Health and Human Services Policy Committee Meeting
CSAC 126th Annual Meeting
Monday, November 16, 2020 10:15 a.m. – 11:15 a.m.
Via Zoom | Click here to join or call (669) 900-6833
Meeting ID: 871 6930 1703
Passcode: 084685

Supervisor Jeff Griffiths, Inyo County, Chair
Supervisor Doug Chaffee, Orange County, Vice Chair
Supervisor Janice Rutherford, San Bernardino County, Vice Chair

Agenda

10:15 a.m.	**I.**	**Welcome and Introductions** Supervisor Jeff Griffiths, Inyo County, Chair Supervisor Doug Chaffee, Orange County, Vice Chair Supervisor Janice Rutherford, San Bernardino County, Vice Chair
10:20 a.m.	**II.**	**Department of Health Care Services: Stronger Equity Focus and New Leadership** Will Lightbourne, Director, California Department of Health Care Services
10:35 a.m.	**III.**	**First 5 California – Strengthening County Partnerships** Melissa Stafford Jones, Executive Director, First 5 Association of California
10:50 a.m.	**IV.**	**Policy Platform Review – ACTION ITEM** Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative Justin Garrett, CSAC Human Services Legislative Representative Roshena Duree, CSAC Health and Human Services Legislative Analyst
11:05 a.m.	**V.**	**2021 HHS Priorities – ACTION ITEM** Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative Justin Garrett, CSAC Human Services Legislative Representative Roshena Duree, CSAC Health and Human Services Legislative Analyst
11:15 a.m.	**VI.**	**Closing Comments and Adjournment**
Informational Item:		**2020 Legislative Year in Review**

ATTACHMENTS

II. Department of Health Care Services: Stronger Equity Focus and New Leadership

Attachment One..... CSAC Memo: Department of Health Care Services: Stronger Equity Focus and New Leadership

III. First 5 California – Strengthening County Partnerships

Attachment Two ..... CSAC Memo: First 5 California – Strengthening County Partnerships

IV. Policy Platform Review

Attachment Three ..... CSAC Memo: Review of the Draft Platform Chapters: Health, Human Services, and Realignment

Attachment Four ..... Draft Health Services Platform Chapter

Attachment Five..... Draft Human Services Platform Chapter

Attachment Six ..... Draft Realignment Chapter

V. 2021 HHS Priorities

Attachment Seven..... CSAC Memo: Health and Human Services 2021 Draft Priorities

Informational Item. 2020 Legislative Year in Review

Attachment Eight ..... CSAC Memo: Health and Human Services 2020 Year in Review

Department of Health Care Services: Stronger Equity Focus and New Leadership

Attachment One

CSAC Memo: Department of Health Care Services: Stronger Equity Focus and New Leadership

November 16, 2020

To: Health and Human Services Policy Committee

From: Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative
Justin Garrett, CSAC Human Services Legislative Representative
Roshena Duree, CSAC Health and Human Services Legislative Analyst

RE: Department of Health Care Services: Stronger Equity Focus and New Leadership

Introduction. Chair of the CSAC Health and Human Services Policy Committee and Inyo County supervisor Jeff Griffiths is pleased to present the new director of the Department of Health Care Services (DHCS), Mr. Will Lightbourne.

Director Lightbourne was appointed to lead DHCS on June 16, taking the helm of the state's Medi-Cal program, behavioral health services, and health plan oversight in the midst of the COVID-19 crisis. He is a familiar and welcome face to the county family, with a long and distinguished county and state career, including in Santa Cruz, Santa Clara, and San Francisco Counties and as a former director of the California Department of Social Services.

Director Lightbourne came out of retirement to shepherd DHCS through the multiple crises of the pandemic, the economic downturn, and nationwide calls for social justice and racial equity. Throughout his career, Director Lightbourne has had a special interest in racial equity and ensuring access to health and behavioral health services for underserved or underrepresented populations.

Before his appointment to DHCS, Mr. Lightbourne served on Governor Newsom's Council of Regional Homeless Advisors. Mr. Lightbourne is also the father of the state's Continuum of Care Reform (CCR) effort, dedicating the last 10 years to reforming the foster care system to ensure family placements and critical services for the state's foster children and youth.

Background. As mentioned above, Mr. Lightbourne previously served as Director of the California Department of Social Services from 2011 through 2018. Before his state service, he was director of the Santa Clara County Social Services Agency, director of the Human Services Agency of the City & County of San Francisco, director of the Santa Cruz County Human Services Agency, and general director of Catholic Charities of the Archdiocese of San Francisco. Mr. Lightbourne earned his Bachelor of Arts degree from San Francisco State University.

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First 5 California – Strengthening County Partnerships

Attachment Two

CSAC Memo: First 5 California – Strengthening County Partnerships

November 16, 2020

To: Health and Human Services Policy Committee

From: Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative
Justin Garrett, CSAC Human Services Legislative Representative
Roshena Duree, CSAC Health and Human Services Legislative Analyst

RE: First 5 California – Strengthening County Partnerships

Introduction. Counties are pleased to welcome Melissa Stafford Jones as Executive Director of the First 5 Association of California. The First 5 Association of California is a nonprofit membership organization that advocates on behalf of the state's 58 First 5 county commissions. First 5 is funded by Proposition 10, the 1998 tobacco tax that voters approved to provide funding for early childhood development programs.

Ms. Stafford Jones brings a wealth of policy and advocacy experience on health and children's issues to her new role. She previously served as the Executive Director at the Dean & Margaret Lesher Foundation, President & CEO of the California Association of Public Hospitals and Health Systems (CAPH), and Regional Director of the U.S. Department of Health and Human Services. Her prior work experience includes helping to implement the Affordable Care Act, developing strategies to identify causes of poverty for children, and leading a CSAC HHS affiliate.

First 5 Areas of Interest and Partnership Opportunities. The First 5 Association of California is a strong partner and affiliate of CSAC on numerous children's health and development issues. The policy agenda for the First 5 Association of California includes four broad areas of focus – (1) Resilient Families, (2) Comprehensive Health and Development, (3) Quality Early Learning, and (4) Sustainability and Scale. In 2020, CSAC partnered closely with First 5 on several policy issues including First 5 revenues, the proposed nicotine-based vaping tax, and implementation of legislation to establish local memorandums of understanding (MOUs) to ensure coordination of services for children and youth who have experienced severe trauma.

As County Supervisors continue to actively engage with First 5 on local First 5 Commissions, there has been a growing interest in further developing this partnership at the state level. Earlier in 2020, CSAC hosted a meeting for County Supervisors with First 5 leaders where members were able to share local First 5 successes and talk through next steps in growing this partnership. One of the key outcomes from this meeting was a commitment to examine CSAC's policy platform language to ensure it reflects the shared goals of CSAC and First 5. As detailed in the HHS Policy Platform Review memo, CSAC is proposing changes to support advocacy around the need for quality early learning, supporting families, and comprehensive health and development of children and families.

The COVID-19 pandemic has highlighted the need for key investments and supports for children and families. Combined with Governor Newsom's prioritization of early childhood as a

key issue for his Administration, there are significant opportunities for important progress on these issues. Counties look forward to working with Ms. Stafford Jones and continuing to expand upon our strong partnership with the First 5 Association of California.

Please welcome Ms. Stafford Jones back to the county family! She can be contacted at:
Melissa Stafford Jones
Executive Director, First 5 Association of California
melissa@first5association.org

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Policy Platform Review

Attachment Three

CSAC Memo: Policy Platform Review

November 16, 2020

To: Health and Human Services Policy Committee

From: Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative
Justin Garrett, CSAC Human Services Legislative Representative
Roshena Duree, CSAC Health and Human Services Legislative Analyst

RE: Review of the Draft Platform Chapters: Health and Human Services – ACTION ITEM

Staff Recommendation. Staff recommends that the Health and Human Services Policy Committee approve the recommended changes to the CSAC policy platform as drafted and forward to the CSAC Board of Directors.

Background. At the start of each two-year legislative session, CSAC undertakes a policy platform review process. To begin that process of updating the guiding policy document for the Association, we have attached proposed drafts of the Health Services, Human Services, and Realignment chapters of the CSAC Platform for your review and input. There are no proposed changes to the Realignment chapter, but that has been attached for reference. We invited all counties and members of the HHS Policy Committee to review and submit comments, ideas, or questions by 5:00 p.m. on October 16. Following the submission of comments, we have prepared a draft of the platform chapters for review by the Health and Human Services Policy Committee.

This review is intended to serve as the second step in the process of developing the 2021-2022 platform. If the Committee has any further agreed upon edits, staff will make the suggested changes and present the updated draft version to the CSAC Board of Directors for approval in early 2021.

Below is a high-level summary of the changes made to each of the chapters based on both an internal review and committee member comments.

Chapter Six – Health Services

Edits were made throughout the chapter to remove language that was out-of-date and to streamline the platform. Further edits were made to reformat the chapter to make it more reader-friendly and concise and including language to reflect the county role in advancing health equity and eliminating disparities. Additional substantive changes are noted below:

- Section 2: Public Health – Expanding on the need for additional federal and state support public health responsibilities including retaining a skilled public health workforce.
- Section 3: Behavioral Health – Adding language to reflect CSAC's advocacy on the Mental Health Services Act (MHSA) based on the principles approved by the CSAC Board of Directors, adding language to reflect the significant role county behavioral

health departments have in criminal justice prevention; eliminating the separate substance use disorder subsection, and reorganizing bullet points under the new County Specialty Behavioral Health Plans subsection.

- Section 5: Children's Health – Updating language to reflect the full implementation of the Whole Child Model. Proposition 10 sub-section was updated to reflect the collective goals of the First 5 county commissions and county Boards around the need for quality early learning, supporting families and comprehensive health and development of children and families.
- Section 6: Medi-Cal: Californian's Medicaid Program – Adding language to reflect the shared state county responsibility for eligibility timelines and accuracy and proposals under the CalAIM initiative, updating language to reflect the role of county welfare departments in Medi-Cal eligibility determination, deleting old references to the 2012-13 IHSS MOE and updating principles to reflect counties current work on aging issues. The section reflects updates for consistency with the Human Services platform chapter.
- Section 8: California Health Services Financing – Revising section to reflect the move from large Medicaid waivers.

Chapter Eleven – Human Services

Edits were made throughout the chapter to remove language that was out-of-date and to streamline the platform. Further edits were made to reformat the chapter and to make it more reader-friendly and concise. Additional substantive changes are noted below:

- Section 3: Child Welfare Services/Foster Care – Updating section to reflect the substantial role county behavioral health departments have in CCR and combined CSEC language into one bullet point.
- Section 6: Aging and Dependent Adults – Updating the In-Home Supportive Services section to reflect the new 2019-20 MOE, adding support for efforts to prevent homelessness for older adults, and adding language to support funding for a range of aging programs and services.
- Section 7: Child Support Enforcement – Updating language for consistency throughout document.
- Section 9: Proposition 10: The First 5 Children and Families Commissions – Updated to reflect the collective goals of the First 5 county commissions and county Boards around the need for quality early learning, supporting families and comprehensive health and development of children and families.

We wish to thank each of the supervisors, county affiliate organizations, and county staff who reviewed the proposed changes and suggested additional clarifications.

Attachments.

1. Draft Health Services Platform Chapter
2. Draft Human Services Platform Chapter
3. Realignment Platform Chapter

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Policy Platform Review

Attachment Four

Draft Health Platform Chapter

Chapter Six

Health Services

Section 1: General Principles

Counties are mandated to protect Californians against threats of widespread disease and illness and are tasked with promoting health and wellness equitably across all populations in California. This chapter deals specifically with health services and covers the major segments of counties' functions in health services. Health services in each county shall relate to the needs of residents within that county in a systematic manner without limitation to availability of hospital(s) or other specific methods of service delivery. The board of supervisors in each county sets the standards of care for its residents.

Local health needs vary greatly from county to county. Counties support and encourage the use of multi-jurisdictional approaches to health care. Counties support efforts to create cost-saving partnerships between the state and the counties, and other organizations to achieve better health outcomes and health equity. Therefore, counties should have the maximum amount of flexibility in managing programs. Counties should have the ability to expand or consolidate facilities, services, and program contracts to provide a comprehensive level of service and accountability, access for all populations, and ~~achieve~~ maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state must work with counties to encourage maximum program flexibility and minimize disruptions in county funding, from the transition phase to new reimbursement mechanisms and outcome development and assessment.

Counties also support a continuum of preventative health efforts – communicable disease control and chronic disease prevention – and the inclusion of public health in the design and planning of healthy communities. Counties also support efforts to prevent and treat substance use and mental health disorders. Preventative health efforts have proven to be cost effective and provide a benefit to all residents.

Federal health reform efforts, including the Patient Protection and Affordable Care Act (ACA) of 2010, provide new challenges, as well as opportunities, for counties. Counties, as providers, administrators, and employers, are deeply involved with health care at all levels and must be full partners with the state and federal governments t to expand Medicaid and provide health insurance and access to care ~~to a broader population of Californians~~. Counties believe in maximizing the allowable coverage for their residents in accordance with eligibility criteria, while also preserving access to local health services for the residual uninsured. Counties remain committed to serving as an integral part of any effort to improve or reform California's health system.

At the federal level, counties also support economic stimulus efforts that help maintain services levels and access for the state's neediest residents, regardless of an extenuating circumstance such as an emergency or disaster. Counties strongly urge that any federal stimulus funding, enhanced matching funds, or innovation grants that include~~have~~ a county share of cost be allocated~~shared~~ directly to each county that qualifies~~with counties~~.

Section 2: Public Health

County health departments and agencies are responsible for protecting, assessing and assuring individual, community and environmental health. Public health agencies are tasked with controlling the spread of infectious diseases through immunizations, surveillance, disease investigations, laboratory testing and planning, preparedness, and response activities. Furthermore, county health agencies are tasked with evaluating the health needs of their communities and play a vital role in chronic disease and injury prevention through education, policy, system, and environmental changes promoting healthier communities.

County health departments are also charged with responding to public health emergencies, ranging from terrorist and biomedical attacks to natural disasters and emerging infectious diseases, including maintaining the necessary infrastructure – such as laboratories, medical supply, and prescription drug caches, as well as trained personnel – needed to protect our residents~~..~~. Currently, counties are concerned about the lack of funding, planning, and ongoing support for critical public health infrastructure. The state and federal governments must work with counties and provide funding to ensure adequate planning, medical supplies, access to laboratory testing services, workforce and alternative care capacity to appropriately respond to any local, state, or global health emergency.

County health departments are also working to reduce health inequities with efforts to eliminate barriers to good health and supporting the equitable distribution of resources necessary for the health of California's diverse population, including underserved communities. Strategies addressing the social determinants of health by ~~include~~ working with other sectors to maintain and expand affordable, safe, and stable housing; ensuring a health equity lens is applied to economic and social policies to identify and address unintended consequences and potential effects on vulnerable populations; and collecting, analyzing, and sharing information to understand and address the health impacts of racism, discrimination and bias.

1) To effectively respond to these local needs, counties must have adequate, sustained funding for local public health communicable disease control, epidemiological surveillance, chronic disease and injury prevention, emergency preparedness, planning and response activities~~,~~ and other core public health functions. Counties must also have state and federal support in growing and retaining a highly skilled public health workforce.

2) Counties support the preservation of the federal Prevention and Public Health Fund for public health activities, and oppose any efforts to decrease its funding. Counties support efforts to secure direct funding for counties to meet the goals of the Fund.

3) Counties believe strongly in comprehensive health services planning. Planning must be done through locally elected officials, both directly and by the appointment of quality individuals to serve in policy and decision-making positions for health services planning efforts. Counties must also have the flexibility to make health policy and fiscal decisions at the local level to meet the needs of their communities.

Section 3: Behavioral Health

Counties provide a full continuum of community-based prevention and treatment services for individuals living with severe mental illness and with substance use disorders (SUD). Counties have responsibility for providing treatment and administration of mental health and substance use disorder programs for individuals across all payors, including the uninsured, and specifically for Medi-Cal beneficiaries. Counties must~~should~~ have the flexibility to design and implement behavioral health services that best meet the needs of their local communities. The appropriate treatment of people living

with substance use and severe mental health ~~issues~~ disorders should be provided equitably and within ~~in~~ the framework of local, state, and federal criteria.

Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority and flexibility. At the same time, the state must ensure that counties have adequate funding to continue such services.

Behavioral health services may also reduce criminal justice costs and recidivism through prevention, diversion and reentry services. The state and counties must partner to ensure adequate resources for addressing the complex needs of individuals involved in or at risk of being involved in the criminal justice system who also live with serious mental illness and substance use disorders.

The state must acknowledge the critical role of counties in responding to natural disasters and local emergencies and the need for disaster response trauma-related behavioral health services.

Proposition 63: Mental Health Services Act

The adoption of Proposition 63, the Mental Health Services Act of 2004 (MHSA), assists counties in mental health service delivery to the public. ~~It~~ The Act is intended to provide new funding that expands and improves the capacity of ~~existing~~ county behavioral health systems of care and provides ~~an~~ opportunities~~y~~ to fund initiatives not otherwise funded via Medicaid, such as infrastructure, workforce, prevention, the "whatever it takes" model of care, and ~~integrate funding and~~community-led innovations~~e at the local level~~. MHSA funding is also dedicated to meeting the needs of each community ~~,~~ via robust stakeholder input~~,~~ to determine spending priorities. The Act is crucial to the stability of the Medi-Cal behavioral health safety net as counties expertly leverage MHSA funding to provide more than $1 billion in Medi-Cal services annually.

1) Counties oppose additional reductions in state funding for behavioral health services that will result in the shifting of state or federal costs to counties, or require counties to use MHSA funds for that purpose. These cost shifts result in reduced services available at the local level and disrupt treatment options for behavioral health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor behavioral health programs to individual community needs consistent with the Act.

2) Counties also strongly oppose any effort to redirect ~~the~~ MHSA funding to existing state services instead of the local services for which it was designated by the voters~~originally intended~~. The realignment of health and social services programs in 1991 restructured California's public behavioral health system. Realignment required local responsibility for program design and delivery within statewide standards of eligibility and scope of services, and designated revenues to support those programs to the extent that resources are available.

3) MHSA funds have been diverted in the past due to economic challenges and the establishment of the No Place Like Home Program in 2016. Any further diversions of MHSA funding will require robust county engagement, keeping the needs of local communities at the forefront without ~~be~~ disruption~~ve~~ to current programming at the local level.

4) Counties support timely and clear reporting standards, including reversion timelines, for MHSA expenditures and seek guidance from the Department of Health Care Services on all reporting standards, deadlines, and formats. Any development or update to reporting should be clearly established with county stakeholder involvement. Further, updates should be data-driven and measureable.

5) Counties support the fiscal integrity of the MHSA and transparency in stakeholder input, distributions, spending, reporting, and reversions.

6) Counties support the continued evaluation of MHSA funding silos to allow for greater funding flexibility, accountability for outcomes, and its usage for individuals living with a substance use disorder or co-occurring disorders, provided counties are central to the development of reforms and any shift to accountability for outcomes is grounded in sound data science and client and community input..

~~5)~~

County Specialty ~~Mental~~ Behavioral Health Plans

Counties are committed to service delivery that manages and coordinates services to persons with behavioral health needs and that operates within a system of performance outcomes ~~that~~ which assures funds are spent in a manner that provides access to the highest quality of care for all residents. ~~Integration of care and parity requirements require c~~County specialty ~~mental~~ behavioral health plans must to adapt to new models, ~~and~~ lead collaborative efforts, and receive adequate and sustainable resources for ~~in~~ the next era of behavioral health care.

Counties assumed the role of Medi-Cal specialty plans for behavioral health when they supported ~~actions to~~the consolidation of~~e the~~ what were then two distinct Medi-Cal behavioral health systems ~~,~~ one operated by county behavioral health departments and the other operated by the state Department of Health Services~~, and to operate~~ into a single Medi-Cal ~~behavioral~~ Mental ~~h~~Health services ~~as~~ managed care ~~program~~ plan at the local level that operates separately, or is "carved-out," of Medi-Cal managed care. California counties ~~chose to operate as a Medi-Cal Mental Health Plans, and many counties have chosen~~ subsequently developed the first in the nation 1115 Medicaid waiver to ~~operate as managed care plans for~~deliver substance use disorder services through a managed care model under the Drug Medi-Cal Organized Delivery System waiver program. There is a negotiated sharing of risk for services between the state and counties, particularly because counties became solely responsible for managing the nonfederal share of cost for all Medicaid specialty ~~these~~ behavioral health services under 2011 Realignment.

1) Counties ~~have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority, flexibility, and funding to continue such services.~~recognize that access to high quality prevention and treatment services for adolescents and young adults with behavioral health needs can be improved, and support fiscally viable strategies for building a more comprehensive continuum of care including residential treatment services, for this vulnerable age group.

2) Counties ~~anticipate increased demand for behavioral health services including substance use disorder services, under Medi-Cal parity, and must seek collaboration at the local level to meet care standards for these populations.~~ support technical

assistance for counties and providers to ensure timely and accurate billing, as well as compliance with quality and service requirements. Responsibility for billing errors, code errors, or other billing oversights must be shared by the state, counties and any applicable providers.

3) ~~Behavioral health services can reduce criminal justice costs and utilization through prevention, diversion, and during, or post incarceration.~~The State must ensure that Medi-Cal specialty behavioral health plans are adequately resourced.

4) Counties ~~continue to work across disciplines and within the 2011 Realignment structure to achieve good outcomes for persons with mental illness and/or substance abuse issues to help prevent incarceration and to treat those who are about to be incarcerated or are newly released from incarceration and their families~~continue to support state and federal efforts to provide behavioral health benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve behavioral health parity.

~~*Substance Use Disorder Prevention and Treatment*~~

~~Counties provide community-based treatment for individuals who meet income eligibility requirements and qualify for medically necessary substance use disorder treatment services and provide individual and community-based prevention services. Counties support federal parity requirements and are working to ensure evidence-based treatment capacity, but are also challenged by new managed care requirements that may strain local systems. .~~

~~1)~~5)Counties support and seek additional housing options for people with mental health and substance use disorders, including recovery and treatment housing options within the community, as well as residential treatment services.

~~2) Adequate early intervention, substance use disorder prevention, and treatment services have been proven to reduce criminal justice costs and utilization. However, appropriate funding for diagnosis and treatment services must be available. Appropriate substance use disorder treatment services benefits the public safety system. Counties will continue to work across disciplines to achieve good outcomes for persons with substance use disorder issues and/or mental illness.~~

~~3)~~6)Counties support cross-sector, multi-jurisdictional collaboration to promote education on substance use disorders, and mental health conditions, and to prevent suicide, overdoses and disparities in mortality for individuals with behavioral health conditions~~substance use related deaths~~.

~~4) Counties continue to support state and federal efforts to provide substance use disorder benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve substance use disorder services and treatment parity.~~

~~5)~~7)The courts may still refer individuals to counties for treatment under Proposition 36 or by court order, but counties are increasingly unable to provide these voter and judge-mandated services without adequate dedicated state funding.

~~6) Counties recognize that access to high quality substance use disorder prevention and treatment services for adolescents and young adults can be improved, and support fiscally viable strategies for building a more comprehensive continuum of substance use disorder prevention and treatment services for this age group.~~

8) Counties ~~support technical assistance for counties and providers to ensure timely and accurate billing, as well as compliance with quality and service requirements.~~urge the state to prioritize coordination and alignment with county based systems of care when funding new mental health and substance use disorder initiatives, and to include counties in opportunities for supplemental or flexible funding for behavioral health services. Funding behavioral health services in a fragmented or siloed manner is unlikely to promote access or quality.
~~7)~~

Section 4: Public Guardians/Administrators/Conservators

Public Administrators, Public Guardians and Public Conservators act under the authority granted by the California Superior Court, but are solely a county function and funded with county General Funds. The recent rise in interest in conservatorships as vehicles to help manage justice involved and homeless populations also places significant fiscal and workload pressure on county guardians and conservators.

1) CSAC supports the acquisition of additional and sustainable non-county resources for public guardians, conservators, and administrators to ensure quality safety-net services for all who qualify. Any proposal from the Legislature to expand the responsibility of county public conservators of LPS "gravely disabled" conservativees must come with additional funding and time for the system to treat and manage the expanded population.

2) CSAC opposes additional duties, mandates, and requirements for public guardians, conservators, and administrators without the provision of adequate funding to carry out these services.

3) CSAC will work to support placement capacity for public guardians, conservators, and administrators as California severely lacks safe and secure housing for the majority of residents under conservatorship. This includes supporting efforts to acquire additional resources for licensed adult residential facilities and residential care facilities for the elderly.

Section 5: Children's Health

California Children's Services

Counties administer the California Children's Services programs on behalf of the State. ~~Recent~~ With the implementation of the Whole Child Model within County Organized Health Systems (COHS) counties, moved service authorization and case management services to local managed care plans. Under the Whole Child Model, counties also are still responsible for determination of residential, medical, and financial eligibility for the program. Counties also provide Medical Therapy Program services for California Children's Services children, and retain a share of cost for services to non-Medi-Cal children.

1) Maximum federal and state matching funds for The California Children's Services program must continue to avoid the shifting of costs to counties. Counties cannot

continue to bear the rapidly increasing costs associated with both program growth and eroding state support.

2) Counties also support efforts to test alternative models of care under pilot programs.

3) ~~As counties shift towards the Whole Child Model, c~~Counties seek to ensure these high-need patients continue to receive timely access to quality care, and there are no disruptions in care.~~,~~ In addition, counties must be adequately resourced ~~-~~to provide services to children that remain the county's responsibility.~~and there is an adequate plan for employee transition.~~

State Children's Health Insurance Program

1) CSAC supports sustained funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). In 2018, the CHIP program was reauthorized through 2023. However, the federal match rate decreases over time during this period and limits the requirement to provide coverage for children in families with income at or below 300% of the federal poverty level. Without federal funding, some families risk losing coverage for their children if their income is too high to qualify for Medicaid/Medi-Cal and too low to purchase family coverage.

Proposition 10: The First 5 Children and Families Commissions

In November 1998, California voters passed Proposition 10, the ~~California~~ "Children and Families Act ~~Initiative~~ of 1998" initiative, ~~provides significant resources to enhance and strengthen early childhood development at the local level and created First 5 commissions in all 58 counties~~which created the 58 First 5 county commissions across the state. The act levies a tax on cigarettes and other tobacco products and provides funding for early childhood development programs and mandates that commissions work across systems to integrate service delivery and promote optimal childhood development.

First 5 Children and Families Commissions believe that every child deserves to be healthy, safe, and ready to succeed in school and life. Based on extensive research, First 5 promotes the importance of collective impact to support children and families from the earliest moments possible. This prevention framework leads to improved child health and development outcomes, increased school success, and over time increases economic benefit across all public systems.

1) Counties recognize the importance of polices that advance whole child, whole family approaches, increase racial equity, build integrated systems and focus on prevention to enhance critical services for children and families. As such, counties support strengthening early care, comprehensive health and development, and learning programs and systems, with a focus on programs that counties administer, facilitate participation in, or that enhance the ability of First 5 commissions to serve communities and families. Counties will also give consideration to how improved early childhood outcomes can have positive impacts related to potential interaction between children and families with other programs that counties administer.

~~1) Local children and families commissions (local First 5 Commissions), established~~

~~as a result of the passage of Proposition 10, must maintain the full discretion to determine the use of their share of funds generated by Proposition 10.~~

2) ~~Local~~ Counties oppose any effort to restrict local First 5 expenditure authority. First 5 commissions must maintain the necessary flexibility to direct these resources address the greatest needs of communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale. ~~Counties oppose any effort to diminish Proposition 10 funds or to impose restrictions on local First 5 Commissions' expenditure authority.~~

3) Counties oppose any effort to diminish First 5 funding, lower or eliminate state support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues. ~~Further, counties will support the backfill that Proposition 10 now receives from the state's most recent tobacco tax, Proposition 56 (2016), just as Proposition 10 pays to the previous tobacco initiatives.~~Due to the declining nature of tobacco tax revenues, counties support the inclusion of existing tobacco taxes, including Proposition 10, in any subsequent tobacco tax proposal.

4) Counties support efforts that improve system coordination and encourage ~~local and state collaborations and~~ leveraging of resources within counties and between local and state agencies to enhance critical services for ~~First 5 commissions funding to sustain and expand critical services for~~ children and families. ~~in our communities.~~

Section 6: Medi-Cal: California's Medicaid Program

California counties have a unique perspective on the state's Medicaid program, Medi-Cal. Counties are charged with preserving the ~~public~~ health and safety of communities; they also operate health plans, provide direct services, specialize in care for patients with complex social needs, conduct eligibility for benefits, and bear a significant amount of risk for financing the program. As the local public health authority, counties are vitally concerned about health outcomes. Undoubtedly, changes to the Medi-Cal program, including efforts to integrate and coordinate care for Medi-Cal enrollees, will affect all counties.

1) Counties remain concerned about state ~~and~~, ~~federal~~federal and local partner proposals that would decrease access to health care or shift costs and risk for Medicaid services to counties.

2) Any Medi-Cal reform that results in decreased access to or funding of county hospitals and health systems will be devastating to the safety net and the patients we serve. The loss of Medi-Cal funds translates into fewer dollars to ~~help pay for safety net services~~ operate our facilities and deliver care to ~~for~~ all persons served by county facilities. Counties are not in a position to absorb or backfill the loss of state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services.

3) Counties support the continued role of county welfare departments in Medi-Cal eligibility, enrollment, outreach, and retention functions. The state should fully fund county costs for the administration of the Medi-Cal program, and consult with counties on all policy, operational, and technological changes in the administration of the program. Further, enhanced data matching and case management of these enrollees must include adequate funding and be administered at the local level.

~~3) County welfare departments determine eligibility for the Medi-Cal program and must receive adequate funding for these duties.~~

4) County behavioral health departments provide Medi-Cal Managed Care Specialty Mental health services, and must receive adequate funding for these critical services and new sustainable funding for additional responsibilities. Changes to the Medi-Cal program, including the move toward integrated care, will undoubtedly affect the day-to-day business and fiscal viability of California counties as wells as the people we serve.

5) It is vital that changes to Medi-Cal preserve the viability and innovations of the local safety net and not shift additional costs to counties. Counties support examining payment reform within the county specialty mental health plans as longs as efficiencies and administrative workload are simplified and counties do not shoulder additional costs.

6) Counties oppose any efforts to decrease funding for or reverse expansions to the Medi-Cal program, which will eliminate coverage for consumers and shift the responsibility of ~~providing~~ these individuals with healthcare from the Medi-Cal program to counties, which are required to provide services to the medically indigent.

7) The state should continue to provide options for counties to implement managed care systems that meet local needs. The state should work openly with counties as primary partners in this endeavor and allow counties a role in managed care plan selection.

8) The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems. The Medi-Cal program must offer a reasonable reimbursement and rate mechanism for local managed care systems.

9) Changes to Medi-Cal must preserve access to medically necessary behavioral health care and drug treatment services. Counties also support proposals, such as the CalAIM proposal of 2019, to modify the state's definition of medically necessary to include services provided before a clinical diagnosis is made. This modification will increase timely access to critical services for children, those with substance use disorders, and all mental health plan clients. These changes must be accompanied by the ability to claim federal Medicaid funding for pre-diagnosis services

10) The carve-out of specialty behavioral health services within the Medi-Cal program must be examined in the era of integrated care, but any change must preserve federal funding~~,~~ available to counties and minimize county risks to continue the effective delivery of rehabilitative community-based mental health services to local Medi-Cal enrollees.

11) Counties recognize the need to continue to innovate under the Drug Medi-Cal Organized Delivery System Waiver program in ways that maximize federal funds, ensure access to medically necessary evidence-based practices, allow counties to retain authority and choice in contracting with accredited providers, and minimize county fiscal risks.

12) Any Medi-Cal reform effort must recognize the importance of substance use disorder treatment and services in the local health care continuum, as well as the evidence of good outcomes under integrated care models.

13) Counties will not accept a share of cost to locally support the Medi-Cal program. Counties also

believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.

14) The state should fully fund county costs associated with the local administration of the Medi-Cal program.

15) Complexities of rules and requirements should be minimized or reduced so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome to recipients, providers, and administrators and are no more restrictive or duplicative than required by federal law.

16) The State should consider counties as full partners in the administration of Medi-Cal, and consult with counties in formulating and implementing all policy, operational and technological changes.

Medicare Part D

Medicare Part D led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and behavioral health systems.

1) Counties strongly oppose any change to realignment funding that may result and would oppose any reduction or shifting of costs associated with this benefit that would require a greater mandate on counties.

Medicaid and Aging Issues

1) Counties support reliable funding for programs that affect older and dependent adults, such as Adult Protective Services and In-Home Supportive Services, and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments. Please see the Human Services Chapter of the CSAC Platform for more details on IHSS and APS.

2) Counties support efforts to prevent, identify, and prosecute instances of elder abuse.

3) Counties support investments of new state and federal resources to support the APS workforce and enhance the direct services available to victims of abuse and neglect.

4) Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum of services as part of a long-term system of care for this vulnerable but vibrant population.

5) Counties support federal and state funding to support Alzheimer's disease and dementia research, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer's disease and dementia.

6) Counties support legislative efforts to prevent homelessness among at-risk older adults and people with disabilities.

7) Counties support funding for the full range of aging programs that provide services to older adults including services provided by Area Agencies on Aging (AAAs), senior nutrition programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports.

~~1) Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum of services as part of a long-term system of care for this vulnerable but vibrant population.~~

~~2) Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.~~

~~3) Counties support the continuation of federal and state funding for the In-Home Supportive Services (IHSS) program, and oppose any efforts to shift additional IHSS costs to counties.~~

~~4) Counties support the IHSS Maintenance of Effort (MOE) as negotiated in the 2012-13 state budget.~~

~~5) Counties support moving collective bargaining for the IHSS program to the Statewide IHSS Authority or another single statewide entity.~~

~~Counties also support federal and state funding to support Alzheimer's disease and dementia research, early detection and diagnosis, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer's disease and dementia.~~

~~6)~~

Section 7: Health Reform Efforts

Counties support affordable, comprehensive health care coverage for all persons living in the state. The sequence of changes and implementation of federal or state healthcare reform efforts must be carefully planned, and the state must work in partnership with counties to successfully realize any gains in health care and possible cost increases or decreases~~s~~.

Under AB 85, Counties must also retain sufficient health realignment revenues for residual responsibilities, including existing Medi-Cal non-federal share responsibilities to care for the remaining uninsured, and public health. Any changes to AB 85 must also allow counties to retain sufficient health realignment revenues for these residual responsibilities and future needs.

1) Counties support offering a truly comprehensive package of health services that includes mental health and substance use disorder treatment services at parity levels and a strong prevention component and incentives.

2) Counties support the integration of health care services for inmates and offenders of county and state correctional institutions, detainees, and undocumented immigrants into the larger health care service model.

3) Health reform efforts must address access to health care in rural communities and other underserved areas and include incentives and remedies to meet these needs as quickly as possible.

4) Counties strongly support maintaining a stable and viable health care safety net with adequate funding.

5) The current safety net is grossly underfunded. Any diversion of funds away from existing safety net services will lead to the dismantling of the health care safety net and will hurt access to care for all Californians.

6) Counties believe that delivery systems that meet the needs of vulnerable populations and provide extensive primary, specialty and tertiary care ~~– such as emergency and trauma care and training of medical residents~~ are essential providers. Their education, training and ongoing work ~~and other health care professionals –~~ must be supported in any health care reform effort.

7) Counties strongly support adequate funding for the local public health system as part of a plan to reform health care and achieve universal health coverage. A strong local public health system ~~will~~ can help reduce medical care costs, ~~contain or mitigate disease~~assist patients in managing chronic disease, reduce health inequities, and address disaster preparedness and response.

8) Counties support access to affordable, comprehensive health coverage through a combination of mechanisms that may include improvements in and expansion of the publicly funded health programs, increased employer-based and individual coverage through purchasing pools, tax incentives, and system restructuring. The costs of universal health care and health care reform shall be shared among all sectors: government, labor, and business.

9) Health reform efforts, including efforts to achieve universal health care, should simplify the health care system – for consumers, providers, and overall administration. Any efforts to reform the health care system should include prudent utilization control mechanisms that are appropriate and do not create barriers to necessary care.

10) The federal government has an obligation and responsibility to assist in the provision funding of health care coverage.

11) Counties encourage the state to pursue ways to maximize federal financial participation in health care expansion efforts, and to take full advantage of opportunities to simplify Medi-Cal, and other publicly funded programs with the goal of achieving maximum enrollment and provider participation.

12) County financial resources are currently overburdened; counties are not in a position to contribute permanent additional resources to expand or integrate health care coverage.

13) Counties strongly encourage public health and equity as ~~to be a~~ key components to ~~of~~ any health care coverage expansion. Public health prevention activities in addition to access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes. Health equity efforts will increase access to health care for underserved populations and improve the overall health of our communities.

14) Counties, as both employers and administrators of health care programs, ~~believe that~~recognize that, under the current system in the United States every employer has an obligation to contribute to health care coverage, and counties advocate that such an employer policy should also be pursued at the federal level and be consistent with the goals and principles of local control at the county government level.

15) Reforms of health care coverage should offer opportunities for self-employed individuals, temporary workers, and contract workers to obtain affordable quality health coverage.

Section 8: California Health Services Financing

1) Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal.

2) Counties are concerned about the erosion of state program funding and the inability of counties to sustain current program levels. As a result, we strongly oppose additional cuts in county administrative programs as well as any attempts by the state to shift the costs for these programs to counties. With respect to the County Medical Services Program (CMSP), counties support efforts to improve program cost effectiveness and oppose state efforts to shift costs to participating counties, including administrative costs and elimination of other state contributions to the program. Due to the unique characteristics of each county's delivery system, health care accessibility, and demographics of client population, counties believe that managed care systems must be tailored to each county's needs, and that counties should have the opportunity to choose providers that best meet the needs of their populations. Where cost-effective, the state and counties should provide non-emergency health services to undocumented immigrants and together seek federal and other reimbursement for medical services provided to undocumented immigrants.

3) Counties support the continued use of federal Medicaid funds for emergency services for undocumented immigrants. Counties support increased funding for trauma and emergency room services overall.

4) Although reducing the number of uninsured through expanded health care coverage will help reduce the financial losses to trauma centers and emergency rooms, critical health care safety-net services must be supported to ensure their long-term viability.

Realignment

1) Counties believe the integrity of realignment should be protected. ~~However, c~~Counties also strongly oppose any change to realignment funding that would negatively impact counties fiscal or administratively.

2) Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further mandates of new and greater fiscal responsibilities to counties in this partnership program.

3) Any effort to realign additional programs must occur in the context of Proposition 1A constitutional provisions and must guarantee that counties have sufficient revenues

for residual responsibilities, including public health programs.

4) In 2011, counties assumed fiscal responsibility for Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Drug Medi-Cal; drug courts; perinatal treatment programs; and women's and children's residential treatment services as part of the 2011 Public Safety Realignment. Please see the Realignment Chapter of the CSAC Platform and accompanying principles.

5) Counties bear significant responsibility for financing the non-federal share of Medi-Cal services in county public health systems. They also continue to have responsibility for uninsured services.

Hospital Financing

Public hospitals are a vital piece of the local safety net, and serve as indispensable components of a robust health system, providing primary, specialty, and acute health services, as well as physician training, trauma centers, and burn care. California's public hospitals are increasingly providing funding for provide a significant portion of the state's non-federal share of the state's Medicaid in the Medi-Cal program, and these local expenditures are made at the sole discretion of the county Supervisors.

1) Counties have been firm that any proposal to change hospital Medicaid financing must guarantee that county hospitals do not receive less funding than they currently do, and are eligible for more federal funding in the future as needs grow and challenges arise.

2) Counties strongly support the continuation of a robust and innovative Medicaid Section 11115000 and 1915(b) waivers to help ensure that county hospitals are paid for the safety net care they provide to Medi-Cal recipients and uninsured patients and have the ability to innovate and improve access to care.

3) As California moves away from large Medicaid waivers that county public hospitals have relied on for critical funding, funding levels must be preserved and strengthened through other vehicles. Counties support a five-year state Medicaid Waiver that provides funding to counties at current levels. The successor waiver should: 1) support a public integrated safety net delivery system; 2) build on previous delivery system improvement efforts for public health care systems so that they can continue to transform care delivery; 3) allow for the creation of a new county pilot effort to advance improvements through coordinated care, integrated physical and behavioral health services and provide robust coordination with social, housing and other services critical to improve care of targeted high-risk patients.; 4) improve ability to share and integrate health data and systems; 5) and provide flexibility for counties/public health care systems to deliver more coordinated care and effectively serve individuals who will remain uninsured.

4) Counties are supportive of opportunities to reduce costs for county hospitals and health systems, particularly for mandates such as seismic safety requirements and nurse-staffing ratios. Therefore, counties support infrastructure bonds that will provide funds to county hospitals for seismic safety upgrades, including construction, replacement, renovation, and retrofit.

~~5)~~4) Counties also support opportunities for county public hospitals and health systems to make delivery system improvements, including improving care coordination, ~~and upgrades,~~ which will help ~~these institutions, compete in the modern health care marketplace.~~ ensure the provision of high quality, accessible carte to all patients they serve.

~~6)~~5) Counties support proposals to preserve supplemental payments to public and private hospitals ~~as the Federal Medicaid Managed Care rules are implemented in California~~. Any loss of federal funds through changes to waiver agreements or ~~modifications to federal managed care rule implementation~~ federal regulations must ~~address~~ identify ~~through~~ other fiscal opportunities and support to ensure the continued viability of the safety net.

Section 9: Family Violence

CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts that target family violence prevention, intervention, and treatment. Specific strategies for early intervention and success should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues, taking into account that violence adversely impacts Californians, particularly those in disadvantaged communities, at disproportionate rates and that these impacts have long ranging health and economic consequences for these individuals and the state as a whole.

Section 10: Healthy Communities

Built and social environments significantly impact the health of communities. Counties support public policies and programs that aid in development of healthy communities including food and beverage policies that increase access to healthier food in county-operated no/low cost food programs (e.g., USDA Summer Lunch, inmate programs, and senior meals) or concession and vending operations. Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable and safe developments, to promote healthy community events and activities.

Section 11: Veterans

Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state and local governments, as well as community and private organizations serving veterans.

Counties support coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

Section 12: Emergency Medical Services

1) Counties do not intend to infringe upon the service areas of other levels of government who provide similar services, but will continue to discharge our statutory duties to ensure that all county residents have access to the appropriate level and quality of emergency services, including medically indigent adults.

2) Counties support ensuring the continuity and integrity of the current emergency medical

services system, including county authority related to medical control, trauma planning, and alternative destination efforts.

3) Counties recognize that effective administration and oversight of local emergency medical services systems includes input from key stakeholders, such as other local governments, private providers, state officials, local boards and commissions, and the people in our communities who depend on these critical services.

4) Counties support maintaining the authority and governing role of counties and their local emergency medical services agencies to plan, implement, and evaluate all aspects and components of the local Emergency Medical Services system.

5) Counties oppose efforts that would weaken the local authority of local medical services agencies or lead to system fragmentation and safety issues.

Section 13: Court-Involved Population

Counties recognize the importance of enrolling the court-involved population into Medi-Cal and other public programs. Medi-Cal enrollment provides access to important behavioral health, substance use, and primary care services that will improve health outcomes and may reduce recidivism. CSAC continues to look for partnership opportunities with the Department of Health Care Services, foundations, and other stakeholders on enrollment, eligibility, quality, and improving outcomes for this population. Counties are supportive of obtaining federal Medicaid funds for inpatient hospitalizations, including psychiatric hospitalizations, for adults and juveniles while they are incarcerated.

Section 14: Incompetent to Stand Trial

Counties affirm the authority of County Public Guardians under current law to conduct conservatorship investigations and are mindful of the potential costs and ramifications of additional mandates or duties in this area.

Counties support collaboration among the California Department of State Hospitals, county Public Guardians, Behavioral Health Departments, and County Sheriffs to find secure placements for individuals originating from DSH facilities, county jails, or who are under conservatorship. Counties support a shared funding and service delivery model for complex placements, such as the Enhanced Treatment Program.

Counties recognize the need for additional secure placement options for adults and juveniles who are conserved or involved in the local or state criminal justice systems, including juveniles.

Policy Platform Review

Attachment Five

Draft Human Services Platform Chapter

Chapter Eleven

Human Services

Section 1: General Principles

Counties are committed to the delivery of public social services at the local level. However, counties require adequate and ongoing federal and state funding, maximum local authority, and flexibility for the administration and provision of public social services.

Inadequate funding for program costs strains the ability of counties to meet accountability standards and, in some programs, avoid penalties, putting the state and counties at risk for hundreds of millions of dollars in federal disallowances and fiscal penalties. Freezing program funding also shifts costs to counties and increases the county share of program costs above statutory sharing ratios, while at the same time running contrary to the constitutional provisions of Proposition 1A.

At the federal level, counties support additional federal funding to help maintain service levels and access for the state's neediest residents. Counties are straining to provide services to the burgeoning numbers of families in distress. With each downturn in the economy, counties experience an increased need of individuals and families seeking assistance through vital safety net programs such as Medicaid, Supplemental Nutrition Assistance Program (SNAP, or Food Stamps), Temporary Assistance to Needy Families (TANF), and General Assistance. Even in strong economic times, millions of Californians struggle to make ends meet. For these reasons, counties strongly urge that any additional federal or state funding must be shared directly with counties for programs that have a county share of cost.

Despite state assumption of major welfare program costs after Proposition 13, counties continue to be hampered by state administrative constraints and cost-sharing requirements, which ultimately affect the ability of counties to provide and maintain programs. The state should set minimum standards, allowing counties to enhance and supplement programs according to local needs of each county. If the state implements performance standards, the costs for meeting such requirements must be fully reimbursed.

Section 2: Human Services Funding Deficit

While counties are legislatively mandated to administer numerous human services programs including Foster Care, Child Welfare Services, CalWORKs, Adoptions, Adult Protective Services, CalFresh, and In-Home Supportive Services, funding for these services has generally been frozen at 2001 cost levels. The state's failure to fund actual county cost increases contributes to a growing funding gap of nearly $1 billion annually. This places counties in the untenable position of backfilling the gap with their own limited resources or cutting services that the state and county residents expect us to deliver.

2011 Realignment shifted fiscal responsibility for the Foster Care, Child Welfare Services, Adoptions and Adult Protective Services programs to the counties. Counties remain committed to the overall principle of fair, predictable, and ongoing funding for human services programs that keeps pace with actual costs. Please see the Realignment Chapter of the CSAC Platform and accompanying principles.

Section 3: Child Welfare Services/Foster Care

A child deserves to grow up in an environment that is healthy, safe, and nurturing. To meet this goal, families and caregivers should have access to public and private services that are comprehensive and collaborative. Further, recent system reforms and court-ordered changes, such as the Continuum of Care Reform (CCR) effort require collaboration between county child welfare services/foster care and mental health systems as well as other systems.

The existing approach to budgeting and funding child welfare services was established in the mid 1980's. Since that time, dramatic changes in child welfare policy have occurred, as well as significant demographic and societal changes, impacting the workload demands of the current system. 2011 Realignment provides a mechanism that will help meet some of the current needs of the child welfare services system, but existing workload demands and continued pressure to expand services remain a concern without additional investments by the state and federal government.

Further, court settlements (Katie A.) and policy changes (AB 12 Fostering Connections to Success Act of 2010 and AB 403, CCR) require close state/county collaboration with an emphasis on ensuring adequate ongoing funding that adapts to the needs of children who qualify. Additionally, the specified court settlements and policy changes require close coordination across local county systems to ensure that children and youth receive all medically necessary behavioral health services.

The Continuum of Care Reform (CCR) enacted significant changes in the child welfare program and the county behavioral health delivery system that ~~are~~ intended to reduce the use of group homes and improve outcomes for foster youth. In addition, CCR is designed to increase the availability of trauma-informed services and utilize child and family teams to meet the unique needs of foster youth. Counties remain firmly committed to the ongoing implementation of these comprehensive and systematic changes, while seeking the flexibility to create programs and placements to foster success for this unique population.

~~Commercial sexual exploitation of children (CSEC) is a growing national and statewide issue. Counties believe this complex problem warrants immediate attention, including funding for prevention, intervention, and direct services through county child welfare services agencies.~~

1) Counties support comprehensive array of prevention, intervention and post-permanency services for children, youth and families. Both counties and the State have a stake in achieving desired outcomes and as such, these services should be resourced appropriately.

2) When, despite the provision of voluntary services, the family or caregiver is unable to minimally ensure or provide a healthy, safe, and nurturing environment, a range of intervention approaches should be available for families. When determining the appropriate intervention approach, the best interest of the child should always be the first consideration.

3) When a child is in danger of physical harm or neglect, either the child or alleged offender may be removed from the home, and formal dependency and criminal court actions may be taken. Where appropriate, family preservation, and support services should be available in a comprehensive, culturally appropriate, and timely manner.

4) Counties support efforts to reform the congregate care – or youth group home – system under AB 403, the CCR. Providing stable family homes for all of our foster and probation youth is

anticipated to lead to better outcomes for those youth and our communities. However, funding for this massive post-2011 Realignment system change is of paramount importance. Any reform efforts must also consider issues related to collaboration, capacity, and funding. County efforts to recruit, support, and retain foster family homes and provide pathways to ~~mental~~ behavioral health support are but some of the challenges under CCR. ~~—~~Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.

5) When foster children/youth cannot return home, counties support a permanency planning process that matches foster children/youth through adoption and/or guardianship, with a foster caregiver. Counties support efforts to accelerate the judicial process for terminating parental rights in cases where there has been serious abuse and where it is clear that the family cannot be reunified.

6) Counties support adequate state funding for adoption services and post-permanency supportive services.

7) Counties seek to obtain additional funding and flexibility at both the state and federal levels to provide robust transitional services to foster youth such as housing, employment services, and increased access to aid up to age 26. Counties support such ongoing services for former and emancipated foster youth up to age 26. Counties have implemented the Fostering Connections to Success Act of 2010 for non-minor dependents in foster care (aged 18-21) and have assumed hundreds of millions of dollars in costs that have not been reimbursed by the State, an issue that remains unresolved.

8) With regards to caseload and workload standards in child welfare, especially with major policy reforms such as CCR, counties remain concerned about increasing workloads and the possibility of reduced Realignment funding in an economic downturn, both of which threaten the ability of county child welfare agencies to meet their federal and state mandates in serving children and families impacted by abuse and neglect.

9) Counties support a reexamination of reasonable caseload levels given significant recent changes in policy and practice, including CCR and AB 12, and the complex needs of children, youth and families, often requiring cross-system collaboration (i.e. youth with developmental disabilities, behavioral health needs, and special education needs) with youth and families. Counties support ongoing augmentations for Child Welfare Services, including investments in workforce development and workload reduction, to support children and families in crisis. Counties also support efforts to document workload needs and gather data in these areas so that we may ensure adequate funding for this complex system.

10) Commercial sexual exploitation of children (CSEC) is a growing national and statewide issue. Counties believe this complex problem warrants immediate attention, including funding for prevention, intervention, and direct services through county child welfare services agencies. Counties support efforts to build capacity within local child welfare agencies to serve child victims of commercial sexual exploitation. Counties support close cooperation on CSEC issues with law enforcement, the judiciary, and community-based organizations to ensure the best outcomes for child victims.

11) As our focus remains on the preservation and empowerment of families, we believe the potential for the public to fear some increased risk to children is outweighed by the positive

effects of a research-supported family preservation emphasis. Within the family preservation and support services approach, the best interest of the child should always be the first consideration. Counties support transparency related to child fatality and near-fatality incidents so long as it preserves the privacy of the child and additional individuals who may reside in a setting but were not involved or liable for any incidents.

Section 4: Employment and Self-Sufficiency Programs

Self-sufficiency and employment programs play a critical role in the well-being of county residents and provide needed cash assistance, food assistance, and employment services for eligible individuals. The California Work Opportunity and Responsibility to Kids (CalWORKs) program is California's version of the federal Temporary Assistance for Needy Families (TANF) program, which provides temporary cash assistance to low-income families with children to meet basic needs as well as welfare-to-work services that help families become self-sufficient. CalFresh is California's version of the federal Supplemental Nutrition Assistance Program (SNAP), which provides food assistance benefits to help improve the health of low-income families and individuals.

There is a need for simplification of the administration of public assistance programs. The state should continue to take a leadership role in seeking state and federal legislative and regulatory changes to achieve simplification, consolidation, and consistency across all major public assistance programs, including CalWORKs, Medi-Cal, and CalFresh. In addition, electronic technology improvements in human services administration are important tools to obtaining a more efficient and accessible system. It is only with adequate and reliable resources and flexibility that counties can truly address the fundamental barriers that many families have to self-sufficiency.

1) California counties are far more diverse from county to county than many regions of the United States. The state's welfare structure should recognize this diversity and allow counties flexibility in administering welfare programs, while providing overall state-level leadership that draws on the latest understanding of how families in poverty interact with public systems and how to best support them toward self-sufficiency. There should remain as much uniformity as possible in areas such as eligibility requirements, grant levels and benefit structures. To the extent possible, program standards should seek to minimize incentives for public assistance recipients to migrate from county to county within the state.

2) The welfare system should also recognize the importance of and provide sufficient federal and state funding for education, job training, child care, and support services that are necessary to move recipients to self-sufficiency. There should also be sufficient federal and state funding for retention services, such as childcare and additional training, to assist former recipients in maintaining employment.

3) Any state savings from the welfare system should be directed to counties to provide assistance to the affected population for programs at the counties' discretion, such as General Assistance, indigent health care, job training, child care, mental health, alcohol and drug services, and other services required to accomplish welfare-to-work goals.

4) Federal and state programs should include services that accommodate the special needs of people who relocate to the state after an emergency or natural disaster.

5) Counties support providing services for indigents at the local level. However, the state should

assume the principal fiscal responsibility for administering programs such as General Assistance. The structure of federal and state programs must not shift costs or clients to county-level programs without full reimbursement.

6) Welfare-to-work efforts should focus on prevention of the factors that lead to poverty and welfare dependency including unemployment, underemployment, behavioral health and/or illness, ~~a~~ lack of educational opportunities, food security issues, and housing problems. Counties support the development of a continuous quality improvement system with agreed upon measures and the consideration of incentives for improvement. Prevention efforts should also acknowledge the responsibility of absent parents by improving efforts for absent parent location, paternity establishment, child support award establishment, and the timely collection of child support.

7) California's unique position as the nation's leading agricultural state should be leveraged to increase food security for its residents. Counties support increased nutritional supplementation efforts at the state and federal levels, including increased aid, longer terms of aid, and increased access for those in need.

8) Counties recognize safe, dependable, and affordable child care as an integral part of attaining and retaining employment and overall family self-sufficiency, and therefore support efforts to seek additional funding to expand child care eligibility, access, and quality programs.

9) Counties support efforts to address housing supports and housing assistance efforts at the state and local levels. Long-term planning, creative funding, and accurate data on homelessness are essential to addressing housing security and homelessness issues.

10) The state should fully fund county costs for the administration of the CalWORKs and CalFresh programs, and consult with counties on all policy, operational, and technological changes in the administration of the programs.

Section 5: Medicaid Eligibility

Counties support health care reform efforts to expand access to affordable, quality healthcare for all California residents, including the full implementation of the federal Patient Protection and Affordable Care Act of 2010 (ACA) and the expansion of coverage to the fullest extent allowed under federal law. Health care eligibility and enrollment functions must build on existing local infrastructure and processes and remain as accessible as possible. Counties are required by law to administer eligibility and enrollment functions for Medi-Cal, and recognize that many of the new enrollees under the ACA may also participate in other human services programs. For this reason, counties support the continued role of county welfare departments~~ies~~ in Medi-Cal eligibility, enrollment, outreach, and retention functions.

The state should fully fund county costs for the administration of the Medi-Cal program, and consult with counties on all policy, operational, and technological changes in the administration of the program. Further, enhanced data matching and case management of these enrollees must include adequate funding and be administered at the local level.

Section 6: Aging and Dependent Adults

California is home to more older adults than any other state in the nation and this population

continues to grow. The huge growth in the number of older Californians will affect how local governments plan for and provide services, running the gamut from housing and health care to transportation and in-home care services. While many counties are addressing the needs of their older and dependent adult populations in unique and innovative ways, all are struggling to maintain basic safety net services in addition to ensuring an array of services needed by this aging population.

The Adult Protective Services (APS) Program is the state's safety net program for abused and neglected adults. APS is now solely financed and administered at the local level by counties. As such, counties provide around-the-clock critical services to protect the state's most vulnerable seniors and dependent adults from abuse and neglect. Counties must retain local flexibility in meeting the needs of our aging population, and timely response by local APS is critical, as studies show that elder abuse victims are 3.1 times more likely to die prematurely than the average senior.

1) Counties support reliable funding for programs that affect older and dependent adults, such as Adult Protective Services and In-Home Supportive Services, and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments.

2) Counties support efforts to prevent, identify, and prosecute instances of elder abuse.

3) Counties support investments of new state and federal resources to support the APS workforce and enhance the direct services available to victims of abuse and neglect.

4) Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum of services as part of a long-term system of care for this vulnerable but vibrant population.

5) Counties support federal and state funding to support Alzheimer's disease and dementia research, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer's disease and dementia.

6) Counties support legislative efforts to prevent homelessness among at-risk older adults and people with disabilities.

7) Counties support funding for the full range of aging programs that provide services to older adults including services provided by Area Agencies on Aging (AAAs), senior nutrition programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports.

In-Home Supportive Services

The In-Home Supportive Services (IHSS) program is a federal Medicaid program administered by the state and run by counties that enables program recipients to hire a caregiver to provide services that enable that person to stay in his or her home safely and prevents institutional care, which supports California in meeting federal Olmstead Act requirements. Individuals eligible for IHSS services are disabled, age 65 or older, or those who are blind and unable to live safely at home without help.

County social workers evaluate prospective and ongoing IHSS recipients, who may receive assistance with such tasks as housecleaning, meal preparation, laundry, grocery shopping, personal care

services such as bathing, paramedical services, and accompaniment to medical appointments. Once a recipient is authorized for service hours, the recipient is responsible for hiring his or her provider.

Although the recipient is considered the employer for purpose of hiring, supervising, and firing their provider, state law requires counties to establish an "employer of record" for purposes of collective bargaining to set provider wages and benefits.

As California's aging population continues to increase, costs and caseloads for the program continue to grow. According to the Department of Social Services, caseloads are projected to increase between five and seven percent annually going forward.

In response to the end of the Coordinated Care Initiative and the County IHSS Maintenance of Effort (MOE), a new MOE was negotiated during the 2017-18 state budget process. The new MOE included specific offsetting revenue, including a State General Fund contribution.

1) Counties support the continuation of federal and state funding for IHSS, and oppose any efforts to shift additional IHSS costs to counties.

2) The IHSS MOE negotiated in the 2017-18 state budget was~~is~~ not sustainable for counties as the county share of IHSS costs ~~will~~ would have significantly outpaced the available revenues in the ~~coming~~ out years. Counties support changes that provided additional state funding for IHSS costs and~~or~~ lowered the county share of IHSS costs. Counties support a long-term solution that aligns the county share of IHSS costs with the available revenues, which could occur through a lowered sharing ratio, restructured MOE, or increased State General Fund contribution.

3) The state should fully fund county costs for the administration of the IHSS program, and consult with counties on all policy, operational, and technological changes in the administration of the program.

4) Counties support moving collective bargaining for the IHSS program to a single statewide entity.

Section 7: Child Support Program

Counties are committed to strengthening the child support program through implementation of federal mandates and state statutes. Ensuring effective and efficient ongoing operations requires sufficient federal and state funding and any federal or state child support policy changes should ~~must~~ not result in ~~any~~ increased county costs. Counties support maximizing federal funding for child support operations at the county level.

1) The way in which child support funding is structured prevents many counties from efficiently meeting state and federal collection guidelines and occasionally leads ~~forces~~ smaller counties to adopt a regionalized approach or, more alarmingly, fail to provide needed services as mandated by existing standards. Counties need an adequate and sustainable funding stream and flexibility at the local level to ensure timely and accurate child support efforts, and must not be held liable for failures to meet guidelines in the face of inadequate and inflexible funding.

2) Counties must have the freedom to make local decisions at the local level. While program

standards and mandates are codified in state statute and federal mandate, the unique decisions on how to operationalize those mandates must remain a decision that is made at the local level.

A successful child support program requires a partnership between the state and counties. Counties must have meaningful and regular input into the development of state policies and guidelines regarding the child support program and the local flexibility to organize and structure effective programs.

Section 8: Realignment

In 1991, the state and counties entered into a new fiscal relationship known as 1991 Realignment. 1991 Realignment affects health, mental health, and social services programs and funding. The state transferred control of programs to counties, altered program cost-sharing ratios, and provided counties with dedicated tax revenues from state sales tax and vehicle license fees to pay for these changes.

In 2011, counties assumed fiscal responsibility for Child Welfare Services, adoptions, adoptions assistance, Child Abuse Prevention Intervention and Treatment services, foster care and Adult Protective Services as part of the 2011 Public Safety Realignment. Please see the Realignment chapter of the CSAC Platform and accompanying principles.

1) Counties support the concept of state and local program realignment and the principles adopted by CSAC and the Legislature in forming realignment. Thus, counties believe the integrity of realignment should be protected.

2) Counties strongly oppose any change to realignment funding that would negatively impact counties. Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further mandates of new and greater fiscal responsibilities in this partnership program.

3) Any effort to realign additional programs must occur within the context of the constitutional provisions of Proposition 1A or Proposition 30.

Section 9: Proposition 10: The First 5~~Five~~ Children and Families Commissions

In November 1998, California voters passed Proposition 10, the ~~California~~ "Children and Families ~~Initiative~~ Act of 1998" initiative, ~~provides significant resources to enhance and strengthen early childhood development at the local level and created First 5 Commissions in all 58 counties.~~which created the 58 First 5 county commissions across the state. The act levies a tax on cigarettes and other tobacco products and provides funding for early childhood development programs and mandates that commissions work across systems to integrate service delivery and promote optimal childhood development.

First 5 Children and Families Commissions believe that every child deserves to be healthy, safe, and ready to succeed in school and life. Based on extensive research, First 5 promotes the importance of collective impact to support children and families from the earliest moments possible. This prevention framework leads to improved child health and development outcomes, increased school success, and over time increases economic benefit across all public systems.

1) ~~Local children and families commissions (First 5 Commissions), established as a result of the passage of Proposition 10, must maintain the full discretion to determine the use of their share of funds generated by Proposition 10.~~ Counties recognize the importance of policies that advance whole child, whole family approaches, increase racial equity, build integrated systems and focus on prevention to enhance critical services for children and families. As such, counties support strengthening early care, comprehensive health and development, and learning programs and systems, with a focus on programs that counties administer, facilitate participation in, or that enhance the ability of First 5 commissions to serve communities and families. Counties will also consider how improved early childhood and family outcomes lead to positive impacts related to other programs and systems that counties administer.

2) ~~Local~~ Counties oppose any effort to restrict local First 5 expenditure authority. First 5 commissions must maintain the necessary flexibility to direct these resources to address the greatest needs of communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale. ~~Counties oppose any effort to diminish local Proposition 10 funds or to impose restrictions on their local expenditure authority.~~

3) Counties oppose any effort to diminish First 5 funding, lower or eliminate state support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues. ~~Further, counties will support the backfill that Proposition 10 now receives from the state's most recent tobacco tax, Proposition 56 (2016), just as Proposition 10 pays to the previous tobacco initiatives.~~Due to the declining nature of tobacco tax revenues, counties support the inclusion of existing tobacco taxes, including Proposition 10, in any subsequent tobacco proposal.

4) Counties support ~~local and state collaborations and~~efforts that improve system coordination and encourage leveraging ~~First 5 commissions to sustain and expand critical services for children and families in our communities.~~of resources within counties and between local and state agencies to enhance critical services for children and families.

Section 10: Family Violence

CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts that target family violence prevention, intervention, and treatment. Specific strategies for early intervention and success should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues, taking into account that violence adversely impacts Californians, particularly those in disadvantaged communities, at disproportionate rates and that these impacts have long ranging health and economic consequences for these individuals and the state as a whole.

Section 11: Veterans

Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state, and local governments, as well as community and private organizations serving veterans.

Counties support coordination of services for veterans among all entities that serve this population,

especially in housing, treatment, and employment training.

Policy Platform Review

Attachment Six

Draft Realignment Platform Chapter

Chapter 16

Realignment

In 2011, an array of law enforcement and health and human services programs – grouped under a broad definition of "public safety services" – was transferred to counties along with a defined revenue source. The 2011 Realignment package was a negotiated agreement with the Brown Administration and came with a promise, realized with the November 2012 passage of Proposition 30, of constitutional funding guarantees and protections against costs associated with future programmatic changes, including state and federal law changes as well as court decisions. Counties will oppose proposals to change the constitutional fiscal structure of 2011 Realignment, including proposals to change or redirect growth funding that does not follow the intent of the law.

CSAC will oppose efforts that limit county flexibility in implementing programs and services realigned in 2011 or infringe upon our individual and collective ability to innovate locally. Counties resolve to remain accountable to our local constituents in delivering high-quality programs that efficiently and effectively respond to local needs. Further, we support counties' development of appropriate measures of local outcomes and dissemination of best practices.

These statements are intended to be read in conjunction with previously adopted and refined Realignment Principles, already incorporated in the CSAC Platform below. These principles, along with the protections enacted under Proposition 1A (2004), will guide our response to any future proposal to shift additional state responsibilities to counties.

2010 CSAC Realignment Principles: Approved by the CSAC Board of Directors

Facing the most challenging fiscal environment in the California since the 1930s, counties are examining ways in which the state-local relationship can be restructured and improved to ensure safe and healthy communities. This effort, which will emphasize both fiscal adequacy and stability, does not seek to reopen the 1991 state-local Realignment framework. However, that framework will help illustrate and guide counties as we embark on a conversation about the risks and opportunities of any state-local realignment.

With the passage of Proposition 1A the state and counties entered into a new relationship whereby local property taxes, sales and use taxes, and Vehicle License Fees are constitutionally dedicated to local governments. Proposition 1A also provides that the Legislature must fund state-mandated programs; if not, the Legislature must suspend those state-mandated programs. Any effort to realign additional programs must occur in the context of these constitutional provisions.

Counties have agreed that any proposed realignment of programs should be subject to the following principles:

1) **Revenue Adequacy.** The revenues provided in the base year for each program must recognize

existing levels of funding in relation to program need in light of recent reductions and the Human Services Funding Deficit. Revenues must also be at least as great as the expenditures for each program transferred and as great as expenditures would have been absent realignment. Revenues in the base year and future years must cover both direct and indirect costs. A county's share of costs for a realigned program or for services to a population that is a new county responsibility must not exceed the amount of realigned and federal revenue that it receives for the program or service. The state shall bear the financial responsibility for any costs in excess of realigned and federal revenues into the future. There must be a mechanism to protect against entitlement program costs consuming non-entitlement program funding.

   a. The Human Services Funding Deficit is a result of the state funding its share of social services programs based on 2001 costs instead of the actual costs to counties to provide mandated services on behalf of the state. Realignment must recognize existing and potential future shortfalls in state responsibility that have resulted in an effective increase in the county share of program costs. In doing so, realignment must protect counties from de facto cost shifts from the state's failure to appropriately fund its share of programs.

2) **Revenue Source.** The designated revenue sources provided for program transfers must be levied statewide and allocated on the basis of programs and/or populations transferred; the designated revenue source(s) should not require a local vote. The state must not divert any federal revenue that it currently allocates to realigned programs.
3) **Transfer of Existing Realigned Programs to the State.** Any proposed swap of programs must be revenue neutral. If the state takes responsibility for a realigned program, the revenues transferred cannot be more than the counties received for that program or service in the last year for which the program was a county responsibility.
4) **Mandate Reimbursement.** Counties, the Administration, and the Legislature must work together to improve the process by which mandates are reviewed by the Legislature and its fiscal committees, claims made by local governments, and costs reimbursed by the State. Counties believe a more accurate and timely process is necessary for efficient provision of programs and services at the local level.
5) **Local Control and Flexibility.** For discretionary programs, counties must have the maximum flexibility to manage the realigned programs and to design services for new populations transferred to county responsibility within the revenue base made available, including flexibility to transfer funds between programs. For entitlement programs, counties must have maximum flexibility over the design of service delivery and administration, to the extent allowable under federal law. Again, there must be a mechanism to protect against entitlement program costs consuming non-entitlement program funding.
6) **Federal Maintenance of Effort and Penalties.** Federal maintenance of effort requirements (the amount of funds the state puts up to receive federal funds, such as IV-E and TANF), as well as federal penalties and sanctions, must remain the responsibility of the state.

Health and Human Services 2021 Draft Priorities

Attachment Seven

CSAC Memo: Health and Human Services 2021 Draft Priorities

November 16, 2020

To: Health and Human Services Policy Committee

From: Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative
Justin Garrett, CSAC Human Services Legislative Representative
Roshena Duree, CSAC Health and Human Services Legislative Analyst

RE: 2021 Health and Human Services Priorities

Introduction. Each year, CSAC establishes priority advocacy issues for the Association for approval by the Board of Directors. The CSAC advocacy team assesses the policy and political landscape for the coming year and drafts suggested priorities to conform to the Association's existing platform language.

Each policy committee is then tasked with examining and discussing the proposed priorities in their issue area and voting to approve draft priorities. Once approved by the policy committee, these draft priorities will be forwarded to the CSAC Board of Directors for final approval in early 2021. The CSAC Board is also considering a list of initial priorities at the November Board Meeting that are driven by the most pressing county needs.

The below proposed 2021 HHS priorities were developed with the current state and federal political landscapes in mind. The ongoing COVID-19 pandemic, which directly impacts county HHS services and budgets, will continue to require the primary focus of the HHS team. The list of the highest-level priorities reflects that reality, though CSAC will continue to engage on a myriad of HHS issues in 2021. Please review these draft 2021 priorities and prepare for a discussion and action during the November 16 meeting of the policy committee.

County Health and Human Services Budgets

County budgets will continue to face significant hardship and uncertainty in 2021 due to the ongoing pandemic and economic downturn. Revenues that counties rely on for normal operations are eroding, while counties also must respond to the unprecedented demands of the ongoing public health crisis as frontline service providers. The Realignment backfill that CSAC secured in the 2020-21 state budget for 1991 and 2011 Realignments has helped counties maintain the safety net. However, both Realignments did fall short of base, which impacts this funding on an ongoing basis, and there remains significant uncertainty for these revenues in 2020-21. Programs for vulnerable populations that remain at risk when there is reduced funding include child welfare, extended foster care, adult protective services, and inpatient psychiatric care. CSAC will continue to advocate for adequate funding for safety net services that counties provide and increased federal and state assistance for pandemic-related services in order to prevent reductions to the vital health and human services programs that are needed more than ever.

COVID-19

The coronavirus and COVID-19 continues to be a foundational public health issue, but the worldwide pandemic is also spurring an increase in demand for county behavioral health services and eligibility for human services programs, as well as impacting local health systems and spurring increased food insecurity in our communities. Further, the fiscal effects of the pandemic on county operations and workforce, as well as local economies, are dire. CSAC will continue to engage Congress, Governor Newsom, the state Health and Human Services Agency and Department of Public Health, as well as other state agencies, on the state's reopening rubric, the availability of testing, health equity, the need for a specialized workforce including epidemiologists and health care providers, and, most importantly, the crucial resources required for counties to remain on the front lines the COVID-19 battle.

Aging Programs

The Governor is set to release the state's Master Plan for Aging in December. CSAC has actively participated in the Master Plan process and highlighted many of the key principles related to county responsibilities for aging services including the need for local flexibility, building on local strengths, increased coordination, and adequate resources. As the Master Plan moves from the development to the implementation phase, CSAC will continue to remain engaged on recommendations related to In-Home Supportive Services (IHSS), Adult Protective Services (APS), Public Administrators/Public Guardians/Public Conservators, Alzheimer's disease, and services administered by Area Agencies on Aging (AAA). CSAC will also continue to engage on protecting older adults from COVID-19, including facility regulation, workforce assistance, and testing. For IHSS, both related to the Master Plan recommendations and state budget discussions, CSAC will continue to prioritize county fiscal sustainability for IHSS and engage on collective bargaining provisions.

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Health and Human Services 2020 Year in Review

Attachment Eight

CSAC Memo: Health and Human Services 2020 Year in Review

November 16, 2020

To: Health and Human Services Policy Committee

From: Farrah McDaid Ting, CSAC Health and Behavioral Health Senior Legislative Representative
Justin Garrett, CSAC Human Services Legislative Representative
Roshena Duree, CSAC Health and Human Services Legislative Analyst

RE: 2020 Legislative Review

In 2019, the Legislature passed more than 1,000 bills for Governor Newsom to take action on; many of those bills were measures CSAC actively engaged in. In contrast, the 2020 Legislative session saw less than 500 bills go to the Governor's desk. The impacts of COVID-19 dominated the legislative process and significantly impacted the CSAC HHS team's advocacy. Securing county funding and ensuring programs and services continue reaching those in need, were just a couple of the issues that CSAC focused on. This section describes the outcomes for the most significant HHS issues in 2020.

Outcomes of Health and Human Services Issues 2020

Realignment Funding

The Budget Act, signed in June, provided $1 billion to counties for safety net services as a Realignment backfill in 2020-21. This outcome was a result of the extraordinary and sustained advocacy by CSAC, county affiliates, and counties to improve on earlier proposals and communicate how critical this funding was to prevent devastating cuts to services for vulnerable individuals. This funding will be used by counties for human services, health, mental health, and public safety programs funded by 1991 Realignment and 2011 Realignment. Of this total, $750 million was provided directly from state general fund dollars and $250 million was dependent upon the state receiving additional federal COVID-19 relief by October 15. Unfortunately, additional federal COVID-19 relief was not adopted prior to October 15 and the $250 million was not provided. The Budget Act indicated that the backfill funding is contingent upon county compliance with the state's stay-at-home order, Executive Orders, and Department of Public Health orders and guidance issued in response to the COVID-19 emergency.

Throughout the summer, CSAC worked closely with the Administration and Legislature to reach agreement and draft budget bill language (BBL) that was included in SB 115 to allow the Realignment backfill to be distributed to counties as quickly as possible. The BBL required the remainder of the $750 million Realignment backfill amount to be distributed to counties within 15 days of the legislation being chaptered so that counties can preserve the safety net. This funding was distributed on September 17. The language also defined the existing requirement for county compliance with COVID-19 public health orders and maintained a mechanism for the Administration to withhold funding if a county is out of compliance.

Other State Budget Items

Despite the significant budget challenges facing the state, CSAC was able to successfully advocate for investments and prevent cuts to critical health and human services programs.

The key human services budget successes include:

- Continuum of Care Reform – In partnership with the County Welfare Directors Association (CWDA), CSAC advocated for funding to address increased county costs for implementation of the Continuum of Care Reform (CCR). The final budget agreement included $2.6 million for Child and Family Teams and an additional $80 million for counties.
- Family Urgent Response System – The final budget agreement rejected the May Revision proposal to eliminate the Family Urgent Response System (FURS), which will provide foster youth and their caregivers with the immediate support and services they need during times of emotional crisis. CSAC supported the legislation to enact FURS and opposed the May Revision proposal to eliminate the program.
- Expanded Subsidized Employment (ESE) – The final budget agreement rejected the May Revision proposal to eliminate funding for CalWORKs expanded subsidized employment. CSAC opposed this funding reduction as this program proved critical for counties during the Great Recession and will be an important tool within recovery efforts for the pandemic.
- CalFresh County Administration Funding – An additional $80.1 million General Fund for CalFresh county administration was included in the state budget in recognition of the significant caseload increases caused by the pandemic. The budget also included a two-year waiver of the required county match for the additional $80.1 million, allowing counties to access this increased funding without having to fund the county share. This was a CWDA proposal that was supported by CSAC.
- CalFresh Enrollment – The human services budget trailer bill contained many provisions from the CWDA sponsored, and CSAC supported, AB 2413 to increase and simplify enrollment for CalFresh. The bill requires procedures to be established so that counties can first verify information electronically and through self-attestation. It would enact certain policies to increase dual enrollment between CalFresh and Medi-Cal. Finally, the bill would establish a workgroup to examine options to reduce the reporting burden on recipients and workload burden on county staff.

The key health and behavioral health budget successes include:

- Mental Health Services Act (Proposition 63) – The budget agreement between the Governor and Legislature granted several temporary flexibilities for Mental Health Services Act (MHSA) funding due to the COVID-19 pandemic, including:
    - *Fund Reversion:* Suspension of the deadline for reverting unspent MHSA funds until July 1, 2021. This applies only to unspent funds that were scheduled to be reverted as of July 1, 2019 or July 1, 2020.
    - *Accessing Prudent Reserves:* Authorizing counties to use funds from MHSA prudent reserves for mental health expenditures to children and adults, including housing assistance, during the 2020-21 fiscal year.
    - *Flexibility of Funding:* Authorizes counties to determine allocations of MHSA funds within community services and supports, and prevention and early intervention categories for the 2020-21 fiscal year.

- *Administrative Flexibility:* Allowing counties to extend the effective timeframe for MHSA three-year expenditure plans or annual updates to include the 2020- 21 fiscal year. AB 81 also extends the deadline for counties to submit the three-year plan or annual update to the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the Department of Health Care Services (DHCS) to July 1, 2021.

- County Medical Services Program -- The County Medical Services Program (CMSP) was again in the Administration's sights as the Governor proposed to divert $50 million from the program's budget reserves for each of the next four fiscal years to offset state CalWORKs costs in May. We are pleased to report that the Legislature did not agree and the recent budget bills do not contain any changes to CMSP funding or reserves.
- Medi-Cal 2020 Waiver/CalAIM **–** The budget compromise authorizes the Department of Health Care Services, in consultation with stakeholders, to seek federal approval for a temporary extension of the state's Section 1115 Medi-Cal Waiver Demonstration project known as Medi-Cal 2020. This key federal waiver had been set to expire on December 31, 2020 and currently provides millions in needed funding for public hospitals and health systems, authorizes the Whole Person Care pilot projects, and extends addiction treatment in a majority of counties through the Drug Medi-Cal Organized Delivery System. CSAC strongly supported the extension of all waivers due to the COVID-19 pandemic.
- E-Cigarette/Vaping Tax -- The Governor's January budget and May Revision proposed a new e-cigarette tax on top of existing tobacco taxes, but failed to share the anticipated revenue with local First 5 Commissions. CSAC, along with the First 5 Association of California, strongly advocated for inclusion of First 5 into any new tobacco tax. Our efforts resulted in delaying the issue in the 2020 session, but we expect it to return in 2021.

<u>Emergency Medical Services: AB 1544 (Gipson)</u>

In 2019, CSAC partnered with county affiliates to negotiate amendments to bills that would have altered community paramedicine pilots and eroded the medical authority of local emergency medical service agencies. AB 1544, authored by Assembly Member Mike Gipson was one of those bills and was similar to a 2018 measure authored by the same legislator. After tirelessly working throughout 2019 with the bill's sponsors to negotiate provisions to clarify the role of local emergency medical services agencies and ensure this measure does not infringe on the existing authority of local emergency management service agencies. With the safeguards negotiated in 2019, CSAC was able to adopt a neutral position. The bill subsequently became a two-year bill. Governor Newsom signed AB 1544 authorizing a local EMS agency to develop a community paramedicine or triage to alternate destination program to provide community paramedicine services with a sunset of January 1, 2024.

<u>Health: AB 890 (Wood) and SB 932 (Wiener)</u>

Since March, a number of the state legislative proposals that CSAC staff engaged in were dropped by Legislators in both houses due to time restraints and to focus on immediate statewide needs.

Legislators passed measures such as, AB 2537 and SB 275, which require employers of health care workers provide personal protective equipment (PPE) to their employees, and AB 1710 which will authorize pharmacies to independently administer a COVID-19 vaccine when one is approved and available. In addition to bills directly related to the current COVID-19 response CSAC engaged on additional bills of note.

Assembly Member Jim Wood authored AB 890 which establishes the Nurse Practitioner Advisory Committee to advise the Board of Registered Nursing regarding nurse practitioner (NP) issues, including disciplinary actions. The bill also expands the functions a NP may perform if they satisfy specified certification and documentation requirements. The bill requires the Board of Registered Nursing to define standards for NPs to perform additional duties independently. CSAC supported AB 890.

SB 932 authored by Senator Scott Wiener requires any electronic tool used by a local health officer for the purpose of reporting cases of communicable diseases to the California Department of Public Health to include the capacity to collect and report data relating to sexual orientation and gender identity, thereby imposing a state-mandated local program. The bill would also require a health care provider that knows a case or suspected case of specified communicable diseases to report to the health officer for the jurisdiction in which the patient resides the patient's sexual orientation and gender identity, if known. CSAC had concerns with original language, but was neutral on the chaptered language.

Behavioral Health: AB 1976 (Eggman), AB 2112 (Ramos), SB 803 (Beall), SB 855 (Wiener)

CSAC continues to work on a range of behavioral health proposals and issues which look to increase and change how funding sources are used by counties, assist with the workforce shortage, expand telehealth, clarify mental health parity standards, and reduce the stigma of suicide.

Assembly Member Susan Eggman, authored AB 1976 which requires all counties offer assisted outpatient treatment (AOT) programs– commonly known as Laura's Law – and eliminates the current Laura's Law sunset. Specifically, the bill will require county Boards to opt-out of offering AOT services through a resolution and expand the individuals allowed to petition the court. CSAC opposed the language forcing counties to opt-out instead of opting in which unnecessarily complicating the local decision process to implement Laura's Law and increasing staff workload and asked for the petitioner expansion to be eliminated, but did support the provision repealing the sunset.

CSAC continues to prioritize behavioral health enhancement legislation. SB 803 authored by Senator Beall was legislation that Senator Beall previously worked on establishes a statewide behavioral health peer support specialist certification program. Assembly Member James Ramos authored AB 2112, establishes the Office of Suicide Prevention within the California Department of Public Health will provide best practices on suicide prevention, conduct statewide assessments of suicide prevention polices, and report on suicide reduction rates. Both bills expand on work to the expand access to behavioral health services specifically to at risk populations. CSAC supported both bills that were signed by Governor Newsom.

There were several bills that were introduced in the 2019-2020 two-year legislative session to tackle behavioral health parity. Senator Wiener's bill SB 855 on behavioral health parity will require health care plans to provide coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders; prohibit a health care service plan or health insurer from limiting benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute

treatment; specify that treatment include outpatient services, CSAC supported this measure throughout its legislative journey.

Human Services Bills: AB 1979 (Friedman), AB 2746 (Gabriel), and SB 1257 (Durazo)

CSAC has supported advances in policies that increase positive outcomes for the most vulnerable populations throughout the state. Those policies must be funded appropriately so counties can locally implement programs and services. This year legislation ranged from ensuring the safety of children, youth and older adults, expanding the access and availability to public benefits and increasing housing supports. CSAC engaged on a few bills of note.

The County Welfare Directors Association of California sponsored AB 1979, authored by Assembly Member Laura Freidman. The bill improves housing supports for non-minor dependents in extended foster care by expanding the definition of a supervised independent setting to include transitional living placements, supporting county placement agencies in their evaluation of housing needs and resources for non-minor dependents reentering extended foster care, and restructuring the transitional housing placement payment approval process. CSAC supported AB 1979, which was signed by the Governor in September.

In partnership with UCC, RCRC, and CAPH, CSAC engaged with Assembly Member Gabriel on his AB 2746. The bill, which CSAC initially opposed, would have required counties and other entities to provide annual reports on certain data for CalWORKs homelessness programs and Whole Person Care. The initial language would have increased administrative work for county departments and required counties to report on data that was not feasible. The county coalition was successful in securing amendments that allowed us to remove opposition. The Governor vetoed AB 2746 and indicated in his veto message that this bill's requirements were duplicative and would have created unnecessary data collection costs.

Another measure that the Governor vetoed was SB 1257, authored by Senator Maria Elena Durazo, which would have expanded Cal-OSHA workplace safety requirements to employers of certain domestic service employees. A prior version of the bill would have also expanded these workplace standards to publicly funded programs such as IHSS and CalWORKs child care. CSAC, CWDA, CAPA, and the Disability Rights Coalition raised concerns about the unintended consequences on the recipients of these services who would have their homes be workplaces in these situations and the complications related to publicly funded programs. Prior to the Legislature passing, amendments were taken to remove publicly funded programs from the bill. The Governor's veto message indicated that there are complications to treating places where people live as traditional workplaces and pledged to work with the Labor Agency, Cal-OSHA, and stakeholders on this issue.

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