



## **Health and Human Services Policy Committee**

### **CSAC 124<sup>th</sup> Annual Meeting**

**Tuesday, November 27, 2018 — 2:30 p.m. – 4:30 p.m.**

**San Diego Marriott Marquis Hotel (333 West Harbor Drive), Room: Pacific Ballroom 18**

**San Diego County California**

### **Supervisor Das Williams, Santa Barbara County, Chair**

### **Supervisor Jeff Griffiths, Inyo County, Vice Chair**

- 2:30 p.m. I. **Welcome and Introductions**  
*Supervisor Das Williams, Santa Barbara County, Chair*  
*Supervisor Jeff Griffiths, Inyo County, Vice Chair*
- 2:35 p.m. II. **2018 Legislative Review**  
*Farrah McDaid Ting, Legislative Representative, CSAC*  
*Justin Garrett, Legislative Representative, CSAC*  
*Roshena Duree, Legislative Analyst, CSAC*
- 2:45 p.m. III. **In-Home Supportive Services Discussion**  
*Justin Garrett, Legislative Representative, CSAC*  
*Roshena Duree, Legislative Analyst, CSAC*
- 2:55 p.m. IV. **Realignment: What Does the Future Look Like?**  
*Justin Garrett, Legislative Representative, CSAC*  
*Jacqueline Barocio, Fiscal and Policy Analyst, LAO*  
*Lourdes Morales, Fiscal and Policy Analyst, LAO*  
*David Twa, County Administrator, Contra Costa County*
- 3:40 p.m. V. **Policy Platform Review – ACTION ITEM**  
*Farrah McDaid Ting, Legislative Representative, CSAC*  
*Justin Garrett, Legislative Representative, CSAC*  
*Roshena Duree, Legislative Analyst, CSAC*
- 4:05 p.m. VI. **2019 HHS Priorities and Workplan – ACTION ITEM**  
*Farrah McDaid Ting, Legislative Representative, CSAC*  
*Justin Garrett, Legislative Representative, CSAC*  
*Roshena Duree, Legislative Analyst, CSAC*
- 4:30 p.m. VII. **Closing Comments and Adjournment**  
*Supervisor Das Williams, Santa Barbara County, Chair*  
*Supervisor Jeff Griffiths, Inyo County, Vice Chair*

*This will be an in-person only meeting. Thank you.*

## **ATTACHMENTS**

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### **II. 2018 Legislative Review**

Attachment One ..... CSAC Memo: 2018 Legislative Review

### **III. In-Home Supportive Services Update**

Attachment Two ..... CSAC Memo: In-Home Supportive Services Update

### **IV. Realignment – What Does the Future Look Like?**

Attachment Three ..... CSAC Memo: Realignment – What Does the Future Look Like?

### **V. Policy Platform Review**

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

Attachment Five ..... Draft Health Services Platform Chapter

Attachment Six ..... Draft Human Services Platform Chapter

Attachment Seven ..... Draft Realignment Chapter

### **VI. 2019 HHS Priorities and Workplan**

Attachment Eight..... CSAC Memo: 2019 HHS Priorities

Attachment Nine ..... Handout: 2019 HHS Workplan

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2018 Legislative Review  
**Attachment One**  
CSAC Memo: 2018 Legislative Review



November 14, 2018

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To: CSAC Health and Human Services Policy Committee

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

RE: **2018 Legislative Review**

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### **Outcomes of HHS Measures for 2018.**

There were several significant issues that dominated the focus for the HHS team in 2018 – homelessness, county social services administration funding, In-Home Supportive Services (IHSS), Mental Health Services Act (MHSA), and Continuum of Care Reform (CCR). We also engaged on numerous other key legislative issues. This section describes the outcomes on the most significant HHS issues in 2018.

#### Homelessness

Securing funding in the state budget to address the homelessness crisis was a top priority for CSAC and the HHS team partnered with multiple policy teams on this effort. The Budget package approved by the Legislature and sent to the Governor included more than \$700 million in funding to assist local governments in addressing homelessness. The centerpiece of the homelessness package is \$500 million for the Homeless Emergency Aid Program (HEAP), which provides funding to local governments for a spectrum of housing options, from short-term shelters to new affordable housing units to permanent supportive housing units for those living with severe mental illness.

The package also included nearly \$115 million in funding for a new emergency housing program and Housing for a Healthy California, as well as up to \$1.8 billion in bond funding through the No Place Like Home Act of 2018, which was approved by the voters as Proposition 2 in the November 2018 election. It also included funding for several human services programs, such as additional funding for the Housing Support Program, and funding for the new Home Safe program, which will allow counties to prevent homelessness among victims of elder abuse. The nine major programs funded in the 2018-19 Budget Act include:

- Homeless Emergency Aid Program (HEAP) – \$500 million
- No Place Like Home Act of 2018 – Up to \$2 billion
- Homeless Mentally Ill Outreach and Treatment Program – \$50 million
- California Emergency Solutions and Housing Program (CESH) – Up to \$57.5 million
- Housing for a Healthy California – Up to \$57.5 million
- Home Safe Program – \$15 million over three years
- CalWORKs Housing Support Program – \$24.2 million increase in 2018-19, \$48.4 million increase in 2019-20 for a total annual amount of \$95 million
- CalWORKs Homeless Assistance Program – \$8.1 million increase in 2018-19, \$15.3 million increase in 2019-20

- Homeless Youth and Exploitation Program (HX) – \$1 million increase to bring total funding up to \$2.077 million

In addition to the budget package, CSAC also supported SB 918 (Chapter 841, Statutes of 2018) by Senator Scott Wiener, which was signed by the Governor. This bill requires the Homeless Coordinating and Financing Council to establish specific goals to prevent youth homelessness, improve the health and safety of youth experiencing homelessness, and increase system integration to help prevent homelessness for youth involved in the child welfare system or the juvenile justice system.

#### County Social Services Administration Funding

Last year's budget legislation outlined requirements for the Brown Administration to consult with counties during the development of the 2018-19 budget on revising the methodologies to fund county administration costs for three programs – In-Home Supportive Services, California Work Opportunity and Responsibility to Kids (CalWORKs), and Medi-Cal. CSAC advocated for increased General Fund commitments in the 2018-19 budget to accurately reflect county costs to administer these programs and partnered with the County Welfare Directors Association (CWDA) and counties on discussions with the Department of Finance, Department of Social Services and Department of Health Care Services on discussions to revise these methodologies.

For IHSS Administration, the Legislature provided an additional \$15.4 million above the May Revision proposed amount. The total nonfederal funding for IHSS administration in the final budget was \$38 million more General Fund than was provided in 2017-18 and slightly above 2016-17 expenditures. For the CalWORKs Single Allocation, the Legislature provided an additional \$23.5 million General Fund for the Single Allocation in 2018-19. With this additional investment, the overall funding for the Single Allocation is level with 2017-18. For Medi-Cal, the 2018-19 Budget Act included the Governor's budget proposal to provide an increase of \$54.8 million (\$18.5 million General Fund) for Medi-Cal county administration. This amount is based on an adjustment that incorporates the increase in the California Consumer Price Index and similar adjustments will be made in subsequent years.

#### IHSS Implementation and Collective Bargaining

Throughout 2018, CSAC and counties continued to work with the Department of Social Services and Department of Finance on the numerous and complex changes associated with the new county IHSS Maintenance of Effort (MOE). These implementation efforts included revising the accelerated caseload growth amounts as Department of Finance revenue projections were updated, redirecting Realignment growth from the Health and Mental Health subaccounts to Social Services to offset increased IHSS costs, and ensuring accurate implementation of the new collective bargaining tools.

On the collective bargaining provisions, clean-up language was needed in early 2018 to address implementation of the wage supplement, which is a specified amount that can be negotiated in addition to the IHSS county provider wage. CSAC advocated for AB 110 (Chapter 8, Statutes of 2018), which resolved the outstanding issues on wage supplement implementation, protected some pending collective bargaining agreements, and avoided future costs for counties that utilize the wage supplement. AB 110 outlined that the IHSS wage supplement will be subsequently applied when the state minimum wage equals or exceeds the county provider wage absent the wage supplement.

Late in the state budget process, a budget trailer bill, SB 857, was amended to include language related to IHSS provider orientations. SB 857 (Chapter 87, Statutes of 2018) requires Public Authorities in Los Angeles, Merced, and Orange counties to comply with the provisions of AB 119 (Chapter 21, Statutes of 2017), which mandates all public employers to provide union access to New Employee Orientations and directs the employer and the union to determine the “structure, time, and manner” of union access by mutual agreement. CSAC shared concerns and provided suggested amendments that would have established an alternate process to reach an agreement around employee organization participation at provider orientations. Ultimately, that language was not accepted and SB 857 was signed by the Governor.

For more information on IHSS, please see the IHSS Update memo in this agenda packet.

#### Mental Health Services Act: SB 192 (Beall) & SB 688 (Moorlach)

CSAC worked on a raft of Mental Health Services Act (MHSA) bills and issues, most of which sought to reduce the flexibility of the dollars at the local level. Senator Jim Beall introduced SB 192, a measure that establishes a Mental Health Services Act (MHSA) Reversion Account for unspent MHSA funds, a prudent reserve calculation, and a timeline for counties to submit the unspent funds to the account. Counties are required to submit an expenditure plan to the state by January 1, 2019. CSAC worked with the author’s office and supported this measure which provides counties with clear direction for MHSA reserve standards. The measure was signed into law on September 10.

SB 688, authored by Senator John Moorlach, was signed by the Governor on September 14, requiring the MHSA Annual Revenue and Expenditure Report to comply with generally accepted accounting principles and to be submitted electronically in a machine-readable format to the Department of Health Care Services. CSAC supported this measure because it will make the process of submitting financial reports consistent across the state and increase transparency.

#### Emergency Medical Services: AB 3115 (Gipson)

CSAC successfully defeated a bill that would have infringed on local emergency medical services authority system. During the last week of session, AB 3115 was gutted and amended to include two failed community paramedicine pilot bills – AB 1795 (Gipson) and SB 944 (Hertzberg). AB 3115 also included several worrisome provisions related to unworkable standards for the community paramedicine pilots as well as proposed changes to the composition of local medical committees and the state Emergency Medical Services Commission. Through our work in partnership with CSAC Affiliates, the bill was vetoed by Governor Brown on September 30, 2018.

#### Continuum of Care Reform Implementation

CSAC advocated for numerous CCR provisions in the 2018-19 Budget Act and related human services omnibus trailer bill, AB 1811 (Chapter 35, Statutes of 2018). Overall, these changes provide additional funding and stability for counties to continue to implement these comprehensive and systematic changes and help meet the goals and improved outcomes envisioned by CCR.

The Legislature provided two additional investments above the May Revision amounts for county workload related to implementation of the Continuum of Care Reform (CCR). The budget included an additional \$6.3 million to support county efforts related to the backlog for Resource Family Approval (RFA). For implementation of the Level of Care (LOC) assessment tool, the budget provided an additional \$4.8 million.

AB 1811 outlines the requirements for counties and the state to provide emergency assistance payments to caregivers who are caring for children and nonminor dependents while awaiting approval as a resource family, also referred to as payments at the time of placement. For 2018-19, the emergency assistance payments would be provided for up to 180 days, with possible extensions for up to 365 days. AB 1811 also allows for the Department of Social Services to grant an extension for group homes beyond the December 31, 2018 deadline and outlines the process for county child welfare departments to submit a written request. Finally, it codifies the requirement for a methodology to reconcile the state and county costs and savings that result from CCR implementation. The first reconciliation must occur in 2018-19 and include costs and savings incurred since July 1, 2016.

Foster Care: AB 2083 (Cooley), SB 1083 (Mitchell), & AB 2043 (Arambula)

The Continuum of Care Reform (CCR) enacted significant changes in the child welfare program that are intended to reduce the use of group homes, increase the availability of trauma-informed services, and improve outcomes for foster youth. As counties continue to implement these comprehensive changes, CSAC advocated for several bills with additional enhancements to help meet these goals.

AB 2083 (Chapter 818, Statutes of 2018) was sponsored by CWDA and requires counties to work with local agencies and entities to develop Memorandums of Understanding with the goal of ensuring coordination of services for foster youth who have experienced trauma. It also requires the state to establish an interagency placement resolution team to provide guidance and technical assistance on identifying and securing the appropriate trauma-informed services. SB 1083 (Chapter 935, Statutes of 2018) extends the Resource Family Approval (RFA) deadline for current foster caregivers, including relatives and non-relatives, from December 31, 2019 to December 31, 2020. The RFA system is the new process by which foster parents are approved as caregivers. Both measures were signed by Governor Brown.

AB 2043 would have created a Family Urgent Response System to provide immediate response to current or former foster youth and their caregivers in a crisis. CSAC supported this measure as it would have helped prevent the unnecessary separation of the youth from their caregiver and ensured access to needed services in a time of crisis. The bill passed the Legislature, but was vetoed by Governor Brown.

Behavioral Health: AB 2099 (Gloria) & AB 2983 (Arambula)

CSAC supported both AB 2099 (Gloria) and AB 2983 (Arambula) in their efforts to mitigate county concerns regarding burdensome processes that sometimes impact the level of effective care provided. AB 2099 allows a copy of involuntary 72-hour psychiatric hold paperwork to be treated the same as the original. CSAC supported this bill to address recent problems involving denials of care due to providers refusing to accept digital or photocopies of the required legal paperwork. AB 2983 will prohibit acute care and psychiatric hospitals from placing a patient who is voluntarily seeking health care on a 5150 psychiatric hold as a condition of accepting a transfer. CSAC supported this measure to address the improper practice of using the 5150 hold to admit individuals who are voluntarily seeking services.

### Substance Use Disorder: AB 2861 (Salas), SB 992 (Hernandez), & SB 275 (Portantino)

CSAC continues to advocate and support legislation that will expand the quality and access to substance use disorder prevention and treatment. AB 2861 and SB 992 passed the legislature with the support and advocacy of CSAC and were signed by the Governor. AB 2861 requires the Department of Health Care Services to allow Medi-Cal billing for Drug Medi-Cal certified providers delivering services through telehealth. SB 992 requires residential alcoholism or drug abuse recovery facilities to develop discharge and continuing care plans for clients who relapse while receiving treatment and requires facilities to disclose any ownership or financial interest in unlicensed recovery facilities to the Department of Health Care Services. CSAC supported this measure to ensure all clients are provided with access to a continued treatment plan. Senator Portantino's SB 275 passed the legislature, but was subsequently vetoed by the Governor. It would have required the Department of Health Care Services to establish a comprehensive continuum of substance use disorder care for California youth and young adults under age 26, which would have included a requirement for identifying outcomes and oversight. CSAC supported this bill as a first step toward ensuring quality substance use disorder treatment for children and youth.

### Social Services Program Eligibility: AB 3224 (Thurmond)

CSAC actively engaged on AB 3224, authored by Assembly Member Thurmond, related to eligibility determinations for safety net programs. Early in 2018, there were indications that this bill could be amended in a way that would restrict contracting authority for services that counties currently may contract out. CSAC engaged early on with the author's office and the sponsors of the bill to ensure the language simply codified existing practice into state law wherein eligibility determinations for Medi-Cal, CalWORKs, and CalFresh must be made by county employees under a merit or civil service system. The language remained limited in scope to this specific purpose and CSAC remained neutral on the bill. The Governor signed AB 3224 on August 20.

### Funding for Child Support Programs

In partnership with numerous counties, CSAC advocated for additional State General Fund for county child support programs, as well as the development of a new child support program allocation methodology. Ultimately, the budget included \$3 million General Fund for county child support programs, short of the county request, and language that requires the Director of the Department of Child Support Services to work with the Child Support Directors Association to identify refinements to the child support budgeting methodology and to identify programmatic operational efficiencies.

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In-Home Supportive Services Update

**Attachment Two**

CSAC Memo: In-Home Supportive Services Update



November 14, 2018

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To: Members of the Health and Human Services Policy Committee

From: Justin Garrett, CSAC Legislative Representative, Human Services  
Roshena Duree, CSAC Legislative Analyst, Health and Human Services

**RE: In-Home Supportive Services Update**

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**Implementation.** It is nearing the midway point of the second year of the new In-Home Supportive Services (IHSS) county maintenance of effort (MOE) that was enacted in 2017-18 budget legislation (SB 90, Chapter 25, Statutes of 2017). Counties have been working diligently to implement these numerous and complex changes. Along with the new MOE, there were additional provisions related to offsetting revenue, including State General Fund, collective bargaining, and county administration costs. Below are updates on recent progress for several of these provisions.

#### Redirected Vehicle License Fee (VLF) Growth

Counties received the 2017-18 VLF growth payments in early November. A total of \$57.9 million was redirected to the Social Services subaccount from the Health, Mental Health, and County Medical Services Program (CMSP) subaccounts, with the redirected CMSP growth only available to the 35 CMSP counties. This redirected growth was allocated to counties based on the approved MOE methodology and each county's percent share of offsetting revenue.

#### Accelerated Caseload Growth

Accelerated caseload growth is the process by which a certain amount of anticipated 2018-19 sales tax growth will be accelerated to counties throughout 2018-19, instead of being distributed at the end of the realignment year, in order to help counties offset IHSS costs throughout the current year. It is anticipated that 2018-19 accelerated sales tax growth will be included in the sales tax base payments for the Social Services subaccount starting late this month (November). CSAC is working with the Department of Finance to finalize the initial amount of accelerated caseload growth and should be able to provide a more detailed update during the policy committee meeting. The accelerated caseload growth amount will be adjusted with updated estimates in the Governor's January budget and the May Revision Budget Proposal.

#### Collective Bargaining

Since the beginning of the new MOE, at least ten counties have reached agreements with IHSS provider unions to increase IHSS provider wages. Thus far, every county with a new agreement has utilized the wage supplement, which is a specified amount that can be negotiated in addition to the IHSS county provider wage. The wage supplement will be subsequently applied when the state minimum wage equals or exceeds the county provider wage absent the wage supplement amount.

Counties that are at or above the state participation cap of \$12.10 have also utilized the new tool that allows for state participation above that amount. The state will participate at 65 percent of the nonfederal share in a cumulative total of up to a 10 percent increase in the sum of the combined total of changes in wages or health benefits, or both over a three-year period.

### County Administration Funding

In partnership with the County Welfare Directors Association, CSAC worked with the Department of Social Services and the Department of Finance on updating the workload and budget assumptions for administration of the IHSS program. CSAC advocated for increased funding in the 2018-19 state budget that would accurately reflect county costs and the Legislature provided an additional \$15.4 million above the May Revision proposed amount. The total nonfederal funding for IHSS administration in the final budget was \$38 million more General Fund than was provided in 2017-18 and slightly above 2016-17 expenditures. The recommended distributions for the county IHSS administration and Public Authority administration General Fund amounts were recently shared with the Administration for implementation.

**Reopener Provision.** While counties are striving to manage the first two years of this new MOE, there are still significant concerns about the anticipated impacts of this new IHSS funding structure in the out years. CSAC was successful in advocating for a critical reopener provision that requires the Department of Finance to issue a report with findings and recommendations on specific aspects of this new IHSS fiscal structure in January 2019. Full details on this Department of Finance report are available in the *Realignment: What Does the Future Look Like?* memo in this agenda packet.

The reopener provides an opportunity to advocate for the long-term solution that counties need to successfully administer IHSS and other realigned programs on behalf of the state. To that end, CSAC formed an IHSS Working Group that is being co-chaired by Supervisor James Gore (Sonoma County) and Supervisor Ken Yeager (Santa Clara County). Other members of the IHSS Working Group include Supervisors, County Administrative/Executive Officers, and representatives from county affiliates. Over the past several months, CSAC and many members of the IHSS Working Group have engaged with the Department of Finance to advocate and provide input and data related to the IHSS reopener report. During our communications with the Department of Finance, counties have advocated that several critical points about the IHSS fiscal structure be addressed in the findings and recommendations. These key points include:

- There is a significant and growing gap between the IHSS program costs that counties are responsible for and the available revenues.
- There will be negative impacts on other Realignment programs, including public health and behavioral health programs, due to the IHSS cost pressures.
- Additional revenues will be needed to ensure the sustainability of IHSS and other critical services that counties administer on behalf of the state.

**Next Steps.** The sustainability of IHSS and 1991 Realignment will be a top legislative priority for CSAC in 2019. CSAC will work closely with the Administration and the Legislature on identifying sustainable pathways for counties to continue to successfully deliver realigned services, including IHSS and other critical programs, on behalf of the state.

CSAC will also continue to partner with the Department of Social Services and the Department of Finance on implementation efforts. In addition, CSAC will provide continued email updates, resources, and training opportunities so that counties have the information they need in order to manage these changes locally.

**Resources:**

California State Controller 2017-18 Fiscal Year Growth (includes redirected growth for IHSS costs)  
[https://www.sco.ca.gov/ard\\_payments\\_realign\\_fy1718\\_growth.html](https://www.sco.ca.gov/ard_payments_realign_fy1718_growth.html)

Text of IHSS Reopener Provision (SB 90, Chapter 25, Statutes of 2017)  
[http://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=17600.70](http://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=17600.70).

CSAC IHSS Resources

<http://www.counties.org/ihss-moe>

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Realignment – What Does the Future Look Like?

**Attachment Three**

CSAC Memo: Realignment – What Does the Future Look Like?

November 14, 2018



To: Members of the Health and Human Services Policy Committee

From: Justin Garrett, CSAC Legislative Representative, Human Services  
Farrah McDaid Ting, CSAC Legislative Representative, Health and Behavioral Health  
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**RE: Realignment: What Does the Future Look Like?**

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**Introduction.** Counties rely on 1991 Realignment to fund various social services, public health, and behavioral health programs. Overall, 1991 Realignment has worked well for counties since it was enacted. However, recent program growth, specifically with the In-Home Supportive Services (IHSS) program, and other policy and revenue changes have put increasing pressure on 1991 Realignment revenues and county budgets. These pressures will grow over the next several years and counties are recognizing that changes are needed to 1991 Realignment to provide sustainability for counties to continue to successfully deliver realigned services on behalf of the state. The policy committee meeting will feature a panel of key experts to help the Committee understand the state of 1991 Realignment, the current analyses on this issue, and the opportunities for action in the coming year.

**Background.** In the midst of a recession, 1991 Realignment was enacted to address a budget crisis and potentially significant cuts to health and human services programs. Counties were provided with a dedicated funding source from a sales tax increase and vehicle license fee (VLF) revenue to utilize for increased responsibilities for certain social services, health services, and mental health services. These programs include foster care, child welfare services, IHSS, California Work Opportunity and Responsibility to Kids (CalWORKs), local health services, indigent health, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and numerous other programs.

While the basic structure has remained the same, there have been changes to aspects of 1991 Realignment and the realigned programs over the years. Some of the major changes include:

- California expanded Medi-Cal eligibility under the Affordable Care Act, which reduced county indigent health costs. These savings are shifted from the Health subaccount to the Family Support subaccount to offset General Fund costs for CalWORKs grant increases.
- IHSS was transitioned to a Medi-Cal benefit and entitlement program, which secured more federal funds, but also limits the ability to control program costs.
- There has been significant caseload growth in certain programs, including IHSS.
- Increased program requirements have been adopted for certain realigned programs, including several mental health programs.

More recently, there were significant changes to 1991 Realignment that were negotiated in the 2017-18 budget process in response to the end of the Coordinated Care Initiative, which eliminated the County IHSS Maintenance of Effort (MOE) that had been in place for five years.

The 2017-18 Budget Act enacted numerous reforms to the IHSS fiscal structure. Significantly, it established a new County IHSS MOE with increased county costs and an annual inflation factor of 5% for the first year and 7% thereafter. To help counties offset these increased costs, the 2017-18 Budget Act included State General Fund contributions (\$400 million in 2017-18, \$330 million in 2018-19, \$200 million in 2019-20, \$150 million thereafter), redirected Health, Mental Health, and County Medical Services Program (CMSP) 1991 Realignment vehicle license fee (VLF) growth funding to Social Services, and accelerated caseload growth payments from 1991 Realignment sales tax growth so that counties receive this funding earlier to partially offset increased county IHSS costs.

Counties are striving to manage the first two years of this new MOE. However, counties maintain concerns that this new IHSS fiscal structure will not be sustainable for counties in the out years.

**Current Examinations of 1991 Realignment.** The establishment of the new IHSS MOE and associated 1991 Realignment changes that were included in the 2017-18 Budget Act have created momentum to more closely examine the overall 1991 Realignment structure. Specifically, there is a requirement that the Department of Finance examine the new IHSS fiscal structure during the development of the 2019-20 state budget. This report requirement also served as an impetus for the Legislative Analyst's Office to evaluate 1991 Realignment. Finally, another state entity, the Little Hoover Commission, recently started a review of 1991 Realignment. Below are full details about each of these different examinations.

#### Department of Finance

CSAC secured a reopener provision in the 2017-18 budget legislation that established the new county IHSS MOE to ensure that the new IHSS fiscal structure will be reevaluated prior to the out years when the increased county IHSS costs become unsustainable for counties. Specifically, the reopener provision requires the Department of Finance to consult with affected stakeholders and submit findings and recommendations to the Legislature by January 10, 2019. The four elements of the reopener report are:

1. The extent to which revenues available for 1991 Realignment are sufficient to meet program costs that were realigned.
2. Whether the In-Home Supportive Services program and administrative costs are growing by a rate that is higher, lower, or approximately the same as the maintenance of effort, including the inflation factor.
3. The fiscal and programmatic impacts of the In-Home Supportive Services Maintenance of Effort on the funding available for the Health Subaccount, the Mental Health Subaccount, the County Medical Services Program Subaccount, and other social services programs included in 1991 Realignment.
4. The status of collective bargaining for the In-Home Supportive Services program in each county.

While counties are a primary stakeholder and had a significant voice in engaging with the Department of Finance on this report, the Department of Finance also consulted with other stakeholder groups throughout the process including provider unions and disability rights organizations. The Department of Finance will write the report and present recommendations for consideration by the new Governor. The findings and recommendations are anticipated to be released with the new Governor's first January budget proposal.

#### Legislative Analyst's Office

On October 15, the Legislative Analyst's Office (LAO) released a report titled *Rethinking the 1991 Realignment*. This report analyzes whether 1991 Realignment is currently meeting the original intent of

aligning the finances, responsibilities, and risks associated with providing social services, health, and mental health services at the local level. The report also offers potential solutions for improving 1991 Realignment. The LAO has been working on this report for nearly two years and consulted with CSAC, county affiliates, and numerous counties during their research and drafting of the report. Their mission is to inform the Legislature on contemporary policy issues, and the enactment of the 2017 In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) prompted them to focus on the overall structure of 1991 Realignment.

Overall, the report concludes that 1991 Realignment is no longer meeting some of the key LAO Realignment principles. Specifically, the LAO cites the following principles as a necessary foundation for any realignment of programs and services from the state to counties:

- Counties' share of costs should reflect their ability to control costs in the program.
- Revenues generally cover costs over time.
- Flexibility to respond to changing needs and requirements.
- Funding is transparent and understandable.

The report details how policy changes, increased service requirements, growing caseloads, and additional program requirements have led to their conclusion. The LAO also dedicates significant analysis to IHSS and how state and federal policy changes and caseload growth have changed the program dramatically since 1991. The report identifies IHSS as the main factor in why 1991 Realignment revenues are no longer sufficient to cover counties' share of costs for social services programs. The report indicates that it is not clear if the funding for 1991 Realignment health and mental health programs is aligned with program responsibilities. The LAO was unable to provide a comprehensive analysis because county spending on these services varies widely, information is not readily available in a common format, and revenues are allocated by a formula instead of actual costs.

For solutions, the LAO identifies three pathways for improving 1991 Realignment so that it can more closely match the original intent and identified LAO principles:

1. Change Cost Sharing Ratios – The LAO outlines an option to reduce the county share of cost for certain programs and to replace those costs with a share of cost for a program that counties would have more discretion in controlling costs. The LAO notes that it makes sense to reduce the county share of cost for IHSS as counties' ability to control program costs has been constrained or altered since 1991. They recommend replacing that reduced cost with a county share of cost in felony forensic court commitments, an idea that counties have opposed in the past.
2. Better Align Revenues and Costs – The LAO includes some suggestions to alter Realignment funding allocations. These include shifting growth funding for the Family Support and Child Poverty subaccounts to the Health and Mental Health subaccounts and reducing the funding in the Family Support and Child Poverty subaccounts and redirecting it to the Social Services subaccount.
3. Other Improvements to Align to Principles – The final set of options include changes that may better align 1991 Realignment with the LAO's identified principles. These include applying lessons from 2011 Realignment to 1991 Realignment (constitutional mandate protections, base restoration, and simplified funding transfers), tracking Realignment revenues and costs, encouraging reserves, and considering the long-term impact of policy decisions.



### Little Hoover Commission

The Little Hoover Commission is an independent state oversight agency that investigates state government operations and policy. The Commission makes recommendations to the Governor and Legislature to promote improvements and efficiency in state operations. The Commission recently indicated that they are launching a review of the statutory scheme and funding mechanisms for 1991 Realignment. Initially, the Commission was scheduled to have a hearing on 1991 Realignment on November 15, but that hearing has now been postponed to January or later to allow for more time to study this issue. Staff from the Commission reached out to CSAC in the early stages of their research on this topic. CSAC and counties were invited to participate on panels at the hearing when it was scheduled for November and anticipate having that same role once the hearing is rescheduled.

**Conclusion.** The increased cost pressures on 1991 Realignment from IHSS and the numerous examinations and reports on this issue are creating momentum for legislative action on 1991 Realignment in 2019. The LAO report provides a comprehensive analysis that can help inform the discussion and action on this issue. The Department of Finance report will provide specific recommendations that will be evaluated and considered throughout the budget process as the Administration, the Legislature, counties and other stakeholders work together on this critical issue. Counties are looking to 2019 as an opportunity to identify sustainable pathways to successfully deliver realigned services, including IHSS and other critical programs, on behalf of the state.

### **Resources:**

Text of IHSS Reopener Provision (SB 90, Chapter 25, Statutes of 2017)

[http://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=17600.70](http://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=17600.70).

Legislative Analyst's Office Report: Rethinking the 1991 Realignment (October 2018)

<https://lao.ca.gov/reports/2018/3886/1991-realignment-101518.pdf>

CSAC IHSS Resources

<http://www.counties.org/ihss-moe>

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Policy Platform Review

**Attachment Four**

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

November 14, 2018



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To: Members of the Health and Human Services Policy Committee

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

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

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**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 November 7. 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 2019-2020 platform. After receiving comments and feedback from the Committee, staff will make the suggested changes agreed upon by Committee members and present the updated draft version to the CSAC Board of Directors in early 2019 for approval.

Below is a high-level summary of the changes made to each of the chapters and the comments received on the initial draft.

### **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. Additional substantive changes are noted below:

- The Public Health section was updated to reflect the expansive health department responsibilities in prevention efforts.
- The Behavioral Health section was updated to encompass substance use disorder in conjunction with mental health, and reorganized to include substance use disorder near the mental health section.
- The section on Proposition 63 was updated to include the words Mental Health Services Act (MHSA), which is how Proposition 63 is commonly known. There were two added points to demonstrate the need for clear state guidance for MHSA reversion and county support for MHSA funding transparency.
- A section was added for Public Guardians/Administration/Conservators to reflect the growing pressures and fiscal concerns regarding conservatorships throughout California.

- Language was changed in the Substance Use Disorder Prevention and Treatment section to reflect our members' desire to use evidence-based services while acknowledging the potential fiscal challenges. Language was also added to reflect the need for SUD services for youth.
- Edits were made to the section on Emergency Medical Services to clarify county support for ensuring the continuity and integrity of the local emergency medical services system, including county authority on all aspects related to medical control.

### **Chapter 11 – 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:

- Out-of-date language on federal stimulus efforts was removed from the document.
- The Medi-Cal Eligibility paragraphs were shifted to their own section.
- Edits to the Child Welfare Services/Foster Care section enhance the Continuum of Care Reform (CCR) language and reflect recent reforms.
- The Employment and Self-Sufficiency Programs section was updated to include background information on employment and self-sufficiency programs, edits to reflect recent reforms, and language on county administrative costs for self-sufficiency programs.
- The enforcement and penalties language in the Child Support Enforcement Program section was updated to reflect the program's shift from an enforcement focus.
- The In-Home Supportive Services (IHSS) language in the Aging and Dependent Adults section was updated to replace the outdated language on the prior Maintenance of Effort (MOE) and to reflect the new IHSS MOE and need for additional resources to address the gap between IHSS costs and available revenues.
- The Adult Protective Services (APS) language in the Aging and Dependent Adults section was updated to include the need for program resources.

### **Comments Received**

The below comments were submitted in response to the drafts shared earlier for HHS policy committee review. Staff made initial edits to remove language that was out-of-date and streamline the platform via formatting. Further edits were accepted to make the chapters more reader-friendly and concise.

Additional substantive changes are noted below:

- Update the Proposition 10/First 5 Commissions section in the Health Services chapter and Human Services chapter to reflect the most recent First 5 Policy Agenda that focuses on the most vulnerable populations, adds language about the backfill under Prop 56's newest tobacco tax, and enhances the language that reflect the state-local partnership in children's service delivery.
- Modify the State Children's Health Insurance Program subsection to include the key provisions of the CHIP reauthorization that was extended in January 2018.
- Update the Public Health section to emphasize the role of counties in prevention and health equity efforts.

In response to these comments, staff made most of the suggested changes to the proposed platform chapters, which are attached. 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 Five**  
Draft Health Platform Chapter

## Chapter Six

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## Health Services

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### Section 1: General Principles

Counties ~~serve as the front-line defense~~ are mandated to protect Californians against threats of widespread disease and illness and are tasked with promoting health and wellness ~~among all Californians~~. 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 ~~in order~~ to achieve better fiscal health ~~outcomes for both entities~~. 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 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.

Counties also support a continuum of preventative health efforts ~~– including behavioral health services, substance use disorder services, nutrition awareness and~~ communicable disease control and chronic disease prevention – and the inclusion of public health in the design and planning of healthy communities ~~healthy living models for all of our communities, families, and individuals~~. 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 ~~care~~-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 ~~in the effort~~ to expand Medicaid and provide health insurance and care to ~~millions~~ 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 reform California's health system ~~Counties remain committed to serving as an integral part of ACA implementation, and support initiatives to assist with outreach efforts, access, eligibility and enrollment services, and delivery system improvements~~.

Comment [RD1]: Deleting outdated reference to ACA.

At the federal level, counties also support economic stimulus efforts that help maintain services levels and access for the state's neediest residents. Counties strongly urge that any federal stimulus funding, enhanced matching funds, or innovation grants that have a county share of cost ~~must~~ be shared directly with counties.

## Section 2: Public Health

~~The County public 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. the only health agencies with direct day-to-day responsibility for protecting the health of every person within each county. The average person does not have the means to protect him or herself against contagious and infectious diseases. Government must assume the role of health protection against contagious and infectious diseases. It must also provide services to prevent disease and disability and encourage the community to do likewise. These services and the authority to carry them out become especially important in times of disaster and public emergencies. To effectively respond to these local needs, counties must be provided with full funding for local public health communicable disease control and surveillance activities.~~

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, ~~hospitals~~, medical supply, and prescription drug caches, as well as trained personnel – needed to protect our residents. ~~Furthermore, counties play an integral role in chronic disease prevention through policy, system, and environmental changes promoting healthier communities. Counties welcome collaboration with the federal and state governments on the development of infrastructure for bioterrorism and other disasters.~~ Currently, counties are concerned about the lack of funding, planning, and ongoing support for critical public health infrastructure.

County health departments are also working to reduce health inequities with efforts to eliminate barriers to good health and support the equitable distribution of resources necessary for the health of California's diverse population. Strategies 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 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.

2) Counties ~~also~~ support the preservation mission of the federal Prevention and Public Health Fund for public health activities, and oppose any efforts to decrease it's funding.

**Comment [RD2]:** Move to a stand alone section.

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**Comment [RD3]:** Update paragraph for a concise description of health department responsibilities.

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**Comment [RD4]:** Moved to separate bullet point from opening Public Health paragraph.



Counties support efforts to secure direct funding for counties to meet the goals of the Fund.

- 2)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 community-based treatment 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. Counties should have the flexibility to design and implement mental 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 should be in the framework of local, state, and federal criteria.

#### Proposition 63: ~~Mental Health Services Act~~

The adoption of Proposition 63, the Mental Health Services Act of 2004 (MHSA), assists counties in service delivery. ~~However, it~~ is intended to provide new funding that expands and improves the capacity of existing systems of care and provides an opportunity to integrate funding and innovate at the local level. MHSA funding is also dedicated to meeting the needs of each community, via stakeholder input, to determine spending priorities.

- 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.
- 2) Counties also strongly oppose any effort to redirect the ~~Proposition 63~~ MHSA funding to existing state services instead of the local services for which it was 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) ~~Proposition 63~~ MHSA funds have been diverted in the past due to economic challenges and the establishment of the No Place Like Home Program. Any further diversions of ~~Proposition 63~~ MHSA funding will be disruptive to programming at the local level.

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Comment [RD5]: Adding to encompass both mental health and substance use disorder throughout document.

Comment [RD6]: Adding commonly used MHSA when referencing Proposition 63.

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4) Counties support timely and clear reporting standards, including reversion timelines, for MHSAs expenditures and seek guidance from the Department of Health Care Services on all reporting standards, deadlines, and formats.

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3)5) Counties support the fiscal integrity of the MHSAs and transparency in stakeholder input, distributions, spending, reporting, and reversions.

**Comment [RD7]:** Recommendation to add in order to clearly demonstrate counties transparency

#### Specialty Mental Health Plans

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Counties are committed to service delivery that manages and coordinates services to persons with ~~mental illness~~ behavioral health needs and that operates within a system of performance outcomes that assures funds are spent in a manner that provides the highest quality of care. Integration of care and parity requirements require county specialty mental health plans to adapt to new models and lead collaborative efforts in the next era of behavioral health care.

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Counties supported actions to consolidate the two 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 Medi-Cal behavioral health services as managed care program. Counties chose to operate as a Medi-Cal Mental Health Plans, and many counties have chosen to operate as managed care plans for substance use disorder services 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 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.
- 2) Counties anticipate increased demand for ~~these~~ 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. ~~have adequate revenues to meet the federal standards and needs of these children.~~
- 3) Behavioral health services can reduce criminal justice costs and utilization through prevention, diversion, and during, or post incarceration.
- 4) Counties continue to work across disciplines and within the 2011 Realignment structure to achieve good outcomes for persons with mental illness and/or ~~co-occurring~~ 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.

#### Section 4: Public Guardians/Administrators/Conservators

**Comment [RD8]:** New section added

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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

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recent rise in interest in conservatorships as vehicles to help manage justice involved and homeless populations also places significant fiscal pressure on county guardians and conservators.

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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.

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2) 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.

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

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4) 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.

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Section 5: Children's Health

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*California Children's Services*

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Counties administer the California Children's Services programs on behalf of the State. Recent implementation of the Whole Child Model provide diagnosis and some case management services, in conjunction with County Organized Health Systems (COHS) counties, moved service authorization and case management services to local managed care plans. where they exist under the Whole Child Model (WCM), to more than 200,000 children enrolled in the California Children's Services (CCS) program, whether they are in Medi-Cal or the CCS-Only program. Under the Whole Child ModelWCM, counties also are still responsible for determination of residential, medical, and financial eligibility for the program. Counties may also provide Medical Therapy Program (MTP) services for both California Children's Services children and special education students, and retain a share of cost for services to non-Medi-Cal children.

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- 1) Maximum federal and state matching funds for The California Children's Services program services must continue in order 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 CCS-pilot programs. s in the 2010 Medicaid Waiver and subsequent waivers.
- 3) As counties shift towards the Whole Child Model, counties seek to ensure these high-need patients continue to receive timely access to quality care, there are

no disruptions in care, and there is an adequate plan for employee transition.

#### *State Children's Health Insurance Program*

- 1) CSAC supports sustained a four-year extension of funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). In 2018, As a block grant, the CHIP appropriation for the program wasis being considered for reauthorization in 2017 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.

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#### *Proposition 10: The First 5 Commissions*

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development at the local level and created First 5 commissions in all 58 counties.

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- 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 First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate address the greatest needs of their communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale, including childhood health, childhood development, nutrition, school readiness, child care, and other critical community-based programs. Counties oppose any effort to diminish Proposition 10 funds or to impose restrictions on local First 5 Commissions' expenditure authority.

**Comment [RD9]:** Reflective of First 5's policy agenda.

- 3) Counties oppose any effort to 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.

- 4) Counties support local and state collaborations and leveraging First 5 commissions funding to sustain and expand critical services for children and families in our communities.

#### Substance Use Disorder Prevention and Treatment

**Comment [RD10]:** Sub-section will be moved under Section 3: Behavioral Health.

Counties ~~are 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~~ ~~concerned about~~ evidence-based treatment capacity, ~~but are also challenged by new managed care requirements that may strain local systems. for all persons requiring substance abuse treatment services.~~

1) Counties support and seek ~~additional more~~ housing options ~~for people with 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, but~~ appropriate funding for diagnosis and treatment services must be available. Appropriate substance use disorder treatment services ~~will~~ ~~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) ~~Counties support cross-sector, multi-jurisdictional collaboration to promote education on substance use disorders, and prevent overdoses and substance use related deaths.~~

2)

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) 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.~~

7) ~~Counties support technical assistance for counties and providers to ensure timely and accurate billing, as well as compliance with quality and service requirements.~~

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.

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Comment [RD11]: Adding to illustrate existing county challenges

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- 1) Counties remain concerned about state and federal proposals that would decrease access to health care or shift costs and risk 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. The loss of Medi-Cal funds translates into fewer dollars to help pay for safety net services for all persons served by county facilities. Counties are not in a position to absorb or backfill the loss of ~~additional~~ state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services.
- 3) County welfare departments determine eligibility for the Medi-Cal program and must receive adequate funding for these duties.
- 4) County behavioral health departments ~~are the health plan for provide~~ Medi-Cal Managed Care Specialty Mental health services, ~~for public behavioral health services~~ and must receive adequate funding for these critical services ~~duties~~. Changes to the Medi-Cal program, including the move toward integrated care, will undoubtedly affect the day-to-day business of California counties.
- 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 ~~the counties~~y.
- 6) Counties oppose any efforts to decrease funding for or reverse expansions to the Medi-Cal program, which will 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.
- 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 managed care.
- 9) Changes to Medi-Cal must preserve access to medically necessary behavioral health care and drug treatment 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 must ~~preserved to maximize~~ federal fundings and minimize county risks to and 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 ~~reform 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 risks.

- 12) Any reform effort ~~should~~ 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 ~~for~~ 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.

~~15)~~16) The State should consider counties as full partners in the administration of Medi-Cal, ~~including its expansion under ACA~~, 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 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. Please see the Human Services Platform Chapter for additional IHSS

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[principles.](#)

~~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.~~

6) 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](#).

### **Section 72: Federal Healthcare Reform Efforts**

~~The fiscal impact of federal action on the ACA on counties is uncertain and there will be significant county-by-county variation. However, c~~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 costs.

1) 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](#).

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#### **A. Access and Quality**

- 1) Counties support offering a truly comprehensive package of health ~~care~~ 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 ~~prisoners~~ [inmates](#) and offenders [of county and state correctional institutions](#), detainees, and undocumented immigrants into the larger health care service model.
- 3) Health ~~care~~ 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 specialty care – such as emergency and trauma care and training of medical residents 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 reduce medical care costs, contain or mitigate disease, [reduce health inequities](#), and address disaster preparedness and response.
- 8) Counties support ~~increased~~ 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 ~~care~~ reform efforts, including efforts to achieve universal health care, should simplify the health care system – for ~~recipients~~ [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 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 health care coverage.
- 13) [Counties strongly encourage public health to be a key component of any health care coverage expansion. Public health prevention activities in addition to](#) ~~A~~ access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes.
- 14) Counties, as both employers and administrators of health care programs, believe that 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 83: 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.
- 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 safety-net services must be supported to ensure their long-term viability.

#### Realignment

- 1) Counties believe the integrity of realignment should be protected. However, counties strongly oppose any change to realignment funding that would negatively impact counties.
- 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.

4)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 but also~~ serve as indispensable components of a robust health system, providing ~~both primary, specialty, and acute and specialized~~ health services ~~to health consumers in our communities~~, as well as physician training, trauma centers, and burn care. California’s public hospitals are increasingly providing funding for the non-federal share of the state’s Medicaid program, and these local expenditures are made at the sole discretion of the county Supervisors.

- 1) ~~CSAC~~ 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.
- 2) Counties strongly support the continuation of a robust Medicaid Section 15000 waiver to help ~~believe implementation of the federal Section 15000 waiver is necessary to~~ ensure that county hospitals are paid for the safety net care they provide to Medi-Cal recipients and uninsured patients.
- 3) 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~~ access to share and integrate health data and systems; 5) and provide flexibility for counties/public health care systems to ~~deliver~~ provide 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) Counties also support opportunities for county hospitals and health systems to make delivery system improvements and upgrades, which will help these ~~institutions~~ institutions, compete in the modern health care marketplace.
- 6) 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 must address through other support to

ensure the continued viability of the safety net.

**Section 94: 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 that target family violence prevention, intervention, and treatment 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.

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**Section 105: 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. and eCounties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable and safe developments, ~~where feasible,~~ to promote healthy community events and activities.

**Section 116: 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.

~~1)~~ — Counties ~~also~~ support coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

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**Section 7: Emergency Medical Services**

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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.

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~~1)~~  
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.

~~2)~~  
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. \_

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- 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.
- 3)5)Counties oppose efforts that would weaken the local authority of local medical services agencies or lead to system fragmentation and safety issues.

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### **Section 138: 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 149: 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.

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Policy Platform Review  
**Attachment Six**  
Draft Human Services Platform Chapter

## Chapter ~~Twelve~~ Eleven

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### Human Services

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#### Section 1: General Principles

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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 ~~economic stimulus efforts and~~ 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 ~~report experience an increased long lines in their welfare departments as increasing numbers of people need of individuals and families seeking assistance through vital safety net~~ apply for programs such as Medicaid, ~~Supportive 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 ~~stimulus or state~~ funding must be shared directly with counties for programs that have a county share of cost. –

~~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 counties in Medi-Cal eligibility, enrollment, 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.~~

Comment [JG1]: Moved this language to a new section on Medicaid Eligibility.

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 [the each county's local needs of each county](#). If the state implements performance standards, the costs for meeting such requirements must be fully reimbursed.

~~1) Counties support federal economic stimulus efforts in the following areas: An increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid and Title IV-E, and benefit increases for the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); the Child Abuse Prevention and Treatment Act (CAPTA); Community Services Block Grants (CSBG); child support incentive funds; and summer youth employment funding.~~

**Comment [JG2]:** This point is specific to stimulus efforts at a specific point in time. The overall federal funding need is outlined already.

~~2) Counties also 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.~~

**Comment [JG3]:** General Assistance platform language was included in two separate sections and is being combined and included in the Employment and Self-Sufficiency section.

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## **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, and Adult Protective Services, [CalFresh, and In-Home Supportive Services](#), funding for these services ~~was~~ [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 ~~puts 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.

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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 [policy system reforms](#) and court-ordered changes, such as ~~those proscribed in the Katie A. settlement~~ [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 ~~the~~ some of the current needs of the child welfare services system, but existing workload demands and ~~regulations~~ [continued pressure to expand services](#) remain a concern [without additional investments by the state and federal government](#).

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Further, ~~recent~~ court settlements (Katie A.) and policy changes (AB 12 Fostering Connections to Success Act of 2010 and AB 403, [CCR](#) ~~ontinuum of Care Reform~~) require close state/county collaboration with an



emphasis on ensuring adequate ongoing funding that adapts to the needs of children who qualify.

The Continuum of Care Reform (CCR) enacted significant changes in the child welfare program 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.

~~Counties support efforts to build capacity within local child welfare agencies to serve child victims of commercial sexual exploitation. Commercial sexual exploitation of children (CSEC) is an emerging national and statewide issue. In fact, three of the top ten highest trafficking areas in the nation are located in California: San Francisco, Los Angeles, and the San Diego metropolitan areas. Counties believe this growing and complex problem warrants immediate attention in the Golden State, including funding for prevention, intervention, and direct services through county child welfare services (CWS) agencies.~~

**Comment [JG4]:** This sentence fits better in the principles and was combined with the CSEC principle below.

~~1) Counties support efforts to reform the congregate care or youth group home system under AB 403, the Continuum of Care Reform. 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 health support are but some of the challenges under AB 403. Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.~~

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~~Counties support efforts to build capacity within local child welfare agencies to serve child victims of commercial sexual exploitation. Commercial sexual exploitation of children (CSEC) is an emerging national and statewide issue. In fact, three of the top ten highest trafficking areas in the nation are located in California: San Francisco, Los Angeles, and the San Diego metropolitan areas. Counties believe this growing and complex problem warrants immediate attention in the Golden State, including funding for prevention, intervention, and direct services through county child welfare services (CWS) agencies.~~

**Comment [JG5]:** Combined with the existing below platform principles instead of its own section.

~~1) Counties also support close cooperation on CSEC issues with law enforcement, the judiciary, and community based organizations to ensure the best outcomes for child victims.~~

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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.

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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 ~~will be undertaken~~ 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.

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Where appropriate, family preservation, and support services should be ~~provided available~~ in a comprehensive, culturally appropriate, and timely manner.

~~—~~ Counties support efforts to reform the congregate care – or youth group home – system under AB 403, the CCRContinuum of Care Reform. 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 health support are but some of the challenges under CCRAB 403. —Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.

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4)5) When ~~parental rights must be terminated~~ foster children/youth cannot return home, counties support a permanency planning process— that matches foster children/youth through adoption and/or guardianship that quickly places children in the most stable environments, with —a foster caregiver adoption being the permanent placement of choice. 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.

5)6) Counties ~~also~~ support adequate state funding for adoption services and post-permanency supportive services.

6)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 ~~also~~ support such ongoing services for former and emancipated foster youth up to age 26, ~~and pledge to help implement the~~ 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 ~~to help ensure the future success of this vulnerable population~~.

7)8) With regards to caseload and workload standards in child welfare, especially with major policy reforms such as ~~AB 403 CCR~~, counties remain concerned about increasing workloads and ~~fluctuations in funding~~ 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 at a time when CCR and AB 12, and the cases are becoming more 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); often more than one person is involved in working on a given case with youth and families, and when extensive records have to be maintained about each case. Counties support ongoing augmentations for Child Welfare Services, including investments in workforce

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~~development and workload reduction, to partially mitigate workload concerns and the resulting impacts 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.

8) 10) Counties support efforts to build capacity within local child welfare agencies to serve child victims of commercial sexual exploitation. Counties also support close cooperation on CSEC issues with law enforcement, the judiciary, and community-based organizations to ensure the best outcomes for child victims.

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9) 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. ~~The Temporary Assistance for Needy Families (TANF) and California Work Opportunity and Responsibility to Kids (CalWORKs) programs allow counties to take care of children regardless of the status of parents.~~

Comment [JG6]: Sentence does not fit with this principle and appears to have been inadvertently included on existing platform.

#### 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.

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There is ~~a need for~~ strong support for the 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 ~~Temporary Assistance for Needy Families (TANF), California Work Opportunity and Responsibility to Kids (CalWORKs),~~ Medi-Cal, and ~~Food Stamps~~ CalFresh. In addition, electronic technology improvements in ~~human services~~ welfare administration are ~~an~~ important tools ~~in 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 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. ~~Each county must have the ability to identify differences-~~

~~in the population being served and provide services accordingly, without restraints from federal or state government.~~ There should, ~~however, be~~ 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) ~~A~~ The welfare system ~~that includes shrinking time limits for assistance~~ 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 also 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.
- ~~5) The state should assume principal fiscal responsibility for the General Assistance program.~~
- 6) Welfare-to-work efforts should focus on prevention of the factors that lead to poverty and welfare dependency including unemployment, underemployment, 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 ~~also~~ 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.

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**Comment [JG7]:** General Assistance platform language was included in two separate sections and this edit combines it into one section.

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~~9)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 counties in Medi-Cal eligibility, enrollment, 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 75: Child Support Enforcement Program**

Counties are committed to strengthening the child support ~~enforcement~~ program through implementation of ~~– federal mandates and state statutes~~ the child support restructuring effort of 1999. Ensuring ~~a seamless transition~~ effective and efficient ongoing operations requires sufficient federal and state funding and 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 ~~enforcement~~ funding is structured prevents many counties from efficiently meeting state and federal collection guidelines and forces smaller counties to adopt a regional approach or, more alarmingly, fail ~~to outright to meet~~ 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 ~~enforcement~~ efforts, and must not be held liable for failures to meet guidelines in the face of inadequate and inflexible funding.

~~2) The state must assume full responsibility for any federal penalties for the state's failure to establish a statewide automated child support system. Any penalties passed on to counties would have an adverse impact on the effectiveness of child support enforcement or other county programs.—~~

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.

3) A successful child support ~~enforcement~~ program requires a partnership between the state and counties. Counties must have meaningful and regular input into the development of state

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policies and guidelines regarding [the child support program enforcement](#) and the local flexibility to organize and structure effective programs.

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### **Section ~~96~~: Proposition 10: The First Five Commissions**

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development [at the local level and created First 5 Commissions in all 58 counties](#).

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- 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.
- 2) Local First 5 commissions must maintain the necessary flexibility to direct these resources to ~~the most appropriate~~ [address the greatest](#) needs of ~~their~~ communities [surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale, including childhood health, childhood development, nutrition, school readiness, child care and other critical community-based programs](#). 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 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.](#)
- 3)4) [Counties support local and state collaborations and leveraging First 5 commissions to sustain and expand critical services for children and families in our communities.](#)

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### **Section ~~87~~: 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.

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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.

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- 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.

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- 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.

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**Section 108: 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 those in disadvantage communities, at disproportionate rates.

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**Section 69: Aging and Dependent Adults**

California is ~~already~~ home to more older adults than any other state in the nation and this population continues to grow, and the state's 65 and older population is expected to double from 3.5 million in 2000 to 8.2 million in 2030. 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.

Comment [JG12]: The new section order will be reflected in the clean version of the platform, but not reordered in this version for ease of review.

The Adult Protective Services (APS) Program is the state's safety net program for abused and neglected adults. APS ~~and 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.

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- 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.

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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.

2)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.

- 3)5) Counties ~~also~~ 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](#).

~~Adult Protective Services~~

~~The Adult Protective Services (APS) Program is the state’s safety net program for abused and neglected adults and 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 2.1 times more likely to die prematurely than the average senior.~~

- ~~1) Counties support efforts to prevent, identify, and prosecute instances of elder abuse.~~

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.

~~However, c~~[As California’s aging population continues to increase, c](#)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.

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~~2)~~ ~~Counties support the MOE as negotiated in the 2012-13 state budget and will oppose any proposals to change the MOE as outlined in statute.~~ The IHSS MOE negotiated in the 2017-18 state budget is not sustainable for counties as the county share of IHSS costs will significantly outpace the available revenues in the coming years. Counties support changes that provide additional state funding for IHSS costs or lower 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.

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~~2)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.

~~3)4)~~ Counties support moving collective bargaining for the IHSS program to a single statewide entity.

**Section 1110: 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.

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~~2)~~ Counties ~~also~~ support coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

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Policy Platform Review  
**Attachment Seven**  
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.

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2019 HHS Priorities and Workplan  
**Attachment Eight**  
CSAC Memo: 2019 HHS Priorities

November 14, 2018



To: CSAC Health and Human Services Policy Committee

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

**RE: 2019 HHS Priorities and Workplan – ACTION ITEM**

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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 2019.

The proposed 2019 HHS priorities were developed with the current state and federal political landscapes in mind. Please review these draft 2019 priorities and prepare for a discussion and action during the November 27 meeting of the policy committee.

The below section briefly describes the highest-level potential 2019 HHS Priorities. In addition to the three highest-level priorities described below, there are myriad HHS issues that we have identified for counties to consider in 2019. These include the continued implementation of Continuum of Care Reform, foster youth services, budget methodologies for county-run programs, 2-1-1 referral systems, and preservation of the Affordable Care Act.

A full description of each of these priorities can be found in the attached draft workplan.

### **Top HHS Priorities for 2019**

*(please see the attached workplan for a more detailed description of each of the proposed HHS priorities)*

#### **In-Home Supportive Services**

In 2019, CSAC's sustained commitment to navigating the impacts of the increasing In-Home Supportive Services (IHSS) program costs will shift toward seeking a more feasible long-term solution to the IHSS cost pressures. CSAC secured a reopener provision in the 2017-18 budget legislation that established the new IHSS Maintenance of Effort (MOE) that requires the Department of Finance to issue a report examining this new IHSS fiscal structure during the development of the 2019-20 budget. There is a significant and growing gap between IHSS program costs and available revenues, and the impacts of the MOE on other Realignment-funded programs are growing. The priority for 2019 will be leading the effort to reopen the MOE deal and developing fiscal solutions to ensure long-term sustainability for counties to administer IHSS and other realigned programs on behalf of the state. In addition, CSAC will continue working with a new Administration on allocation of offsetting revenue, MOE adjustments, and other provisions. Finally, CSAC will continue to partner with counties and other stakeholders on implementation and education efforts.

### Homelessness and Poverty Issues

Homelessness issues remain at the top of the county agenda and CSAC will continue to leverage the policy expertise of the health and human services, housing and land use, and administration of justice policy committees and staff to implement homelessness funding programs from 2018. CSAC will also continue to identify and solicit new opportunities to assist counties in combatting homelessness, including incentivizing all types of affordable housing – whether it is transitional shelters, permanent supportive housing, sober living environments, and the full spectrum of housing in between. CSAC will also continue to advocate for funding and flexibility at the local level to help meet the unique needs of each community.

### Behavioral Health Issues

County Behavioral Health will continue to be a focus of the federal government, state Department of Health Care Services, and the Legislature in 2019, and remains the linchpin in many of the most difficult policy issues for counties, such as homelessness, housing, and justice system recidivism and diversion. The spotlight on Mental Health Services Act funding and a potential \$180 million federal recoupment of erroneous mental health billing will require strong advocacy by counties. Furthermore, the state's interest in integrating behavioral health services into the health care system requires close monitoring and coalition-building. CSAC will continue to engage on behalf of all counties on behavioral health funding, services, and legislative proposals in 2019.

### **Attachments.**

CSAC Health and Human Services Draft 2019 Workplan

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2019 HHS Priorities and Workplan

**Attachment Nine**

Handout: 2019 HHS Workplan





## Draft 2019 Health and Human Services Work Plan – Presented November 27, 2018

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The HHS team anticipates significant continued effort on several large state and federal fiscal issues in 2019, including In-Home Supportive Services (IHSS), Behavioral Health, and Homelessness. The Legislature will include new members, and CSAC will be forming relationships with a new Governor. This all comes at a time when there is a potential for the state's revenue to slowdown, so the balancing act between the new Governor's policy initiatives and the state's fiscal health will bear close watching.

### State

***In-Home Supportive Services.*** In 2019, CSAC's sustained commitment to navigating the impacts of the increasing In-Home Supportive Services (IHSS) program costs will shift toward seeking a more feasible long-term solution to IHSS cost pressures. CSAC secured a reopener provision in the 2017-18 budget legislation that established the new IHSS Maintenance of Effort (MOE) that requires the Department of Finance to issue a report examining this new IHSS fiscal structure during the development of the 2019-20 budget.

The priority for 2019 will be leading the effort to reopen the MOE deal and developing fiscal solutions to ensure long-term sustainability for counties to administer IHSS and other realigned programs on behalf of the state. There is a significant and growing gap between IHSS program costs and available revenues, and the impacts of the MOE on other Realignment-funded programs are growing. During our engagement with the Department of Finance on the reopener report, CSAC has provided several options for ongoing sustainability within Realignment and the IHSS program, including adjusting the state/county sharing ratios, lowering the MOE base, and reducing the MOE inflation factor.

CSAC will also continue working with a new Administration on allocation of offsetting revenue, MOE adjustments, and other provisions. In addition, CSAC will continue to partner with counties and other stakeholders on implementation and education efforts.

***Behavioral Health Funding.*** Counties provide specialty mental health and substance use disorder services on behalf of the state through county-run mental health plans (MHPs). The various and complicated funding streams that support behavioral health services, such as the 1991 and 2011 Realignments, the Mental Health Services Act, and new homelessness funding, are of intense interest to the Legislature and state stakeholders.

Furthermore, the Department of Health Care Services is leading an effort to examine whether to relieve counties of the responsibility to provide behavioral health services and give the funding and duties to managed care plans or other entities. Counties are also examining the efficacy of the current behavioral health reimbursement structure, and may consider a new, capitation-based fiscal model.

Counties must also adapt to the priorities of a new Administration, and must exhibit innovative thinking and leadership to navigate this new era for behavioral health services in California in 2019.

***Homelessness and Poverty Issues.*** Homelessness issues will remain at the top of the Legislature's agenda, partly based on the fact that California's poverty and homelessness rates remain among the highest in the nation, affecting all Californians including children, adults, veterans, seniors, and families. CSAC will continue to leverage the policy expertise of the health and human services, housing, land use, and transportation, and administration of justice policy committees and staff to address the need for continued funding and flexibility to combat homelessness.

CSAC will also continue to work hand-in-hand with California departments and agencies to implement new homeless programs and funding for counties, including the Homeless Emergency Aid Program and the No Place Like Home Program.

CSAC will continue working with all counties on communication and education efforts related to homelessness, including featuring CSAC issue videos, sharing best practices, and leveraging social and web media to ensure the best outcomes for counties and the people we serve.

***Continuum of Care Reform Implementation.*** CSAC will continue to focus on the wholesale reform of the group home system in California known as Continuum of Care Reform (CCR), which was supposed to be fully implemented at the end of 2018, but has received a limited extension into 2019. The Department of Social Services and Department of Health Care Services continue to make incremental progress on implementation, but local issues such as recruiting and retaining foster families and contracting with Short-Term Residential Therapeutic Programs (STRTPs) require continued effort by counties. CSAC will continue working closely with the county child welfare services, behavioral health, and juvenile probation systems to ensure adequate resources for this massive policy change, and also to establish relationships with the Administration of a new Governor. CSAC will also continue to convene county affiliates in discussions to ensure coordinated and strategic advocacy efforts and continue the work of quantifying the fiscal implications of the reforms.

***Budget Methodologies for County Administration of Social Services Programs.*** The state provides critical funding for counties to administer health and human services programs. However, the methodologies that are used to provide this funding do not always align with the actual costs that counties incur. Significant progress was made on updating these methodologies in 2018 and efforts will continue in the 2019 budget process.

In partnership with the County Welfare Directors Association, CSAC will continue to engage in discussions with the Department of Finance and the Department of Social Services to work towards revising these methodologies and to help counties obtain sufficient resources to effectively deliver these services. The California Work Opportunity and Responsibility to Kids (CalWORKs) program Single Allocation is what the state provides to counties to administer the CalWORKs program. The creation of a new methodology to revise the current caseload-driven budget methodology for the Single Allocation is necessary to insulate counties and beneficiaries from experiencing huge swings in year-to-year funding levels. The overall effort to revise this methodology is ongoing and will build off of updates made to certain aspects of the Single Allocation in 2018. For administration of the IHSS program, there are also ongoing conversations related to the actual costs for certain aspects of administering the program.

***Foster Youth Services.*** CSAC will continue to identify opportunities to engage in legislative efforts to support foster youth, who are among the most at-risk populations in California. A significant potential issue relates to the recent state law changes that expanded eligibility for foster care services from age 18 to age 21 and resulted in additional local costs beyond the cap on county expenditures for older foster youth in current statute. CSAC will work with state and county social services, the Department of Finance, and county counsels on this cost issue, as well as working to assess costs within individual counties. Lastly, CSAC will work with affiliates and stakeholders to ensure that foster youth receive critical care and services, especially under the Continuum of Care Reform.

***Drug Medi-Cal Implementation.*** CSAC continues to monitor the implementation of the Drug Medi-Cal Organized Delivery System Waiver, and will begin efforts to obtain approval from the federal

government to continue the waiver past 2020. CSAC will also engage in efforts to erect a residential treatment system for youth, as well as strategies to add additional funding for counties and providers in both the adult and youth systems of care.

***Potential Changes to State and Federal Health Care Delivery.*** CSAC will continue to monitor legislative or other proposals to modify or reform the health care insurance and delivery system in California. The single-payer model remains on the Legislature’s radar, as do national movements to create a system of “Medicare for All.”

On a more macro level, the Department of Health Care Services is also undertaking a project to potentially integrate behavioral health care with the managed health care system. This could potentially modify or eliminate the county role in providing behavioral health services, and will require close engagement throughout 2019.

At the federal level, the continuation of the Affordable Care Act (ACA) policies and funding remains a priority. CSAC will continue to work with our Washington representatives, county affiliates, and the Administration of the new Governor to respond to any county impacts associated with changes to the ACA.

***Child Support Funding.*** CSAC will continue to advocate for increased funding for county child support programs and the development of a new child support program allocation methodology. Incremental progress was made in 2018 with \$3 million in new funding that came with direction for the State Department of Child Support Services to work with the Child Support Directors Association (CSDA) on identifying refinements to the budgeting methodology. CSAC will partner with CSDA and counties to advocate for the resources needed to effectively deliver these essential services, which help families become self-sufficient and address poverty issues.

***2-1-1 Referral Systems.*** CSAC and the CSAC Finance Corporation actively support both state and federal legislation to help build and fund a statewide 2-1-1 referral system that is responsive to local needs and natural or man-made disasters. CSAC will continue to work with counties, the state, and community based organizations to realize the goal of statewide implementation of 2-1-1 services.

### **Federal**

The below section briefly describes some significant potential 2019 federal HHS Priorities. For more detail on these and other priorities, please see the 2019 Draft Federal Priorities Document.

***Child Welfare Services.*** CSAC will continue to work with county affiliates on implementation of key aspects of the federal Family First Prevention Services Act, which could have negative impacts on the state and county efforts to implement the Continuum of Care Reform. CSAC will continue to support increased financial support for programs that assist foster youth in the transition to self-sufficiency, including post-emancipation assistance such as secondary education, job training, and access to health care. In addition, CSAC will work to support an extension of the federal foster care Title IV-E waiver. The seven waiver counties in California utilize the flexibility provided by these resources for innovative efforts to expand the services and supports available to families. Finally, CSAC supports federal funding to address the service needs of youth who are victims of commercial sexual exploitation.

***Medicaid and Social Services Funding.*** At the federal level, CSAC will closely monitor efforts to block grant, impose work requirements, or otherwise restrict programs and funding for low-income residents and immigrants. Of particular concern is the Trump Administration’s proposal to implement “public

charge” requirements on additional federally-supported programs, including Medicaid and the Supplemental Nutrition Assistance Program.

**Addressing the Opioid Crisis.** CSAC will engage on the implementation of the new Support for Patients and Communities Act, which is a recently signed federal measure to combat the opioid crisis by increasing access to addiction treatments and other interventions at the local level.

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