of grants usually goes toward rent.

These increases will assist about 1.3 million low-income Californians (72% with disabilities and 28% who are elderly).

- A one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible poor people enrolled in the SSI/SSP program.

The federal government covers 72% of the total costs of the SSI/SSP program, so state and local benefits are multiplied significantly for each newly eligible recipient.

California has more than one third of the nation’s chronically homeless – those with mental illness or other significant problems, and an even higher percentage among homeless women. Of the 28,200 chronically homeless in California, nearly 85 percent are unsheltered with this group absorbing the greatest amount of taxpayers’ resources, often toping \$100,000 annually per person in public costs for emergency room visits, hospital stays, law enforcement, and other social services.

The Senate proposal supports a “housing first” strategy which many homeless advocates and social service experts across the state prefer because it provides safe, secure housing creates an environment that allows for wrap-around services, such as mental health treatment, to take hold. Studies show homelessness aggravates mental illness, making it more difficult to reach and house those with the greatest need of shelter and treatment.

There are local programs, such as Project 25 in San Diego, which are successfully housing, treating, and transitioning chronically homeless clients back into society. Project 25 is a 3-year-pilot program funded by the United Way of San Diego and led by St. Vincent de Paul which uses the housing first model as a means of intensive case management and delivery of psychiatric and medical care to several dozen clients. Project 25 is paying dividends for the taxpayers. In two years the annual public costs related to participants of Project 25 were reduced nearly 63 percent, to \$1.6 million from \$4.3 million.

- See more at: <http://sd24.senate.ca.gov/news/2016-01-04-senate-announces-%E2%80%9Cno-place-home%E2%80%9D-initiative-tackle-homelessness-california#sthash.X0BxC95o.dpuf>

-End-



CBHDA Housing Principles **Adopted February 11, 2016**

Expanding safe and affordable housing is a key priority for the County Behavioral Health Directors Association (CBHDA). County behavioral health departments are essential partners in any effort to reduce and prevent homelessness when mental illness and/or substance use are key contributing factors. A safe place to call home is essential for personal recovery and wellness, and behavioral health services are critical in preventing homelessness. Based on our experiences, we strongly believe the following principles must be considered in designing new efforts and targeting new investments:

1. Utilize the Public Behavioral Health Target Population Definition for Homelessness Prevention and Reduction Efforts

In public behavioral health, Mental Health Services Act (MHSA) funded supportive housing is targeted for people who are low-income and who are homeless or at risk of being homeless. A person who lives on the streets or lacks a fixed and regular night time residence is considered homeless. The target population is further defined as adults, older adults, transition-age youth with serious mental illness, children with severe emotional disorders and their families, who at the time of assessment for housing services meet the criteria for MHSA programming. Use of MHSA funding must be consistent with the voter mandate.

2. Utilize Proven Models To Respond to Homelessness

Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – while providing supportive services. This approach posits that having a roof over one’s head is an essential step in reducing homelessness while acknowledging the many mental health and substance use challenges that prevent the homeless from accepting assistance. Rapid Re-housing rapidly connects families and individuals experiencing homelessness to permanent housing. Efforts should also be made to ensure that individuals in temporary and bridge housing are targeted for permanent, supportive housing (i.e., not just those individuals who are homeless). A variety of proven strategies should be considered in any investment to end homelessness.

3. Invest in Supportive Services and Break the Cycle of Long-Term Homelessness

Supportive services, for people with behavioral health challenges, are essential to housing stability and to maximizing each individual’s ability to live independently. County Behavioral health departments are uniquely positioned to identify and intervene, in collaboration with community partners, to address the dual, interwoven, public health crises of substance use and mental illness that complicate homelessness. A successful strategy to combat homelessness will build on local and statewide collaborations and include essential mental health and substance use services.

4. Fund Construction, Operating Subsidies, and Supportive Services

Construction is only one of the *three* major costs to permanent supportive housing. Equally important is funding to make up the difference between what it costs to operate the housing – such as paying for maintenance, property management and other employees, or a new roof -- and what residents can afford to pay. Most homeless individuals lack income beyond a monthly check provided under federal Social Security programs for people with disabilities and could not afford the rent of an apartment without a subsidy. Therefore, in order to make the units affordable for the tenants, the units must be subsidized through a capitalized operating reserve or some other form of subsidy. And finally – supportive services including mental health and substance use are essential.

5. Ensure Residents of All Counties Can Benefit from Additional Housing Investments

Homelessness impacts all counties. Therefore, any MHSAs set aside for the purpose of expanding housing capacity should be available, through a noncompetitive process, to all counties to invest in additional housing and supportive services.

6. Balance Investment

Counties and providers are working diligently to achieve the goals of the MHSAs which calls for more expansive, inclusive, effective, innovative, and an accountable mental health system. Every dollar devoted to a statewide approach to housing is a dollar that will not be spent providing direct mental health and substance use services at a time of overwhelming need. There needs to be a balance between investing in affordable housing and investing in other critical mental health and substance use services.

7. Consider MHSAs Revenue Volatility

MHSA funding allocations are not consistent each year. The annual amount of MHSAs funding diverted for housing needs to be adjusted and matched with the volatility of the revenue source and each county should be able to determine what funding is used to pay back any bond debt (e.g. Prevention and Early Intervention (PEI), Innovation, Community Services and Supports (CSS), funds at risk of reversion or new funding). In addition, there needs to be a consideration given to fund services *in the long term* to people living in permanent supportive housing created by any statewide program as well as funding for long term operating costs of maintaining housing.

8. Ensure Flexibility to Address Local Needs

There is not a “one size fits all” approach to housing across the State; there are a number of housing models for supportive housing. The housing setting can vary and is based on a range of factors including the resident’s preference, the type of housing available, affordability, and the history of a local community’s real estate market. For example, in cities, large apartment buildings are typical while in suburban and rural communities; single-family homes are more common. Programs need flexibility with regard to the utilization of housing such as options for Master Lease agreements and housing rehabilitation, in addition to capital investments.

9. Address “Not in My Backyard” (NIMBY) and Siting Challenges

Organizations that provide housing and supportive services to people with mental health and substance use disorders have tremendous challenges including identifying housing sites, obtaining necessary funding, arranging for services, navigating complex administrative systems, and securing scarce funding sources even when neighbors and local government support the project. The process becomes far more difficult when neighbors protest about housing “those people” in “our” neighborhood. Any statewide

housing initiative should support efforts to reduce stigma and housing discrimination against people with mental health and substance use challenges.

10. Leverage and Increase the Impact of Existing and Emerging State Housing and Services

The MHSAs Housing Program developed in August 2007 set aside \$400 million in funds to provide capital development loans and critical funding for long term operating subsidies for the development of affordable rental housing for MHSAs individuals. Each county's Department of Mental Health provides MHSAs residents with an *individualized array of supportive services* needed for recovery and the opportunity to become fully functioning community members. These program funds are administered for counties by the California Housing Finance Agency (CalHFA) and the California Department of Health Care Services (DHCS). The funds from the MHSAs Housing Program will ultimately house approximately 2,600 MHSAs residents. Several counties plan to continue the partnership and assign additional MHSAs dollars to CalHFA to administer under a new statewide program. Additionally, as authorized under the Affordable Care Act, States can create "Health Homes" to serve individuals with chronic conditions including mental health and substance use. One of the primary goals of the Health Home Program in California is to link individuals to housing and services. This is another opportunity to address the needs of the homeless. Aligning with initiatives such as these is imperative.