Health and Human Services Policy Committee

Tuesday, November 29 ▪ 2:30 p.m. – 4:30 p.m.
Madera Room ▪ Renaissance Palm Springs Hotel
888 Tahquitz Canyon Way ▪ Palm Springs, CA ▪ Riverside County

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

2:30 p.m.	I.	**Welcome and Introductions** *Supervisor Ken Yeager, Committee Chair, Santa Clara County* *Supervisor Hub Walsh, Committee Vice Chair, Merced County*
2:35 p.m.	II.	**New Affiliate: Introducing CAPAPGPC – Public Guardians** *Scarlett D. Hughes, Executive Director of the California Association of Public Administrators, Public Guardians, and Public Conservators*
2:55 p.m.	III.	**Ventura County's Foster Health Link Improves the Health of Children** *Barry Zimmerman, Director, Human Services Agency, Ventura County*
3:25 p.m.	IV.	**Health, Human Services, and Realignment Platform Review – ACTION ITEM** *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst*
3:55 p.m.	V.	**Establishing HHS Priorities for 2017 – ACTION ITEM** *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst*
4:25 p.m.	VI.	**2016 Legislation and 2016-17 Budget Review** *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst*
4:30 p.m.	VII.	**Adjournment**

ATTACHMENTS

New Affiliate: CAPAPGPC – Public Guardians

Attachment One ..... CSAC Memo: New Affiliate: Introducing CAPAPGPC – Public Guardians

Ventura County Presentation on Foster Youth Passport

Attachment Two ..... CSAC Memo: Ventura County Presentation on Foster Youth Passport

Attachment Three ..... Ventura County Handouts: Overview – Ventura County Foster Health Link

Attachment Four ..... Ventura County Handouts: FAQ – Ventura County Foster Health Link

Health, Human Services, and Realignment Platform Review

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

Attachment Six ..... Draft Health Platform Chapter

Attachment Seven ..... Draft Human Services Platform Chapter

Attachment Eight ..... Draft Realignment Chapter

Establishing HHS Priorities for 2017

Attachment Nine ..... CSAC Memo: Establishing HHS Priorities for 2017

2016 Legislation and 2016-17 Budget Review

Attachment Ten ..... CSAC Memo: 2016 Legislation and 2016-17 Budget Review

New Affiliate: CAPAPGPC – Public Guardians

Attachment One

CSAC Memo: New Affiliate: Introducing CAPAPGPC – Public Guardians

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

November 16, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: New Affiliate: Introducing CAPAPGPC – Public Guardians

Introduction. The issues surrounding public guardianship and conservatorship are complex and increasing in visibility among the courts, legislature, and general public.

In response to this, the statewide association for these issues, The California Association of Public Administrators, Public Guardians, and Public Conservators (CAPAGPGC), has reorganized to allow the organization to hire a full-time Executive Director.

Scarlet Hughes, formerly the Public Guardian in San Joaquin County, is the association's first Executive Director, and we have asked her to join the policy committee to provide an overview of her members' responsibilities and share with us their issues and concerns.

Background. All counties have a public guardian, conservator, or administrator, but they often operate behind the scenes. It is important for county supervisors to understand the critical role played by these offices in caring for especially vulnerable people in our communities.

Public Administrators. The Public Administrator (PA) investigates and may administer the estates of persons who die with no will or without an appropriate person willing or able to act as administrator. Primary duties of a Public Administrator include:

- Protecting the decedent's property from waste, loss, or theft.
- Making appropriate burial arrangements.
- Conducting thorough investigations to locate all assets.
- Ensuring that the estate is administered according to the decedent's wishes.
- Paying decedent bills and taxes.
- Locating persons entitled to inherit from the estate.

Public Guardians/Conservators. The Public Guardian or Public Conservator (PG/PC) conducts the official county investigation into conservatorship matters. The PG/PC also acts as the legally appointed guardian or conservator for persons found by Superior Court to be unable to properly care for themselves or their finances or who are unable to resist undue influence or fraud. Clients served by the PG/PC usually suffer from severe mental illness or are older, frail, dependent, and vulnerable adults. Primary duties of a PG/PC include:

- Serving as the conservator of the person only, estate only, or both person and estate depending on the needs of the individual.
    - Conservator of the Person: The Conservator arranges for the client's care and protection, determines where the client will live and makes appropriate arrangements for health care, housekeeping, transportation, and recreation.
    - Conservator of the Estate: The Conservator manages the client's finances, locates and takes control of the assets, collects income due, pays bills, invests the client's money, and protects known assets.
- Providing case management services including placement services.

- Providing estate management including applying and maintaining appropriate public benefits, paying bills, providing personal needs funds, and acting as the representative payee.
- Ensuring the conservatee receives appropriate mental health and physical health services.
- Providing real and personal property management, including safeguarding of assets and valuables and seeking court authority for sale of assets when necessary to provide for the needs of the conservatee.

CAPAPGPC Leadership/Structure. CAPPGPC has been a CSAC affiliate member in good standing for many years. The Association is governed by an Executive Board, which consists of eleven members (listed below). Besides Board meetings, CAPAPGPC administers continuing education and statutorily-required training for their members and retains a contract lobbyist to assist on legislative matters.

To contact the association, call (916) 449-9909 or email info@capapgpc.org.

Executive Director

Scarlet Hughes
Executive Director
California State Association of Public Administrators,
Public Guardians and Public Conservators

Officers

President
Glenda Jackson
Chief Deputy Public Guardian-Conservator
San Bernardino County

President-Elect
Alicia Morales
Director, Division of Adult Protection
Alameda County

Treasurer
Amparo Buck
Public Guardian/Program Manager
Shasta County

Secretary
Michele Pennington
Chief Deputy Public Guardian
San Joaquin County

Sergeant at Arms
Donna McMillin
Deputy Public Administrator Manager
Kern County

Liaison Officers
Rolf Kleinhans
Chief Deputy Public Administrator

Nevada County

Angela Phillips
Social Worker Supervisor
Mariposa County

Connie Draxler
Deputy Director, Office of the Public Guardian
Los Angeles County

Member At Large
Ron Freeman
Chief Deputy Public Administrator
Orange County

Immediate Past President
Chris Koper
Chief Deputy Public Administrator/Guardian/Conservator
Sonoma County

Second Past President
Arlene Diaz, Manager
Public Administrator/Guardian/Conservator
Santa Barbara County

CSAC Staff Contacts.

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Ventura County's Foster Health Link Improves the Health of Children

Attachment Two

CSAC Memo: Ventura County's Foster Health Link Improves the Health of Children

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

November 16, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: Ventura County's Foster Health Link Improves the Health of Children

Introduction. Ventura County has implemented an innovative system to improve the health of foster children in their county, the Foster Health Link. Foster Health Link (FHL) is a website and mobile application providing caregivers, caseworkers, and health providers with health information about children in foster care. The goal is for information to be shared electronically among the care team to better meet the needs of children.

Background. Over the past few years, there have been several major reforms to the foster care system which require counties to adapt to new policies, funding structures, and requirements – all while keeping a singular goal in mind: ensuring every child has a safe and permanent home.

For example, AB 12 and subsequent legislation that became effective January 1, 2012, allow foster care for eligible youth to remain in the system up to age of 21. In order to be eligible, a foster youth must be doing one of the following activities: completing high school or an equivalent program; enrolled at least half-time in college, community college, or a vocational program; employed at least 80 hours a month; participating in a program or activity designed to promote employment or remove barriers to employment; or unable to do one of the previous requirements because of a medical condition.

More recently, the landmark AB 403 was passed to reform the foster care system by moving away from the use of long-term group home care. This will be done by increasing youth placement in family settings and by transforming existing group home care into places where youth who are not yet ready to live with families can receive short-term, intensive treatment. The implementation of AB 403 is in progress, and while major policy and funding questions remain outstanding, counties are currently required to implement it on January 1, 2017.

An August audit by the California State Auditor on California's Foster Care System found that the state and counties have failed to adequately oversee the prescription of psychotropic medications to children in foster care. In September, the Senate Human Services Committee and the Senate Budget Subcommittee #3 on Health and Human Services conducted a lengthy joint hearing on the misuse of psychotropic medications for foster youth. The Committees heard from the California State Auditor, speakers representing state and local agencies, as well as former foster youth and advocates. During this hearing, the role of Ventura's Foster Health Link was discussed by the panelists and committee members as a possible solution to ensure that critical health information for foster youth is both secure and yet accessible to health care and health decision makers, including the foster child.

Speaker: We have invited Barry Zimmerman, Director of Ventura County's Human Services Agency, to speak. He can be reached at (805) 477-5301 or barry.zimmerman@ventura.org.

Attachments.

1. Overview: Ventura County Foster Health Link
2. FAQ: Ventura County Foster Health Link

CSAC Staff Contacts.

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Ventura County's Foster Health Link Improves the Health of Children

Attachment Three

Ventura County Handouts: Overview – Ventura County Foster Health Link

VENTURA COUNTY

Foster Health Link

Goals

The Ventura County **Foster Health Link** web site and mobile application released in July 2015 are designed to engage foster parents and relatives more fully in supporting the health needs of foster children by giving these caregivers easy, secure, electronic access to health information about the children in their care.

Foster parents and relative caregivers play critical roles in helping Ventura County's 1,000 foster children thrive until they can reunite with their biological parents. These caregivers bring foster children to doctor's visits and dental appointments, pick up prescriptions, and stay up at night to console sick children. They are often the first to recognize when a foster child needs extra help or may be experiencing a health issue, but they may be the last to get access to important health documents.

With critical roles to play on foster children's care teams, foster parents need current and accurate health information about the children in their care.

Benefits

Prior to **Foster Health Link**, Ventura County child welfare social workers delivered binders to caregivers containing paper copies of health information.

It took time for updated health information to reach the binders, and more time for the binders to reach caregivers' homes. Information was regularly out of date, leaving caregivers with questions about important issues such as immunization schedules and allergies. While every attempt was made to share important information with caregivers when foster children were placed in their care, delays were inevitable and caregivers could not participate fully in supporting the children's needs.

Now, with **Foster Health Link**, caregivers can securely access updated health information about foster children 24/7 from a computer or mobile device. Ventura County child welfare social workers can view the same information as caregivers, facilitating better sharing and planning among the care team to support foster children's needs.

Now, with Foster Health Link, caregivers can securely access updated health information about foster children 24/7 from a computer or mobile device.

Records

Foster Health Link pulls health and education information from the state-administered Child Welfare Services Case Management System for all foster children regarding: immunizations; allergies; medical conditions; medications; well child physical and dental exams; Medi-Cal insurance; school, grade level and special education plans; and more.

Additionally, **Foster Health Link** pulls e-records from the Ventura County Health Care Agency's patient portal for all foster children through age 11 who have received care within the Ventura County Medical Center system of hospital, clinic and specialty services. This information includes real-time summaries of doctor visits, lab results, medical conditions, immunizations, medications and more.

Further, **Foster Health Link** offers caregivers quick links to the online Network of Care resource library, which contains thousands of user-friendly articles, medical definitions, and other information designed to help caregivers better understand the health needs of foster children. The Network of Care also makes it simple for caregivers to search for, map and contact local service providers such as therapists and counselors.

To view a Foster Health Link video, visit www.FosterVCkids.org/fhl.

Continuity

Ventura County child welfare services attempts to reunify foster children with their biological parents as soon as the families are strong enough to care for their children safely. When children need to stay in foster care for longer periods of time, the goal is to place the

children with relatives or foster families who can provide care with as few disruptive moves and changes to the children's lives as possible.

However, when foster children experience moves to different foster homes over the course of months or years, it becomes critically important to ensure that the children's health histories remain intact with each transition.

Foster Health Link "turns on" access to health information for caregivers when they begin to care for foster children, and then "turns off" access when the children leave the foster home.

The foster children's electronic health records follow them during their stay in foster care, ensuring that each new caregiver gets access to the most updated information such as immunization status and allergies.

Security

The **Foster Health Link** web site and mobile application are hosted on a secure, Verisign-encrypted server – the same type of security used in online banking.

Foster Health Link ensures that foster children's information is accessible only to the caregivers who are approved by Ventura County child welfare services to provide care to the children at a given time. Approved caregivers receive an email link from Ventura County child welfare services that enables them to log in to **Foster Health Link** using a unique username and password.

Caregivers and child welfare social workers who access Foster Health Link receive training regarding Ventura County's high standards for protecting foster children's confidential information.

Partnership

Ventura County was approached about piloting an e-health records system for foster children by The Children's Partnership, a national, nonprofit child advocacy organization that focuses particular attention ensuring that all children have the health care they need.

In alignment with technical agendas established by the California Department of Social Services and the California Department of Health Care Services, the following public and private organizations partnered to develop **Foster Health Link**: Ventura County Human Services Agency; Ventura County Health Care Agency; Ventura County Information Technology Services; The Children's Partnership; Verizon Foundation; Sierra Health Care Foundation; Trilogy Integrated Resources; and Cerner Corporation.

The Verizon Foundation and the Sierra Health Care Foundation provided generous financial support that supplemented County funding, making **Foster Health Link** possible.

Importantly, foster parents and transitional-age foster youth participated in focus groups to provide input into the design and content of **Foster Health Link**. Following a year-long planning and technical development phase, foster parents provided additional feedback as they tested the site prior to its release.

Ventura County encourages foster parents to participate in upcoming surveys regarding their experiences with Foster Health Link, which will help determine future enhancements.

Future

As **Foster Health Link** is released to caregivers in July 2015, system data and survey information will be collected to ensure the site meets caregivers' needs.

With Foster Health Link, it is anticipated that caregivers will: save time in collecting foster children's health information; better understand the needs of the children in their care; schedule medical and dental exams more timely; and participate more fully on children's care teams as important health decisions are made.

Undoubtedly, after using **Foster Health Link**, caregivers will request access to additional information in order to fulfill their roles more effectively. The architecture of **Foster Health Link** allows for additional information—such as school records—to be included in future phases. Further, **Foster Health Link** can accommodate a portal that gives transitional-age foster youth access their own information, empowering them to play a larger role in managing their health and well-being.

Ventura County continues to seek grants and private funding to enhance **Foster Health Link**, and stands ready to offer **Foster Health Link** as a state-wide model for engaging foster parents in the provision of quality care.

More Information

Ventura County foster parents and relative caregivers are encouraged to visit www.FosterVCkids.org/fhl or contact the Children & Family Services Recruitment, Development & Support team at (805) 654-3220.

Human services agencies, foundations, and media outlets are encouraged to visit www.FosterVCkids.org/fhl or contact the Ventura County Human Services Agency at (805) 477-5340.

verizon
INFORMATION TECHNOLOGY SERVICES
TRILOGY Integrated Resources Network of Care
SIERRA HEALTH FOUNDATION
HUMAN SERVICES AGENCY INTEGRITY • COMPASSION • EMPOWERMENT COUNTY OF VENTURA
The Children's Partnership
Cerner
CDSS CALIFORNIA
VENTURA COUNTY HEALTH CARE AGENCY

Ventura County's Foster Health Link Improves the Health of Children

Attachment Four

Ventura County Handouts: FAQ – Ventura County Foster Health Link

VENTURA COUNTY

Foster Health Link

Frequently Asked Questions

What is goal of Foster Health Link?
Foster Health Link (FHL) is a website and mobile application providing caregivers, caseworkers, and health providers with health information about children in foster care. The goal is for information to be shared electronically among the care team to better meet the needs of children.

Who has access to Foster Health Link?
Caregivers, caseworkers, and nurses have access to Foster Health Link. Access to Foster Health Link is granted to caregivers approved by the Ventura County Children and Family Services division. Access is turned on when the child begins their stay and is turned off when they leave the home. Caregivers have access to the health records only of children who are in their care. If caregivers do not have children placed in their care, health information from Foster Health Link will not be available.

What is the source of the information displayed in Foster Health Link?
Information displayed in Foster Health Link is pulled from the State-administered Child Welfare Case Management System or CWS/CMS. Foster Health Link also pulls information from the Ventura County Health Care Agency's patient portal for children up to age 11 who have received care through the Ventura County Medical Center network of clinics and hospitals.

Does Foster Health Link include information from providers outside the Ventura County Medical Center network of clinics and hospitals?
No, Foster Health Link does not include health information from providers outside the Ventura County Medical Center network of clinics or hospitals. As an example, if a child is seen at St. John's hospital as part of Dignity Health or through a private doctor, the information is not available in Foster Health Link. This is under consideration for future enhancements of the application.

What if there are blank fields in the Foster Health Link application?
Foster Health Link depends on data available in the State-administered Child Welfare Case Management System (CWS/CMS) as well as from the Ventura County Health Care Agency's patient portal. As such, there is a chance data may not be available and this will be reflected in a blank field in the application. For children over the age of 11 an account from the Health Care Agency will not be available, in alignment with state law.

How does Foster Health Link ensure privacy?
Privacy and security protections are key components of electronic information exchange. Foster Health Link is hosted on a secure, Verisign-encrypted server – the same type of security used in online banking. System access is granted only to authorized individuals, who utilize credentials with built-in security clearance.

How are accounts set up for Foster Health Link?
Caregivers receive an e-mail notification from Ventura County Children & Family Services which allows them to create a unique username and password. A temporary password is provided separately for initial account set up. Once the credentials are set up there is no need to set up a new account each time a child enters or leaves the home.

Is an e-mail address necessary to access Foster Health Link?
Yes, an e-mail address is necessary to access Foster Health Link. If we do not have your e-mail address on file, notification to access the system will not be provided. Please visit www.fosterVCkids.org or contact the Foster VC Kids program at (805) 654-3220 to provide your e-mail address.

Who should I call for issues related to Foster Health Link?
The phone number to call for technical support, discrepancies with the medical information, or an issue related to the case is (805) 654-3891. Caregivers are also encouraged to visit the www.fosterVCkids.org webpage to learn more information about Foster Health Link.

Who are the partners in Foster Health Link?
Foster Health Link was made possible through a public-private partnership between the Ventura County Human Services Agency, Ventura County Health Care Agency, Ventura County Information Technology Services, The Children's Partnership, the California Health & Human Services Agency, Verizon, Sierra Health Foundation, Cerner, and Trilogy Integrated Resources.

What is the future of Foster Health Link?
Caregivers have offered valuable input about many features they would like to see added to Foster Health Link. The initial launch of Foster Health Link provides foundational features, but the system architecture is flexible enough for additional functionality to be phased in over time. Caregivers are encouraged to participate in upcoming surveys regarding their experiences with Foster Health Link which will help determine future enhancements.

Where can I get more information about Foster Health Link?
Please visit the www.fosterVCkids.org webpage for additional information about Foster Health Link or contact the Foster VC Kids program at (844) 654-3251.

Health, Human Services, and Realignment Platform Review

Attachment Five

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

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

November 16, 2016

To: Members of the Health and Human Services Policy Committee

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

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

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, Human Services, and Realignment chapters of the CSAC Platform for your review and input. 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 2. 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 2017-18 platform. After receiving comments and feedback from the Committee, staff will either make suggested changes or present the draft version to the CSAC Board of Directors for approval.

NOTE: The election of President-Elect Trump will require the committee to more closely examine federal portions of the proposed platform, especially the section on the Affordable Care Act. CSAC staff has taken an initial review of that section and suggested some changes, but we anticipate convening another policy committee meeting, possibly in early January, to further develop our strategy and response to the possibility of the repeal of the ACA.

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

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 in a more reader-friendly manner. Additional substantive changes are noted below:

- The section on Proposition 63 was updated reflect the passage of the No Place Like Home Program and to address the potentially disruptive nature of any further diversions of Proposition 63 funds.
- The Mental Health section was updated to reflect 2011 Realignment while some out-of-date narrative was deleted.
- The California Children's Services (CCS) section was updated to include County Organized Health Systems under the Whole Child Model.
- Edits were made to streamline the section on Proposition 10 by deleting language that explains the differences in how Proposition 10 funds are disseminated in different counties.
- Language was added to the Substance Use Disorder Prevention and Treatment section to reflect our members' desire to seek a wide spectrum of housing options, including recovery and treatment homes, within the community.
- The sections on Medi-Cal and the implementation of the Affordable Care Act were updated to reflect the current status of ACA implementation and the election of President-Elect Trump.

- Language was added to the Medicaid and Aging issues section to express support for moving the IHSS Program to the Statewide IHSS Authority; this change conforms the language to the Human Services Chapter.
- Edits were made to the section on Emergency Medical Services to clarify county support for ensuring the continuity and integrity of the current emergency medical services system, including county authority related to medical control.

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:

- The Child Welfare Services/Foster Care section was updated to reflect AB 403, the Continuum of Care Reform (CCR).
- Language on the Child Support Enforcement Program was updated to reflect county support for maximizing federal funding at the county level.
- Edits were made to streamline the section on Proposition 10 by deleting language that explains the differences in how Proposition 10 funds are disseminated in different counties.
- Clarifying edits about the roles of Proposition 1A and Proposition 30 were made in the Realignment section.
- Language was added to the section on Adult Protective Services to include county support for efforts to prevent, identify, and prosecute instance of elder abuse.
- The In-Home Supportive Services section was updated to reflect recent changes to the program, such as the IHSS MOE that was negotiated in the 2012-13 state budget, and to remove outdated language.
- The Veterans section was updated to include language supporting the coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

Realignment

To increase clarity, the 2010 CSAC Realignment Principles as adopted by the CSAC Board of Directors have been incorporated into the Realignment Chapter. Previously, the 2010 Realignment Principles were an attachment to the Platform. Further edits were made to reformat the chapter into a more reader-friendly product.

Comments Received

Staff received comments on several issues, which are described below:

- Ensuring that adequate care is provided during the CCS shift to the Whole Child Model.
- Preserving supplemental payments to public and private hospitals as Federal Medicaid Managed Care rules are implemented.
- The importance of providing counties with options to implement Medi-Cal managed care systems that meet their local needs.
- The importance of preserving 2011 Realignment growth funding and preventing diversions from growth funds.
- The importance of continuing to support increased access to health care coverage, after implementation of the Affordable Care Act.
- Providing counties with opportunities to provide certain services to the homeless population.
- Affirming counties' support of public policies and programs that aid in the development of healthy communities.

- The importance of ensuring the effective delivery of rehabilitative community-based mental health services to Medi-Cal enrollees.

In response to these comments, staff made 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 Platform Chapter
2. Draft Human Services Platform Chapter
3. Draft Realignment Platform Chapter

CSAC Staff Contacts.

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Health, Human Services, and Realignment Platform Review

Attachment Six

Draft Health Platform Chapter

Chapter Six

DRAFT ~~January 2015~~November2016

Health Services

Section 1: ~~GENERAL PRINCIPLES~~General Principles

Counties serve as the front-line defense against threats of widespread disease and illness and promote 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 in order to achieve better fiscal 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 ~~mental~~ behavioral health services, substance use disorder services, nutrition awareness and disease prevention – and healthy living models for all of our communities, families, and individuals. Preventative health efforts have proven to be cost effective and provide a benefit to all residents.

Comment [CSAC1]: This edit was made throughout the chapter in response to comments from CBHDA.

The enactment and implementation of the federal Patient Protection and Affordable Care Act (ACA) of 2010 provides 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 of Californians. Counties believe in maximizing the allowable coverage expansion under the ACA, while also preserving access to local health services for the residual uninsured. 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.

At the federal level, counties also support economic stimulus efforts that help maintain services levels and access for the state's neediest residents. ~~Counties are straining to provide services to the burgeoning numbers of families in distress. People who have never sought public assistance before are arriving at county health and human services departments. For these reasons, counties~~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.

~~A.~~

Public Health

The county public health departments and agencies are the only health agencies with direct day-today 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 terrorist and biomedical attacks, 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.

1) Counties also support the mission of the federal Prevention and Public Health Fund, and support efforts to secure direct funding for counties to meet the goals of the Fund

~~B. Health Services Planning~~

2) 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.

~~C. Mental~~Behavioral Health

Counties ~~support~~provide community-based treatment ~~of~~for individuals living with severe mental illness. Counties ~~also accept~~have responsibility for providing treatment and administration of ~~such~~ mental health programs. ~~It is believed that~~Counties should have the ~~greatest progress in treating mental illness can be achieved by continuing the counties' current role while providing~~ flexibility ~~for counties~~ to design~~,~~ and implement~~, and support~~ mental health services that best meet the needs of ~~their community. Programs that treat~~the local communities. The appropriate treatment of people living with severe mental ~~illness~~health issues should be ~~designed to meet~~in the framework of local ~~requirements within statewide~~, state, and federal criteria ~~and standards to ensure appropriate treatment of persons with mental illness.~~.

Comment [CSAC2]: CHBDA edit.

Proposition 63

The adoption of Proposition 63, the Mental Health Services Act of 2004, 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 at the local level. ~~We strongly~~

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

2) Counties also strongly oppose any effort to redirect the Proposition 63 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 ~~mental~~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 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 funding will be disruptive to programming at the local level.

Comment [CSAC3]: CBHDA edit.

Counties are committed to service delivery that manages and coordinates services to persons with mental illness and that operates within a system of performance outcomes that assure funds are spent in a manner that provides the highest quality of care. ~~The 2011 Realignment once again restructured financing for the provision of Med-Cal services for children and adults.~~

~~California law consolidated~~ Counties supported actions to consolidate the two Medi-Cal ~~mental~~behavioral health systems, one operated by county ~~mental~~behavioral health departments and the other operated by the state Department of Health Services ~~on a fee-for-service basis, effective in fiscal year 1997-98. Counties supported these actions to consolidate these two systems,~~ and to operate Medi-Cal ~~mental~~behavioral health services as ~~a~~ managed care ~~program.~~ programs. Counties ~~were offered the first opportunity to provide managed mental health systems, and every county~~ chose to operate as a Medi-Cal Mental Health Plan~~. This consolidated program provides for~~, and there is a negotiated sharing of risk for services between the state and counties~~.~~

Comment [CSAC4]: Santa Clara County edit.

Comment [CSAC5]: CBHDA edit.

~~In 2011, Counties~~, particularly because counties became solely responsible for managing the nonfederal share of cost for these ~~mental~~behavioral health services~~.~~ under 2011 Realignment.

1) ~~In response to county concerns, state law also provides funds to county programs to provide specialty mental health services to CalWORKs recipients who need treatment in order to get and keep employment.~~ 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. ~~Similar law~~

~~requires county mental health programs to provide specialty mental health services to seriously emotionally disturbed children insured under the Healthy Families Program. The Healthy Families Program was dissolved in the 2012-13 Budget Act, and counties will continue to provide specialty mental health services to this population under Medi-Cal. However, counties anticipate increased demand for these~~

~~1)~~2) Counties anticipate increased demand for these behavioral health services under Medi-Cal, and must have adequate revenues to meet the federal standards and needs of these children.

Comment [CSAC6]: CBHDA edit.

3) ~~Adequate mental~~ Behavioral health services can reduce criminal justice costs and utilization. ~~Appropriate diagnosis and treatment services will result in positive outcomes for offenders with mental illness and their families. Ultimately, appropriate mental health services will benefit the public safety system.~~

Comment [CSAC7]: CBHDA edit.

~~2)~~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.

~~Despite the passage of federal parity laws (the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008), access to mental health and substance use treatment remains elusive for many Californians. Counties recognize that millions of Californians are suffering from mental health and substance use disorders and support policies to ensure adequate resources are available for effective implementation of federal mental health and substance use parity requirements.~~

~~**D.**~~

Children's Health

California Children's Services

Counties provide diagnosis and some case management services, in conjunction with County Organized Health Systems (COHS) 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 WCM, Counties also are still responsible for determination of medical and financial eligibility for the program. Counties may also provide Medical Therapy Program (MTP) services for both CCS children and special education students, and ~~have~~retain a share of cost for services to non-Medi-Cal children.~~–~~

Comment [CSAC8]: In response to a comment from Butte County Public Health.

1) Maximum federal and state matching funds for CCS 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. ~~Counties support efforts to redesign or realign the program with the goal of continuing to provide the timely care and services~~

~~for these most critically ill children.~~

~~1)~~2) Counties also support efforts to test alternative models of care under CCS pilots 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.

Comment [CSAC9]: Santa Clara County edit

State Children's Health Insurance Program

1) ~~The State Children's Health Insurance Program (SCHIP) is a federally funded program that allows states to provide low- or no-cost health insurance to children up to 250 percent of the Federal Poverty Level (FPL).~~ CSAC supports a four-year extension of funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). As a block grant, the appropriation for the program ~~expires on September 30, 2015.~~is being considered for reauthorization in 2017. 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 through Covered California.

Comment [CSAC10]: In response to comments from Santa Clara and Butte Counties.

Proposition 10

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development.

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. ~~Further, local~~

~~1)~~2) Local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate needs of their communities, 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 their local expenditure authority.

~~2)~~3) ~~In recognition that Proposition 10 funds are disseminated differently based on a county's First 5 Commission structure and appropriated under the premise that local commissions are in a better position to identify and address unique local needs, counties~~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.

~~E.~~ Substance Use Disorder Prevention and Treatment

~~Counties have been, and will continue to be, actively involved in substance use disorder prevention and treatment, especially under the 2011 Realignment rubric, where counties were given responsibility for substance abuse treatment and Drug Medi-Cal services. Counties believe the best opportunity for solutions reside at the local level. Counties continue to provide a wide range of substance use disorder treatment services, but remain~~Counties are concerned about evidence-based treatment capacity for all persons requiring substance abuse treatment services.

1) Counties support and seek more housing options, including recovery and treatment housing options within the community.

~~1)~~2) Adequate early intervention, substance use disorder prevention and treatment services have been proven to reduce criminal justice costs and utilization~~. Appropriate~~, but appropriate funding for diagnosis and treatment services ~~will result in positive outcomes for non-offenders and offenders alike with substance use disorders. Therefore, appropriate~~ must be available. Appropriate substance use disorder treatment services will benefit 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.

Comment [CSAC11]: Santa Clara County edit

~~2)~~3) 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.

~~3)~~4) ~~With the enactment of Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, the demand for substance use disorder treatment and services on counties continues to increase. Dedicated funding for Proposition 36 expired in 2006, and the 2010-11 state budget eliminated all funding for Proposition 36 and the Offender Treatment Program. However, the courts can still refer individuals to counties for treatment under state law, and~~The courts may still refer individuals to counties for treatment under Proposition 36, but counties are increasingly unable to provide these voter-mandated services without adequate dedicated state funding.

~~F.~~ Medi-Cal, California's Medicaid Program

California counties have a unique perspective on the state's Medicaid program. Counties are charged with preserving the public health and safety of communities. As the local public health authority, counties are vitally concerned about health outcomes. Undoubtedly, changes to the Medi-Cal program ~~will affect counties. Even as the Affordable Care Act is implemented, counties~~have affected counties.

Comment [CSAC12]: Butte County edit.

1) Counties remain concerned about state and federal proposals that would decrease access to health care or shift costs and risk to counties.

2) ~~Counties are the foundation of California's safety net system. Under California law, counties are required to provide services to the medically indigent. To meet this mandate, some counties own and operate county hospitals and clinics. These hospitals and clinics~~

~~also provide care for Medi-Cal patients and serve as the medical safety net for millions of residents. These local systems also rely heavily on Medicaid reimbursements.~~ 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) ~~Additionally, county~~ County welfare departments determine eligibility for the Medi-Cal program~~.~~ and must receive adequate funding for these duties.

~~3)~~4) County ~~mental~~behavioral health departments are the health plan for Medi-Cal Managed Care for public ~~mental~~behavioral health services~~.~~ and must receive adequate funding for these duties. Changes to the Medi-Cal program ~~will~~ have undoubtedly affect the day-to-day business of California counties.

Comment [CSAC13]: Butte County edit.

~~In the area of Medi-Cal, counties have developed the following principles:~~

~~4)~~5) ~~**1. Safety Net.**~~ It is vital that changes to Medi-Cal preserve the viability of the safety net and not shift costs to the county.

6) ~~**2. Managed Care.** Expansion of managed care must not adversely affect the safety net and must be tailored to each county's medical and geographical needs. Due to the unique characteristics of the health care delivery system in each county, the variations in health care accessibility and the demographics of the client population, counties believe that managed care systems must be tailored to each county's needs.~~ 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.

~~5)~~7) 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 ~~should~~must offer a reasonable reimbursement and rate mechanism for managed care.

8) ~~**3. Special Populations Served by Counties – Mental Health, Substance Use Disorder Treatment Services, and California Children's Services (CCS).**~~ Changes to Medi-Cal must preserve access to medically necessary ~~mental~~behavioral health care, drug treatment services~~, and California Children's Services.~~.

9) The carve-out of specialty ~~mental~~behavioral health services within the Medi-Cal program must be preserved~~, if adequately funded, in ways that~~ to maximize federal funds and minimize county risks~~. Maximum federal matching funds for CCS program services must~~ and continue ~~in order to avoid~~ the ~~shifting~~effective delivery of ~~costs~~ rehabilitative community-based mental health services to ~~counties.~~ local Medi-Cal enrollees.

Comment [CSAC14]: CBHDA edit.

Comment [CSAC15]: CBHDA edit.

10) Counties recognize the need to reform the Drug Medi-Cal Organized Delevery 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.

Comment [CSAC16]: CBHDA edit.

~~6)~~11) Any reform effort should recognize the importance of substance use disorder treatment and services in the local health care continuum.

12) **~~4. Financing.~~** Counties will not accept a share of cost 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.

~~7)~~13) The state should fully fund county costs associated with the administration of the Medi-Cal program.

~~5. Simplification.~~ 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. ~~Simplification should include removing barriers that unnecessarily discourage beneficiary or provider participation or billing and timely reimbursements. Counties support simplifying the eligibility process for administrators of the Medi-Cal program.~~

~~8)~~14) The State should consider counties as full partners in the administration of Medi-Cal and its expansion under ACA, and consult with counties in formulating and implementing all policy, operational and technological changes.

~~G.~~ Medicare Part D

~~In 2003, Congress approved a new prescription drug benefit for Medicare effective January 1, 2006. The new benefit will be available for those persons entitled to Medicare Part A and/or Part B and for those dually eligible for Medicare and Medi-Cal.~~

~~Beginning in the fall of 2005, all Medicare beneficiaries were given a choice of a Medicare Prescription Drug Plan. While most beneficiaries must choose and enroll in a drug plan to get coverage, different rules apply for different groups. Some beneficiaries will be automatically enrolled in a plan.~~

~~The Medicare Part D drug coverage plan eliminated state matching funds under the Medicaid program and shifted those funds to the new Medicare program. The plan requires beneficiaries to pay a copayment and for some, Medi-Cal will assist in the cost.~~
~~For counties, this change~~Medicare Part D led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and ~~mental~~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.

~~H.~~ Medicaid and Aging Issues

1) ~~Furthermore, counties~~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. ~~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.~~

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

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

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

5) Counties support moving the IHSS program to the Statewide IHSS Authority.

~~2)~~6) Counties also support federal and state funding to support Alzheimer's disease research, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer's disease.

Section 2: ~~AFFORDABLE CARE ACT~~Affordable Care Act (ACA) ~~IMPLEMENTATION~~Implementation

The fiscal impact of the federal ACA on counties is uncertain and there will be significant county-by-county variation. However, counties support health care coverage for all persons living in the state. ~~The sequence of changes and implementation of the Act must be carefully planned, and the state must work in partnership with counties to successfully realize the gains in health care and costs envisioned by the ACA.~~

1) ~~Counties also caution that increased coverage for low-income individuals may not translate into savings to all county health systems. Counties cannot contribute to a state expansion of health care before health reform is fully implemented, and any moves in this direction would destabilize the county health care safety net.~~Under AB 85, Counties must also retain sufficient health revenues for residual responsibilities, including public health.

~~**A. Access and Quality**~~

~~• 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 and offenders, detainees, and undocumented immigrants into the larger health care service model.

3) ~~———~~Health care expansion 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.

~~B. Role of Counties as Health Care Providers~~

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 universal health coverage plan.

7) ~~———~~Counties strongly support adequate funding for the local public health system as part of a plan to achieve universal health coverage. ~~Counties recognize the linkage between public health and health care.~~ A strong local public health system will reduce medical care costs, contain or mitigate disease, and address disaster preparedness and response.

~~C. Financing and Administration~~

- Counties support increased access to 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 shall be shared among all sectors: government, labor, and business.

Comment [CSAC17]: Language kept per Santa Clara County edit.

8) Efforts to achieve universal health care should simplify the health care system – for recipients, providers, and administration. A universal health care system should include prudent utilization control mechanisms that are appropriate and do not create barriers to necessary care.

9) ~~———~~The federal government has an obligation and responsibility to assist in the provision of health care coverage.

10) ~~———~~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.

- ~~County financial resources are currently overburdened; counties are not in a position to contribute permanent additional resources to expand health care coverage.~~

- ~~A universal health care system should include prudent utilization control mechanisms that are appropriate and do not create barriers to necessary care.~~

11) ~~———~~Access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes.

~~D. Role of Employers~~

12) ~~———~~Counties, as both employers and administrators of health care programs, believe that every employer has an obligation to contribute to health care coverage~~. Counties are sensitive to the economic concerns of employers, especially small employers, and employer-based solutions should reflect the nature of competitive industries and job creation and retention. Therefore,~~, 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.

13) ~~———Reforms~~Expansion of health care coverage should offer opportunities for self-employed individuals, temporary workers, and contract workers to obtain affordable health coverage.

~~E. Implementation~~

~~The sequence of changes and implementation must be carefully planned, and the state must work in partnership with the counties to successfully realize the gains in health and health care envisioned by the ACA.~~

Section 3: ~~CALIFORNIA HEALTH SERVICES FINANCING~~ 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~~ as provided prior to the enactment of the federal Personal Responsibility Work Opportunity Reconciliation Act of 1996.~~.

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. ~~Counties support legislation to permit commensurate reductions at the local level to avoid any cost shifts to local government.~~

2) 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. ~~Counties believe that enrollment of Medi-Cal patients in managed care systems may create opportunities to reduce program costs and enhance access.~~ 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. ~~The state must continue to provide options for counties to implement managed care systems that meet local needs. Because of the significant volume of Medi-Cal clients that are served by the counties, the state should work openly with counties as primary partners.~~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.

~~Where cost-effective, the state should provide non-emergency health services to undocumented immigrants. The State should seek federal reimbursement for medical services provided to undocumented immigrants. The ACA provides federal Medicaid funds for emergency services for undocumented immigrants.~~

~~Counties oppose any shift of funding responsibility from accounts within the Proposition 99 framework that will negatively impact counties. Any funding responsibilities shifted to the Unallocated Account would disproportionately impact the California Healthcare for Indigents Program/Rural Health Services (CHIP/RHS), and thereby potentially produce severe negative fiscal impacts to counties.~~

3) ~~Counties support increased funding for trauma and emergency room services. Trauma centers and emergency rooms play a vital role in California's health care delivery system. Trauma services address the most serious, life-threatening emergencies. Financial pressures in the late 1980s and even more recently have led to the closure of several trauma centers and emergency rooms. The financial crisis in the trauma and emergency systems is due to a significant reduction in Proposition 99 tobacco tax revenues, an increasing number of uninsured patients, and the rising cost of medical care, including specialized equipment that is used daily by trauma centers.~~ Counties support increased funding for trauma and emergency room services.

~~3)~~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.

~~A.~~ Realignment

~~In 1991, the state and counties entered into a new fiscal relationship known as 1991 Realignment. 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.~~

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

~~1)~~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.

~~2)~~3) ~~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~~Proposition 1A constitutional provisions~~. Further, any effort to realign programs or resources~~ and must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.

Comment [CSAC18]: Santa Clara County edit

~~3)~~4) In 2011, counties assumed ~~100 percent~~ 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.

Comment [CSAC19]: CBHDA edit.

~~B.~~ Hospital Financing

~~In 2014, 12 counties own and operate 16 hospitals statewide, including Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura Counties. These~~Public hospitals are a vital piece of the local safety net, but also serve as indispensable components of a robust health system, providing both primary and specialized health services to health consumers in our communities, as well as physician training, trauma centers, and burn care.

1) ~~County hospitals could not survive without federal Medicaid funds.~~ CSAC has 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. ~~California's current federal Section 1115 Medicaid waiver (implemented in SB 208 and AB 342, Chapter 714 and 723, respectively, Statutes of 2010) provides county hospitals with funding for five years.~~

2) Counties believe implementation of the federal waiver is necessary to ensure that county hospitals are paid for the care they provide to Medi-Cal recipients and uninsured patients~~ and to prepare counties for federal health care reform implementation in 2014. California's existing Section 1115 "Bridge to Reform" Medicaid Waiver expires in October 2015. The Waiver is a five-year demonstration of health care reform initiatives that invested in the state's health care delivery system to prepare for the significant changes spurred on by the Affordable Care Act (ACA). Continuance of the federal government's commitment to the implementation of the ACA through a successor Waiver will allow the state and counties to further improve care delivery and quality. Through the Waiver, counties seeks federal and state support to promote and improve health outcomes, access to care and cost efficiency, building upon the system of care~~

~~delivery models developed under the 2010 Waiver.~~ ..

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 access to share and integrate health data and systems; 5) and provide flexibility for counties/public health care systems to provide more coordinated care and effectively serve individuals who will remain uninsured.

~~1)~~4) Counties are supportive of opportunities to reduce costs for county hospitals, 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.

~~2)~~5) Counties also support opportunities for county hospitals and health systems to make delivery system improvements and upgrades, which will help these 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.

Comment [CSAC20]: Los Angeles County edit.

Section 4: ~~**FAMILY VIOLENCE**~~ Family Violence

~~CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts~~Specific strategies for early intervention and success 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.

Section 5: ~~**HEALTHY COMMUNITIES**~~ Healthy Communities

Built and social environments significantly impact the health of communities.~~–~~Counties ~~acknowledge the role of public policy as a tool to reshape the environment and~~ support public policies and programs that aid in ~~the~~ development of healthy communities ~~which are designed to provide opportunities for people of all ages and abilities to engage in routine physical activity or other health-related activities. To this end,~~. and Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable developments, where feasible, to promote healthy community events and activities.

Comment [CSAC21]: Santa Clara County edit

Section 6: ~~**VETERANS**~~ Veterans

~~Counties provide services such as mental health treatment, substance use disorder treatment, and social services that veterans may access.~~ 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.

~~**Section 7: EMERGENCY MEDICAL SERVICES**~~

1) ~~Counties are tasked with providing critical health, safety, and emergency services to all residents, regardless of geography, income, or population. Because of this responsibility and our statutory authority to oversee pre-hospital emergency medical services, including ambulance transport service, counties are forced to operate a balancing act between funding, services, and appropriate medical and administrative oversight of the local emergency medical services system.~~ Counties also support coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

Section 7: Emergency Medical Services

1) Counties do not intend to infringe upon the service areas of other levels of government who provide similar services, but will continue to discharge our statutory duties to ensure that all county residents have access to the appropriate level and quality of emergency services~~, including medically indigent adults.~~ .
2) Counties support ensuring the continuity and integrity of the current emergency medical services system~~. Reductions in~~, including county authority ~~for counties in these areas will be opposed.~~ related to medical control.
~~1)~~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.

Section 8: Court-~~**involved population**~~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 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 9~~.~~: 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 ~~supervised~~ placements for individuals originating from DSH facilities, county jails, or ~~conserved status~~who are under conservatorship. Counties support a shared funding and service delivery model for complex placements, such as the Enhanced Treatment Program.

Comment [CSAC22]: CBHDA edit.

Comment [CSAC23]: CBHDA edit.

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

Comment [CSAC24]: CBHDA edit.

Health, Human Services, and Realignment Platform Review

Attachment Seven

Draft Human Services Platform Chapter

Chapter Twelve

DRAFT ~~January 2015~~November 2016

Human Services

Section 1: ~~GENERAL PRINCIPLES~~ General Principles

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

Inadequate funding for program costs strains the ability of counties to meet accountability standards and avoid penalties, putting the state and counties at risk for hundreds of millions of dollars in federal 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 ~~that~~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. ~~People who have never sought public assistance before are arriving at county health and human services departments. Counties~~With each downturn in the economy, counties report long lines in their welfare departments as increasing numbers of people apply for programs such as Medicaid, Supportive Nutrition Assistance Program (SNAP or Food Stamps), Temporary Assistance to Needy Families (TANF), and General Assistance. For these reasons, counties strongly urge that any federal stimulus funding must be shared directly with counties for programs that have a county share of cost.

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.~~

Counties support 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.

~~Prior to Proposition 13 in 1978, property taxes represented a stable and growing source of funding for county-administered human services programs. Until SB 154 (1978) and AB 8 (1979), there was a gradual erosion of local control in the administration of human services due to legislation and regulations promulgated by the state, which included dictating standards, service levels and administrative constraints.~~

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 each county's local needs. If the state implements performance standards, the costs for meeting such requirements must be fully reimbursed.

2) 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.

3) 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.

Section 2: ~~HUMAN SERVICES FUNDING DEFICIT~~ 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, funding for these services was frozen at 2001 cost levels. The state's failure to fund actual county cost increases ~~led~~contributes to a growing funding gap of nearly $1 billion *annually*. This ~~put~~puts counties in the untenable position of backfilling the gap with their own limited resources or cutting services that the state and county residents expect us to deliver.

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

Section 3: ~~CHILD WELFARE SERVICES/FOSTER CARE~~ 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 and court-ordered changes, such as those proscribed in the *Katie A.* settlement require collaboration between county child welfare services/foster care and mental health systems.

The existing approach to budgeting and funding child welfare services was established in the mid1980'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 remain a concern.

Further, recent court settlements (Katie A.) and policy changes (AB 12 Fostering Connections to Success Act of 2010 and AB 403, Continuum 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.

1) Counties support efforts to reform the congregate care – or youth group home – system ~~and strongly support efforts to recruit, support, and retain foster family homes to address~~under AB 403, the ~~decline~~Continuum of ~~foster family home placements in California today.~~ 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, provide pathways to mental health support, and incentivize child and family teaming 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.

Comment [CSAC1]: CBHDA edit.

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.

2) 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.

~~2)~~3) 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. When determining the appropriate intervention approach, the best interest of the child should always be the first consideration. ~~These efforts to protect the best interest of children and preserve families may include:~~

~~1. A structured family plan involving family members and all providers, with specific goals and planned actions;~~
~~2. A family case planning conference;~~
~~3. Intensive home supervision; and/or~~
~~Juvenile and criminal court diversion contracts.~~

~~3)~~4) When a child is in danger of physical harm or neglect, either the child or alleged offender may be removed from the home, and formal dependency and criminal court actions may be taken. Where appropriate, family preservation and support services should be provided in a comprehensive, culturally appropriate and timely manner.

5) When parental rights must be terminated, counties support a permanency planning process that quickly places children in the most stable environments, with 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.

~~4)~~6) Counties also support adequate state funding for adoption services.

~~5)~~7) Furthermore, 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 Fostering Connections to Success Act of 2010 to help ensure the future success of this vulnerable population.

~~6)~~8) With regards to caseload and workload standards in child welfare, especially with major policy reforms such as AB 403, counties remain concerned about increasing workloads and fluctuations in funding, 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.

~~7)~~9) Counties support a reexamination of reasonable caseload levels at a time when cases are becoming more complex, often more than one person is involved in working on a given case, and when extensive records have to be maintained about each case. Counties support ongoing augmentations for Child Welfare Services to partially mitigate workload concerns and the resulting impacts to 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) 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. 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.

Section 4: ~~EMPLOYMENT AND SELF- SUFFICIENCY PROGRAMS~~ Employment and Self-Sufficiency Programs

There is 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), Medicaid, Medi-Cal, and Food Stamps. In addition, electronic technology improvements in welfare administration are an important tool in 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. 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 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 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. ~~In addition, federal~~

~~2)~~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. ~~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.~~

5) The state should assume principal fiscal responsibility for the General Assistance program.

~~3)~~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. 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.

~~4)~~7)California's unique position as the nation's leading agricultural state should be leveraged to increase food security for its residents. ~~Also, with the recent economic crisis, families and individuals are seeking food stamps and food assistance at higher rates.~~ 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.

~~5)~~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.

~~6)~~9)~~Finally, counties~~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.

Section 5: ~~CHILD SUPPORT ENFORCEMENT PROGRAM~~ Child Support Enforcement Program

Counties are committed to strengthening the child support enforcement program through implementation of the child support restructuring effort of 1999. ~~-~~Ensuring a seamless transition and efficient ongoing operations requires sufficient federal and state funding and must not result in any increased county costs. ~~Further, the state must assume full responsibility for any federal penalties for the state's failure to establish a statewide automated child support system.~~ Counties support maximizing federal funding for child support operations at the county level.~~Any penalties passed on to counties would have an adverse impact on the effectiveness of child support enforcement or other county programs.~~

1) ~~More recently, the~~The way in which child support enforcement funding is structured prevents many counties from meeting state and federal collection guidelines and forces smaller counties to adopt a regional approach or, more alarmingly, fail outright to meet 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. ~~Moreover, a~~

~~2)~~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 policies and guidelines regarding child support enforcement and the local flexibility to organize and structure effective programs.

Section 6: ~~PROPOSITION~~Proposition 10: ~~THE FIRST FIVE COMMISSIONS~~ The First Five Commissions

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development.

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. ~~Further, local~~

~~1)~~2)Local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate needs of their communities, 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.

~~2)~~3)~~In recognition that Proposition 10 funds are disseminated differently based on a county's First 5 Commission structure and appropriated under the premise that local commissions are in a better position to identify and address unique local needs, counties~~Counties oppose any effort to lower

or eliminate ~~the state's~~state support for county programs with the expectation that the state or local First ~~5commissions~~ 5 commissions will backfill the loss with Proposition 10 revenues. ~~–~~

Section 7: ~~REALIGNMENT~~ Realignment

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

In 2011, counties assumed ~~100 percent~~ 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.

Comment [CSAC2]: Edit for consistency with Health Chapter.

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. ~~However, counties~~

~~1)~~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.

~~2)~~3)~~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~~within the context of ~~these~~the constitutional provisions~~.~~ of Proposition 1A or Proposition 30 .

~~In 2011, counties assumed 100 percent 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.~~

Section 8: ~~FAMILY VIOLENCE~~ 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.

Section 9: ~~AGING AND DEPENDENT ADULTS~~ Aging and Dependent Adults

California is already home to more older adults than any other state in the nation, and the state's 65 and older population is expected to double ~~over the next 20 years,~~ 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.

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. ~~Furthermore, counties~~

~~1)~~2) 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)~~3) Counties also support federal and state funding to support Alzheimer's disease research, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer's disease.

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. ~~Timely~~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. ~~Counties must retain local flexibility in meeting the needs of our aging population.~~

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. 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. ~~All Supplementary Income/ State Supplemental Payment recipients are also eligible for IHSS benefits if they demonstrate an assessed need for such services.~~

County social workers evaluate prospective and ongoing IHSS recipients, who may receive assistance with such tasks as housecleaning, meal preparation, laundry, grocery shopping, personal care services such as bathing, paramedical services, and accompaniment to medical appointments. Once a recipient is authorized for service hours, the recipient is responsible for

hiring his or her provider.

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

However, as part of the 2012-13 state budget, the Legislature and Governor approved major policy changes within the Medi-Cal program aimed at improving care coordination, particularly for people on both Medi-Cal and Medicare. Also approved as part of this Coordinated Care Initiative (CCI) are a number of changes to the In-Home Supportive Services (IHSS) program, including state collective bargaining for IHSS, creation of a county IHSS Maintenance of Effort (MOE), and creation of a Statewide Authority. ~~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. In 2014, the state became the employer of record for the eight Coordinated Care Initiative (CCI) counties.~~

~~IHSS cases are funded by one of three programs in California: the Personal Care Services Program (supported by federal Medicaid funds, state funds and county funds), the IHSS Residual Program (supported by state and county funds), or the IHSS Plus Waiver (supported by federal Medicaid funds, state funds and county funds). IHSS Program Administration is supported by a combination of federal, state and local dollars.~~

~~Costs~~ However, costs and caseloads for the program continue to grow. ~~State General Fund costs for the IHSS program have quadrupled from 1998 to 2008. Federal funds have almost quadrupled. County costs have grown at slightly slower pace – tripling over ten years.~~ According to the Department of Social Services, caseloads are projected to increase between five and seven percent annually going forward.

1) Counties support the continuation of federal and state funding for IHSS, and oppose any efforts to ~~further shift IHSS costs to counties. Furthermore, counties are committed to working with the appropriate state departments and stakeholders to draft, submit, and implement new ideas to continue and enhance federal support of the program.~~ shift additional IHSS costs to counties.

~~**Section 10: VETERANS**~~

2) ~~Counties provide services such as mental health treatment, substance use disorder treatment, and social services that veterans may access.~~ Counties support the MOE as negotiated in the 2012-13 state budget and will oppose any proposals to change the MOU as outlined in statue.

3) Counties support moving the IHSS program to the Statewide IHSS Authority.

Section 10: 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.

Health, Human Services, and Realignment Platform Review

Attachment Eight

Draft Realignment Platform Chapter

~~1-18-13~~

~~**PROPOSED NEW PLATFORM CHAPTER/LANGUAGE: REALIGNMENT**~~

~~**Proposed for adoption by the CSAC Health and Human Service Policy Committee. Approved by the Administration of Justice and Government Finance and Operations Policy Committees November 2012.**~~

~~Proposed Chapter:~~

DRAFT November 2016

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.

Comment [CSAC1]: Edit made in response to concerns from Santa Clara County about growth funds being redirected.

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~~. Those~~ below. These principles, along with the protections enacted under Proposition 1A (2004), ~~would~~will guide ~~counties'~~our response to any future proposal to shift additional state responsibilities to counties.

~~Attachment:~~**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

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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.

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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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Establishing HHS Priorities for 2017

Attachment Nine

CSAC Memo: Establishing HHS Priorities for 2017

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

November 16, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: Establishing HHS Priorities for 2017 – ACTION ITEM

Each year, CSAC establishes priority issues for the Association. The development of these priorities is done within the current political and fiscal landscape and each are drafted to conform with the proposed platform language. Each policy committee is tasked with examining the proposed priorities and approving them. Once approved by the policy committee, they are forwarded to the CSAC Board of Directors for final approval.

The proposed priorities presented below were developed with the recent national election in mind. Please review these draft 2017 HHS priorities and prepare for a discussion and action during the November 29 meeting of the policy committee.

DRAFT 2017 HHS Priorities

Potential Changes to the Affordable Care Act

With the election of President-Elect Trump, California's counties must engage on any proposals to repeal or alter the Affordable Care Act (ACA). California draws down about $15 billion in federal funds – including a large proportion of dollars associated with the ACA – within a total Medi-Cal budget of $19.1 billion. Further, counties spent between $1.5 and $2 billion annually on medical services for the medically indigent before the ACA expanded Medicaid eligibility – a portion of which has been transferred to the state due to county savings as this population transfers to Medi-Cal. The County response will depend on how President-Elect Trump and the Republican Congress proceed in potentially repealing the ACA in its entirety, or retain parts of it, or develop additional proposals to replace it. CSAC will work with our Washington representatives, county affiliates, and the Brown Administration to respond to any county impacts associated with changes to the ACA.

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, and seniors. 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, as well as continue our collaboration with the League of California Cities on the joint City-County task force to examine issues and solutions for housing and homelessness. CSAC will also continue to work hand-in-hand with the California Department of Housing and Community Development on the new No Place Like Home Program, which will provide $2 billion in bond funding to counties for building or refurbishing permanent supportive housing for those who are homeless and living with mental illness. CSAC will also work to minimize the local effects of the Mental Health Services Act diversions, which are used to pay for the debt service on the bonds. Lastly, CSAC will continue working with all counties on communication and education efforts related to homelessness

issues, including featuring CSAC issue videos, Institute courses, workshops, regional meetings, and social and web media to ensure the best outcomes for counties and the people we serve.

Continuum of Care (AB 403) Reform Implementation

CSAC will continue to focus on the wholesale reform of the group home system in California under AB 403, which requires counties to implement the new system on January 1, 2017. CSAC will continue working closely with county child welfare services, behavioral health, and juvenile probation systems to ensure they are adequately resourced to implement this massive new policy change to improve outcomes for foster and probation youth. CSAC will also continue to convene county affiliates in discussions to ensure coordinated and strategic advocacy efforts and continue the work of ascertaining the fiscal and Proposition 30 implications of the reforms.

In Home Supportive Services Maintenance of Effort

In 2016, CSAC was successful in helping to develop a new three-year Managed Care Organization (MCO) fix that prevented a $1.1 billion loss in state funding and preserved the Coordinated Care Initiative (CCI) pilot project. Our role in 2017 requires CSAC to make strategic decisions calculated to preserve the CCI and effectuate the expansion of the pilot to the remaining 51 counties. This is the first step in eventually transferring collective bargaining for IHHS workers from each county to the state. A specific timeline for statewide implementation of the CCI and the transfer of collective bargaining has yet to be developed.

Foster Youth Services

Foster youth are among the most at-risk populations in California, but recent state law changes, such as expanding eligibility for foster care services from age 18 to age 21, have resulted in additional local costs beyond the cap on county expenditures 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. CSAC will also work to ensure that these vulnerable youth have timely access to child welfare and behavioral health services and that their medical and other records are updated and accessible to all youth, the professionals who are serving them, and the youth's caregiver. CSAC will also work to ensure transparency within all systems that serve foster youth.

Federal Priorities

Affordable Care Act

CSAC will monitor legislative proposals to repeal and replace the *Affordable Care Act* (ACA). California, its counties, and the residents they serve have benefitted greatly from the expansion of Medicaid (Medi-Cal) and the insurance subsidies provided to those individuals and families whose incomes do not qualify them for Medicaid. Those key ACA components and others risk being repealed. CSAC will work to protect the financing of coverage under the ACA and will consider other options to replace the Act which continue coverage and access to care.

Additionally, CSAC will continue to support bipartisan efforts to eliminate the ACA excise tax, which is slated to go into effect in 2020. A number of California counties offer health insurance plans and related programs that will be subjected to the tax on high-cost plans.

Child Welfare Services

CSAC will support increased federal funding for services and income support needed by parents seeking to reunify with children who are in foster care. CSAC also supports 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 protect and retain the entitlement nature of the Title IV-E Foster Care and Adoption Assistance programs while seeking the elimination of outdated rules that base a child's eligibility for funds on parental income and circumstances. Finally, CSAC supports federal funding to address the service needs of youth who are victims of commercial sexual exploitation.

Temporary Assistance for Needy Families (TANF) Reauthorization

CSAC will continue to promote TANF reauthorization legislation that would restore state and county flexibility to tailor work and family stabilization activities to families' individual needs. CSAC also supports maintaining the focus on work activities under TANF, while recognizing that "work first" does not mean "work only."

Children's Health Insurance Program (CHIP)

Current funding for CHIP expires at the end of fiscal year 2016. CSAC supports full funding of CHIP and continuing the 23 percentage point boost in the federal contribution over the normal 65 percent federal match for CHIP. CSAC further supports action on CHIP early in 2017 to allow the State and counties to budget for the upcoming state fiscal year.

CSAC Staff Contacts.

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524
Tom Joseph, Waterman and Associates, tj@wafed.com, (202) 898-1444

2016 Legislation and 2016-17 Budget Review

Attachment Ten

CSAC Memo: 2016 Legislation and 2016-17 Budget Review

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

November 16, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: 2016 Legislation and 2016-17 Budget Review

2016 Year in Review – HHS

The following lists the outcomes for HHS-related state priorities as adopted by the CSAC Board of Directors for 2016.

Successes

- *IHSS MOE/Coordinated Care Initiative/Managed Care Organization Tax.* CSAC was successful in helping to develop a new three-year Managed Care Organization (MCO) fix that prevented a $1.1 billion loss in state funding and preserved the Coordinated Care Initiative (CCI) pilot project. Our role was a strategic decision calculated to preserve the continued implementation of the CCI and, hopefully, the eventual expansion of the pilot to all counties – although a specific timeline for statewide implementation has yet to be developed. CSAC also worked to protect the county In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) and further supported additional MCO fix funding for provider rate increases and forgiveness for retroactive cuts to rural health care providers.

- *Medi-Cal Eligibility Administration Costs.* CSAC worked with the Brown Administration and CAO's to develop a robust allocation formula for the $170 million in additional state funding secured for county administrative activities related to Medi-Cal eligibility in the current year and FY 2017-18. CSAC is also supporting efforts to undertake a work- and time-study project to better determine funding levels in the future and to avoid the year-to-year fluctuations in state funding for county administrative activities. CSAC continues to strategize on ways to ensure sufficient funding for county costs related to Medi-Cal eligibility workload.

- *AB 85 Health Realignment Implementation.* CSAC was successful in convincing the Department of Finance to provide AB 85 "true up" funding in a lump sum amount to each county this fall, totaling nearly $180 million. This is the first year of the AB 85 "true up" calculations for each county's 1991 Health Realignment diversion amounts for the 2013-14 fiscal year, and we were pleased to see counties that were owed funding receive it in a lump sum amount rather than the administration's January budget proposal to credit each county for their amount within the current year redirections. CSAC will continue to monitor the integrity of estimated AB 85 redirections and future true up payments, but is pleased to have achieved the precedent of direct true up payments to counties.

- *Behavioral Health Funding.* The 2011 Realignment Behavioral Health Sub- and Growth Accounts have been of keen interest to the mental health advocate community, the Legislature, and Administration in this post-Affordable Care Act world of expanded eligibility for mental health and substance use treatment services. CSAC, with the Administration and the County Behavioral Health Directors Association, was able to set the 2011 Realignment Behavioral Health Base in September.

This new base is stable, permanent, and includes the "rolling base" concept whereby each county is guaranteed the same funding levels of the previous year's base plus growth amounts. This new base will provide stability to each county's allocation and allow them to build ongoing programs and services. CSAC is also actively working on a permanent growth funding formula that will ensure the timely distribution of growth funding each year for critical programs.

- *Medi-Cal 2020 Waiver Implementation.* The new Section 1115 Medi-Cal 2020 Waiver has been approved by both the Legislature and the federal government, with CSAC supporting the two implementation bills to ensure funding for our safety net public hospitals and to improve the delivery of care. CSAC is now working with the Department of Health Care Services to implement the fiscal and policy aspects of the deal, with a special focus on public hospital funding and the Whole Person Care pilot projects, for which 18 counties have applied for up to $1.5 billion over five years.

- *2-1-1 Referral Systems.* CSAC actively supported both state and federal legislation to help build and fund a statewide 2-1-1 referral system, including supporting SB 1212, which allows the Public Utilities Commission to spend up to $1,500,000 to facilitate expansion of 2-1-1 services into counties that currently do not have 2-1-1 services. The bill was sent to the Governor's desk on August 31 for his signature, but has not yet been signed at the time of this writing. CSAC will continue to work with counties, the state, and community based organizations to realize the goal of statewide implementation or 2-1-1 services.

<u>Ongoing</u>

- *Jail Medi-Cal Claiming (MCIP).* Work continues with the Administration to secure finalized and streamlined claiming protocols for counties to claim up to 50 percent of costs for inmates who have a 24 hour or longer offsite hospital stay. While much progress has been made in this new Medi-Cal Inmate Program, final approval of the protocols is not expected until 2017. CSAC will continue to work with county affiliates and the Administration to determine the process for claiming and determine potential county participation in the program.

- *Drug Medi-Cal Implementation.* CSAC continues to monitor the implementation of the Drug Medi-Cal Organized Delivery System Waiver, including the development of financing mechanisms and rates, as well as working to ensure expanded access to care and services for beneficiaries under the waiver.

- *Continuum of Care Group Home Reform*. The wholesale reform of the group home system in California continues, with CSAC working closely with county child welfare services, behavioral health, and juvenile probation systems to ensure they are adequately resourced to implement this massive new policy change (AB 403) for foster and probation youth. CSAC will continue to convene county affiliates in discussions to ensure coordinated and strategic advocacy efforts and to lead the work on ascertaining the Proposition 30 implications of the bill.

- *Poverty and Homelessness Issues.* Homelessness issues rose to the top of the Legislature's agenda in 2016 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, and seniors. The Senate took the lead on the issue by introducing the No Place Like Home program, and CSAC strategically engaged with the Administration and policy makers to craft the new program in a way that ensures that all counties may access the up to $2 billion in bond funding for building or refurbishing permanent supportive housing for those who are homeless and living with mental

illness. CSAC continues to work hand-in-hand with the state to develop guidelines and other key components of the program to minimize the local effects of the Mental Health Services Act diversions, which are used to pay for the debt service on the bonds.

CSAC joined with the League of California Cities to form an unprecedented joint City-County task force to examine issues and solutions for housing and homelessness. The joint task force held its first meeting on September 23, and will continue to meet through 2017. CSAC is also working with all counties on communication and education efforts related to homelessness issues, including featuring CSAC Institute courses, workshops, and regional meetings on the subject and creating a webpage as a compendium of best practices among local governments.

This issue is expected to continue to dominate local, state, and federal agendas in 2017 as well. CSAC has tapped staff from across issue areas – health and human services, housing and land use, and administration of justice – to provide the best strategy and information available on this multifaceted issue and will continue to engage to ensure the best outcomes for counties and the people we serve.

On the federal level, CSAC, in conjunction with Waterman and Associates, was successful on our federal advocacy priorities:

- *Child Welfare Services.* CSAC, along with the County Welfare Directors Association of California and the California Department of Social Services, successfully thwarted Senate advancement of a major child welfare reform bill (S 3065/HR 5456) that, if approved by Congress, would make State and local implementation of California's Continuum of Care Reform law (AB 403) and other state child welfare reforms much more difficult and costly. As of this writing, it remains unclear if bill proponents will be able to advance the legislation in the upper chamber during the lame duck session.

- *Temporary Assistance for Needy Families (TANF) Reauthorization.* The House passed in 2016 a one-year TANF/CalWORKs extension package that includes $100 million in social impact partnership grants. As part of efforts to secure a long-term TANF reauthorization, CSAC continues to promote the restoration of state and county flexibility to tailor work and family stabilization activities to families' individual needs.

2016-17 Budget Review

Many key budget issues for counties were successfully addressed in the 2016-17 Budget Act. CSAC budget priority highlights include:

- $2 billion in authorized bond issuance for "No Place Like Home" local grants to provide permanent housing for persons with mental illness and who are homeless, or at risk for homelessness.
- $140 million in cap and trade revenues dedicated to local GHG emission reduction programs.
- $270 million for jail construction grants.
- $25 million in grants for hard to site criminal justice facilities to cities and counties.
- $127.3 million for group home reform.
- $10 million in State Responsibility Area Fire Prevention Fund grants, including $5 million in grants to local governments specific to tree mortality and tree removal and $5 million for general fire prevention.
- $11 million to assist in the removal and disposal of trees in high hazard zones.

- $30 million to support local jurisdictions using the California Disaster Assistance Act Program for tree mortality and other disasters.
- $644,000 for PILT (Payment in Lieu of Taxes).
- $2.5 million for Williamson Act.
- Nearly $400,000 in state backfill for counties with insufficient ERAF.

Several CSAC priority issues were left open at time of adjournment or simply unaddressed at the end of the budget season, including:

- $400 million for affordable housing, in combination with the Governor's "By Right" streamlining proposal for developer project approval by cities and counties.
- Comprehensive transportation funding proposal.

For more detail on Health and Human Services budget issues of importance, see below. For more detail on other issue areas, please see the most recent Budget Action Bulletin or contact CSAC Legislative Staff.

No Place Like Home Program

The Senate proposed the "No Place Like Home" program in January, which was created to provide bond funding to counties for permanent supportive housing for people who are homeless and living with a mental illness. The funding source for the bonds is an annual portion of Mental Health Services Act (MHSA) funds.

Ultimately, the Legislature passed two No Place Like Home bills: AB 1618, which contains the program parameters, signed in June, and AB 1628, which contains the bonding and some financing language, signed in August. CSAC negotiated a significant portion of AB 1618 to ensure it would work for counties, and supported the bill. CSAC did not take a position on AB 1628.

In sum, AB 1618 divides potential bond funding into two pots: a competitive pot ($1.8 billion) and a non-competitive pot ($200 million). Within the competitive pot of funding, counties will be grouped into four tiers based on total population, within which they will compete for funding if applicable: Los Angeles County; large counties with a population over 750,000; medium counties with a population between 200,000 and 750,000; and small counties with a population under 200,000. Awards in the competitive pot are not based on a counties' homeless count, and the small county tier will make eight percent of funds available.

There is also an alternative competitive process available for those counties with more than five percent of the statewide homeless population to access funding directly. However, this option limits the total amount of funding that the county can access overall. If money is left over in any of the tiers, it reverts back to the statewide fund and will be made available to other counties to access. AB 1618 requires four funding rounds outside the non-competitive dollars.

The $200 million in non-competitive funding relies on a county's homeless count, which will be developed under the bill's guidelines, and includes a $500,000 minimum award for counties with low homeless counts.

Some money is set aside for implementation assistance and administration. AB 1618 includes up to $2 million for technical assistance to counties based on size and uses up to five percent of funds for state administrative costs. Additionally, four percent of the competitive pot is set aside for a default reserve. AB 1628 includes language that caps the amount of MHSA funding that can be leveraged at $140 million annually, which provides a better sense of the potential cost of the program to counties who

rely on MHSA funds to support valuable local programs for their residents. It also details the flow of funds from MHSA funds for NPLH as well as how the bonds will function.

CSAC is now working with the Department of Housing and Community Development on initial implementation efforts.

MEDI-CAL

County Medi-Cal Administration Costs

The Legislature upheld the January proposal of $169 million in the current year for county Medi-Cal administration costs, plus that amount over baseline in the 2016-17 budget year. The County Welfare Directors have indicated that this amount is reasonable for county costs. As part of this deal, the Department of Finance will begin a time- and work-study to inform the development of a new cost methodology. It is hoped that a fair methodology will stabilize funding for these critical local services. The budget does not include General Fund for shortfalls in county Medi-Cal Administration costs in 2013-14 and 2014-15.

As has been done for the past 15 years, the county COLA for county eligibility administration for 2016-17 was suspended.

The Legislature also adopted several technical and clarifying changes to Medi-Cal, including limiting the State's estate recovery efforts to conform to federal law and restoring acupuncture services as a covered benefit. The annual General Fund limit for state administrative costs for implementing the Medi-Cal Electronic Health Records Incentive Program was increased from $200,000 to $450,000.

Medi-Cal Hospital Quality Assurance Fee

The Legislature passed the extension for the hospital quality assurance fee until January 1, 2018, after which the outcome of the hospital fee ballot measure, Proposition 52, set for November, will be known. CSAC supports Proposition 52.

AB 85 Redirection Estimate

The Legislature approved $57.6 million General Fund for lower-than-expected state savings under AB 85. This was done to account for increased initial state costs under the new Medicaid Section 1115 Waiver. Furthermore, the first "true up" calculation from the AB 85 2013-14 redirection amounts has been finalized, and the state directly reimbursed 12 counties about $170 million.

MENTAL HEALTH

New Children's Crisis Services Grant Program

The Legislature established a one-time grant program to expand the continuum of mental health crisis services for children and youth, including adding child and youth specific mobile crisis and community-based crisis stabilization support teams, additional triage personnel, additional crisis stabilization unit services, additional child and youth crisis residential services, family respite care, and family support services training.

HUMAN SERVICES

Continuum of Care Reform (AB 403 Group Home Reform)

The Legislature did not approve additional funding above the Governor's May Revision for county implementation of AB 403, the Continuum of Care Reform (CCR). This major reform seeks to eliminate the foster and probation youth group home system in California, and is a major undertaking for county Child Welfare Services, county Mental Health Plans, and Probation. CSAC has been advocating for increased first-year funding for AB 403, which is slated to be implemented on January 1, 2017. Currently, the 2016-17 budget includes $127.3 million in total funds for child welfare and county probation departments to implement AB 403.

The Legislature did adopt language requiring the Department of Social Services (DSS) and the Department of Health Care Services to update the Budget Committees of the Legislature on the implementation of the CCR. DSS is additionally required to discuss the proposed foster care rates and rate structure with stakeholders and legislative staff by July 1, 2016.

Child Near Fatality Language

AB 1626 and SB 855, the Human Services Budget Trailer Bills, were amended in August to reflect a compromise on the child near fatality language. The federal law that governs state and federal activities to address child abuse and neglect, the Child Abuse Prevention and Treatment Act (CAPTA), was recently amended to require states to develop procedures for the release of information related to near fatalities that occur to children as the result of abuse or neglect. Federal guidance to the states indicates that a state may determine its procedures for how to release information in accordance with the updates to CAPTA.

The language in AB 1626 and SB 855 would require counties to release information about near-fatalities in the form of a written summary, in addition to releasing a number of specified documents. These documents would be redacted to remove information that is not relevant to the near fatality, which allow the counties to provide important information in a way that accomplishes the goals of the public information sharing requirements in CAPTA while preserving the privacy of the living child, their siblings, and others connected to the family who are innocent of any wrongdoing. AB 1626 and SB 855 additionally preserve the state's ability to continue drawing down $4.8 million in federal child abuse prevention funding by coming into compliance with the federal CAPTA requirements.

Family Resource Agency Money

AB 1623, part of the Budget Act for the 2016-17 fiscal year, was amended to include more funding for resource family agencies. The additional $200,000 that the budget now provides for resource family agencies reflects the importance of providing adequate resources to implement AB 403's group home reform, also known as the Continuum of Care Reform.

Additionally, in the Public Social Services trailer bill, AB 1603, the Legislature made several significant policy changes as outlined below.

CalWORKs

The Legislature repealed the Maximum Family Grant (MFG) Rule using "leftover" funds from the Child Poverty and Family Support Subaccount in 2011 Realignment, as well as some General Fund. The Legislature additionally increased the maximum aid payment under CalWORKs by 1.43% starting July 1, 2016, which is in line with the Governor's recommendation.

The once-in-a-lifetime payment provided to families who have lost their housing allowance by the Homeless Assistance Program (HAP) was repealed by the Legislature. A family now could be allowed to receive HAP once in a twelve month period. CSAC has supported legislation to this effect in past years.

The Legislature also streamlined two CalWORKs subsidized employment programs: the AB 98 program established in 2012 and the Expanded Subsidized Employment Program enacted in 2013.

Bringing Families Home

The Legislature established the Bringing Families Home program with $10 million General Fund, to award program funds to counties for the purpose of providing housing-related supports to eligible families experiencing homelessness. Counties that receive state funds through the Bringing Families Home Program will match that funding on a dollar-for-dollar basis.

Commercial Exploitation of Children (CSEC)

The Legislature approved an additional $12 million General Fund for the county CSEC program, bringing the annual appropriation to $47 million. This program is administered by counties and the charge to increase funding was led by the County Welfare Directors Association (CWDA).

Housing Support Program
The Legislature approved a $12 million augmentation for the Housing Support Program (HSP), bringing the 2016-17 appropriation up to $37 million. This program is administered by counties through the CalWORKs program.

Approved Relative Caregiver (ARC) Program
The Legislature made several changes to the ARC Program, including clarifying that children participating in the ARC Program should receive a $50 child support disregard. The Legislature additionally clarified that a relative who has been approved under the resource family approval process and who is federally ineligible for AFDC-FC is authorized to receive a CalWORKs grant and a supplement amount equal to the resource family basic amount paid to children who are federally eligible for AFDC-FC. The changes adopted by the Legislature also allow non-federally eligible foster youth placed with relative caregivers under the jurisdiction of the tribal court receive a foster care basic rate amount equal to payments made to federally-eligible relative caregivers in tribes that possess a Title IV-E Agreement with the state.

Adult Protective Services
The Conference Committee approved $3 million in one-time funding to create a statewide Adult Protective Services training program for county staff. CSAC had joined CWDA in calling for $5 million for this purpose; the $3 million appropriation will allow the training to be developed, which is a good start.

IN-HOME SUPPORTIVE SERVICES
Service Hours Restoration
The 2016-17 budget includes a restoration of the seven percent across-the-board IHSS service hours reduction, which costs $571.8 million in total funds. This restoration will remain in effect until the Managed Care Organization tax expires in three years pursuant to current law.

IHSS Contract Mode Language
The Department of Finance rescinded its proposed budget trailer bill language that would have negatively impacted counties that are currently in “contract mode” for IHSS services. The County Welfare Directors Association worked hard to explain that the costs for counties in contract mode – which is a very specific designation limited only to counties that contract with an outside entity to administer the local IHSS system – include both locally negotiated costs, such as wages and benefits, but also other costs, such as administration and overhead. CSAC supported these efforts.

CSAC Staff Contacts.

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524