Health and Human Services Policy Committee
CSAC Legislative Conference
Thursday, May 18 · 10:30 a.m. – 12:00 p.m.
Hyatt Regency Sacramento, Regency EF
Sacramento County, California

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Candy Carlson, Tehama County, Vice Chair

10:30 a.m.	**I.**	**Welcome and Introductions** *Supervisor Ken Yeager, Committee Chair, Santa Clara County* *Supervisor Candy Carlson, Committee Vice Chair, Tehama County*
10:35	**II.**	**HHS Legislative and Budget Update** • Update on May Revision of Governor's Budget • Update on CCI/IHSS MOE Issue *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst* *Graham Knaus, Deputy Executive Director of Operations and Member Services*
11:10	**III.**	**Federal Update** *Joe Krahn, Waterman & Associates*
11:25 a.m.	**IV.**	**Platform Update: Child Near Fatality Incidents – ACTION ITEM** *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst*
11:55 a.m.	**V.**	**Other Items**
12:00 p.m.	**VI.**	**Adjournment**
Information Only	**VII.**	**Whole Person Care Pilots Update: Initial Implementation**

ATTACHMENTS

HHS Legislative and Budget Update

Attachment One ..... CSAC Memo: HHS Legislative and Budget Update

Federal Update

Attachment Two ..... CSAC Memo: Federal Update

Attachment Three ..... Letter: Joint County AHCA Letter (April 27, 2017)

Platform Update: Child Near Fatality Incidents

Attachment Four ..... CSAC Memo: Child Near Fatality Incidents Platform Language Review

Whole Person Care Pilots Update: Initial Implementation

Attachment Five ..... CSAC Memo: Whole Person Care Pilots Update: Initial Implementation

Attachment Six ..... Overview Slides: Whole Person Care Pilot Overview (November 2016)

Attachment Seven ..... Fact Sheet: Whole Person Care Applications Statistics – Approved Pilots – First Round (November 2016)

Attachment One

Memo: HHS Legislative and Budget Update

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

May 4, 2017

To: Members of the Health and Human Services Policy Committee

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

RE: HHS Legislative and Budget Update – Information Only

The Governor's May Revision to the January Budget is anticipated to be released in the days prior to the policy committee meeting. Staff will provide the committee with an update on health and human services budget issues, as well as CSAC budget priorities, based on the May Revision.
CSAC is lobbying several HHS-related budget issues including the unwinding of the Coordinated Care Initiative (CCI) and the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE).

Coordinated Care Initiative/In-Home Supportive Services Maintenance of Effort: On January 10, 2017, the Director of the Department of Finance issued notice that the state will end the Coordinated Care Initiative (CCI) resulting in the dismantling of the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) deal enacted in 2012. For the past five years, the IHSS MOE capped counties costs in the program at a 3.5 percent annual inflator – all other program costs were shifted to the State.

The pulling of the trigger potentially shifts $623 million dollars of IHSS program costs to counties beginning July 1. IHSS is an entitlement program and these costs reflect what the county share of costs would have been absent an MOE. The increase in costs include caseload growth of 6 to 7 percent per year based on an aging population and an increase in the number of disabled children on the program as well as new state policies related to minimum wage, the implementation of federal overtime regulations, and, paid sick leave beginning in 2018. Prior to the MOE, nonfederal costs for the IHSS program were funded at 65 percent State and 35 percent County. The County share of IHSS costs has historically been funded with a combination of County General Fund and 1991 Realignment funding.

CSAC has led a coalition of County affiliates and partners to negotiate an alternative solution that would reduce the impact to counties and allow for long-term stability to County budgets and to IHSS and other programs funded by the 1991 Realignment. Staff will provide an update on this issue at the meeting.

Legislative Update: There are several important legislative deadlines coming up in the next few months as the Legislature heads towards its summer recess. May 12, the week before the Legislative Conference, is the deadline for policy committees to hear and report to the floor nonfiscal bills. Next week, May 26 is the deadline for fiscal committees to hear and report bills to the floor. June 2 is the deadline for bills to pass out of their house of origin. Any bills that fail to meet these deadlines will not proceed in the legislative process. CSAC staff is working to engage with and track bills on a wide range of issues such as homelessness, child welfare services, sober living homes, and more.

CSAC Staff Contacts:
Farrah McDaid Ting, CSAC Legislative Representative: fmcting@counties.org, (916) 327-7500 Ext. 559
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Attachment Two

Memo: Federal Update

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

May 4, 2017

To: Members of the Health and Human Services Policy Committee

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

RE: Federal Update – Information Only

After seven long years of pledging to repeal and replace the Affordable Care Act (ACA), House Republicans have made good on their promise to pass legislation dismantling the signature achievement of the Obama administration. Today's 217 to 213 vote (with all 14 CA Congressional Republicans voting yes; and, all 38 CA Congressional Democrats voting no) comes just six weeks after House GOP leaders were forced to pull their reform bill from the floor because of a lack of support from rank-and-file Republican. It illustrates the depth of partisan discord within Congress as it pertains to the future of federal health care policy. In the end, the California congressional delegation voted along party lines.

To secure the necessary support to clear the bill, GOP leaders agreed to make several changes to the legislation (HR 1628). For example, the revised measure includes amendment language that would allow states to apply for waivers that would let insurance companies charge considerably higher premiums for people with pre-existing conditions if those individuals do not maintain continuous coverage. Under the legislation, high-risk pools would be available to cover those particular costs, though most health economists have noted that high-risk pools have failed in the past.

The modified bill also would allow states to establish their own requirements for essential health benefits, beginning in 2020. Under current law, insurers must abide by a list of 10 benefits that were mandated by the ACA.

Read our joint letter of opposition, attached.

It should be noted that the changes to HR 1628 do not address California counties' underlying concerns with the repeal and replacement package, including the elimination of the Medicaid (Medi-Cal) expansion – which would take place beginning in 2020. In addition, the legislation would place a per-capita cap on federal Medicaid spending and institute a number of other changes that would make it more difficult to enroll and maintain individuals on Medi-Cal. Accordingly, if enacted, the measure would shift tens of billions of dollars in costs to counties in California.

As was the case with the initial version of HR 1628, the Congressional Budget Office (CBO) has not had the opportunity to fully evaluate the amended bill's potential effect on both the federal budget and the uninsured rate. Consequently, congressional Democrats and a number of Republicans have decried the lack of an official fiscal analysis from the nonpartisan congressional scorekeeper.

Looking ahead, the GOP reform legislation faces an uphill climb in the Senate where at least eight Republicans are opposed to various elements of HR 1628. Notably, several GOP senators from states that have expanded their Medicaid programs have expressed concerns with the House bill's rollback of the program.

Additionally, while the goal of congressional Republicans has been to design a bill that could be brought up in the Senate under the budget "reconciliation" process (which insulates legislation from the threat of a filibuster and allows a bill to advance on a simple majority vote), the House-passed measure includes provisions that could be deemed outside of the scope of reconciliation. Those particular

decisions will lie with the Senate parliamentarian, who is required to have a CBO score in hand prior to initiating a legislative review.

Attachments:
Joint County AHCA Letter. April 27, 2017.

CSAC Staff Contacts:
Cara Martinson, CSAC Legislative Representative & Federal Affairs Manager: cmartinson@counties.org, (916) 327-7500 Ext. 504
Farrah McDaid Ting, CSAC Legislative Representative: fmcting@counties.org, (916) 327-7500 Ext. 559
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Attachment Three

Letter: Joint County AHCA Letter (April 27, 2017)

CALIFORNIA STATE ASSOCIATION OF COUNTIES

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION

COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA

COUNTY MEDICAL SERVICES PROGRAM

COUNTY WELFARE DIRECTORS ASSOCIATION

March 22, 2017

Dear California Congressional Delegation:

The undersigned California county associations strongly oppose the American Health Care Act (AHCA). If enacted, the bill would shift billions of dollars in costs to counties and reverse the significant progress our state has made in providing health care coverage to millions of our residents.

Among our numerous concerns are the following:

- The bill eliminates the Medicaid expansion in 2020, which has enabled counties to cover 3.7 million new individuals in Medi-Cal;
- The measure places a per-capita cap on federal Medicaid spending, ending the federal state and county partnership that has lasted 50 years and penalizing our state's efforts to keep costs low through managed care and low provider rates;
- The legislation institutes a number of administrative changes to Medicaid that would make it more difficult to maintain health coverage;
- The AHCA eliminates the enhanced federal match California uses to ensure persons with disabilities and older Americans are able to stay in their homes with In-Home Supportive Services (IHSS); and,
- The bill ends the $90 million a year the state has received under the Prevention and Public Health Fund, which is used by local health departments to invest in public health prevention activities protecting all Californians.

Since the enactment of the Affordable Care Act, the state's uninsured rate has been cut by nearly two-thirds - - to 7.1 percent, according to the Centers for Disease Control and Prevention. Last week's Congressional Budget Office (CBO) estimate confirms our deep concern that the bill would seriously harm the residents of our state. According to CBO, over the next ten years:

- 14 million fewer individuals would be insured through Medicaid -- a reduction of roughly 17 percent relative to the number projected under current law;

- Federal contributions to Medicaid would be cut by 25 percent ($880 billion); and,
- The national safety net of public hospitals and health systems, including county systems, would be under further stress with 14 million more people uninsured next year, rising to 24 million by 2026.

Finally, the Manager's Amendment to be considered in the House Rules Committee would further erode health coverage for low income families. Providing states with the options to select a Medicaid block grant and/or require work for coverage would shift even more costs to states and increase the uninsured rate. For these reasons, we urge you to vote 'no' on the American Health Care Act.

Sincerely,

Matt Cate
Executive Director
California State Association of Counties (CSAC)

Kirsten Barlow
Executive Director
County Behavioral Health Directors Association of California (CBHDA)

Erica Murray
President and Chief Executive Officer
California Association of Public Hospitals and Health Systems (CAPH)

Frank Mecca
Executive Director
County Welfare Directors Association of California (CWDA)

Michelle Gibbons
Executive Director
County Health Executives Association of California (CHEAC)

Kari Brownstein
Administrative Officer
County Medical Services Program (CMSP)

Attachment Four

Memo: Child Near Fatality Incidents Platform Language Review

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

May 4, 2017

To: CSAC Health and Human Services Policy Committee

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

RE: Child Near Fatality Incidents Platform Language Review – ACTION ITEM

Background. At the end of each two-year legislative session, CSAC undertakes a policy platform review process. Following CSAC staff's solicitation of comments from counties and members of the HHS Policy Committee in October 2016, staff presented an initial draft of the policy platform chapters on health, human services, and realignment to the committee at its November 29, 2016, meeting. However, the election of President Trump required the committee to more closely examine federal portions of the proposed platform, particularly the section on the Affordable Care Act. Additionally, at the 2016 Annual Meeting, Yolo County Supervisor Matt Rexroad requested that language be added to the Human Services chapter of the Policy Platform to address the need for transparency in child near fatality incidents.

Based on the HHS Policy Committee's feedback at Annual Meeting, CSAC staff undertook additional rounds of edits to better reflect the federal uncertainty regarding the Affordable Care Act (ACA), the unwinding of the Coordinated Care Initiative and In-Home Supportive Services Maintenance of Effort, as well as other comments received. During its February Board Meeting, the CSAC Board of Directors voted to approve the Health and Realignment Chapters as approved by the HHS Policy Committee on February 8. However, after a lengthy discussion around 2 proposals for language on child fatality and near fatality incidents, the Board ultimately voted to approve the Human Services Chapter without the language on child fatality and near fatality incidents. The Board additionally voted to have the language on child near fatality incidents be brought back to the HHS Policy Committee and the Board of Directors.

Proposed Language. The language before the HHS Policy Committee today is the same language that the HHS Policy Committee approved at its February 8 meeting. The Policy Committee had previously considered language on this issue at it January 2017 meeting, however due to technical issues, it was not possible to take a vote at that time and the issue was pushed back to the February 8 meeting. Staff worked with County Counsels and the County Welfare Directors Association to reach the compromise language below:

> *When a child who has been left with a family that has been subject to a report of abuse and neglect dies or nearly dies, the best course is to try and learn what, if anything, could be improved in county operations and policies so that children in the future do not suffer similar fates. As an important part of this effort, counties support transparency related to child deaths and near deaths that occurred because of abuse and neglect, so long as all identifying information is redacted from the documents that are released.*

Under this language, CSAC would support the release of appropriately redacted portions of a juvenile case file that are germane to understanding how a foster child's fatality or near fatality occurred. The focus on documents that are germane to a foster child's death or near death helps counties and the public understand how the tragic event occurred, but would also protect counties against potential

liability for violations of privacy that may arise from including documents that are not related to how the event occurred.

Process. In response to the motion approved by the CSAC Board of Directors in March, staff has brought this issue back to the HHS Policy Committee for consideration. If language is approved by the HHS policy committee, these changes will be submitted to the CSAC Board of Directors for approval during their May 18 meeting. We wish to thank each of the supervisors, county affiliate organizations, and county staff who reviewed the proposed changes and suggested additional clarifications throughout this process.

Staff Recommendation:
Staff recommends adopting the language as previously approved by the HHS Policy Committee.

CSAC Staff Contacts:
Farrah McDaid Ting, CSAC Legislative Representative: fmcting@counties.org, (916) 327-7500 Ext. 559
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Attachment Five

Memo: Whole Person Care Pilots Update: Initial Implementation

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

May 4, 2017

To: Members of the Health and Human Services Policy Committee

From: Elizabeth Marsolais, Legislative Analyst

RE: Whole Person Care Pilots Update: Initial Implementation – Information Only

Background. The Whole Person Care Pilot Programs are intended to coordinate the health, behavioral health, and social services in a patient-centered manner, while aiming to improve beneficiary health and well-being through more efficient and effective use of resources. Entities eligible to participate in Whole Person Care are a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region of more than one county, or a health authority. The Whole Person Care Pilot entities will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

Current Status. After completing a first round Whole Person Care application process, the Department of Health Care Services (DHCS) approved 18 lead entities to operate Whole Person Care pilots. The list of pilots that were approved in the first round is included as an attachment.

In January 2017, DHCS announced a second round of the Whole Person Care application process with applications due on March 1, 2017. As the second round of applicants waits to hear back from DHCS, the pilots approved in the first round of applications are beginning to be implemented.

Next Steps. Currently, DHCS is reviewing applications, and may send written questions to applicants as necessary. Applicants' written responses will be sent to DHCS and reviewed. DHCS will make final decisions and notify the second round of applications on July 2, 2017. The Whole Person Care Lead Entities must then provide formal acceptance to DHCS.

Attachments.
Whole Person Care Pilot Overview. November 2016.
Whole Person Care Applications Statistics – Approved Pilots – First Round. November 2016.

CSAC Staff Contacts:
Farrah McDaid Ting, CSAC Legislative Representative: fmcting@counties.org, (916) 327-7500 Ext. 559
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Attachment Six

Overview Slides: Whole Person Care Pilot Overview (November 2016)

Whole Person Care Program

Medi-Cal 2020 Waiver Initiative

California Department of Health Care Services

November 2016

Program Overview

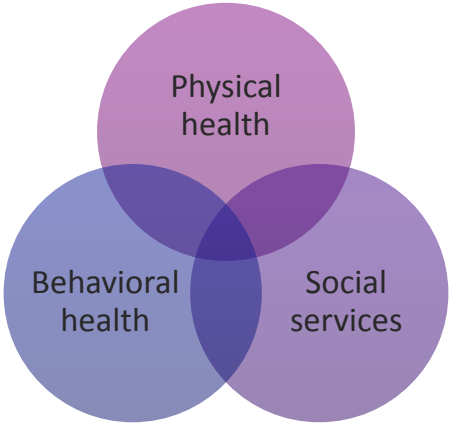
Whole Person Care Overview

Overarching goal for Whole Person Care (WPC)

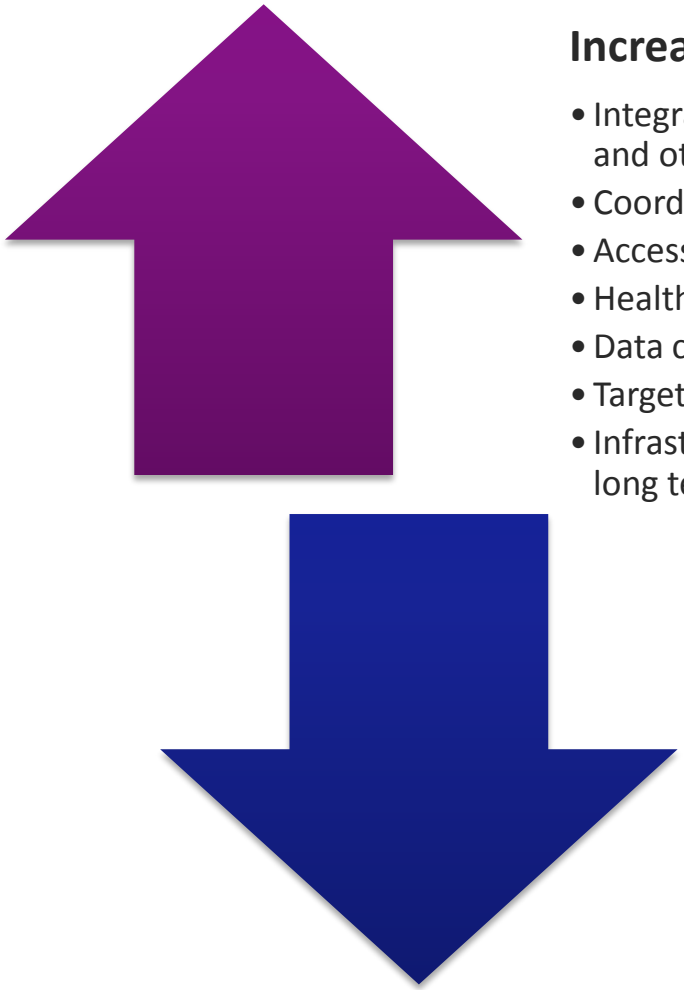
- Coordination of health, behavioral health, and social services
- Comprehensive coordinated care for the beneficiary resulting in better health outcomes

WPC Pilot entities collaboratively to:

- Identify target populations
- Share data between systems
- Coordinate care real time
- Evaluate individual and population progress



Goals and Strategies



Increase, improve, and achieve:

- Integration among county agencies, health plans, providers, and other participating entities
- Coordination and appropriate access to care
- Access to housing and supportive services
- Health outcomes for the WPC population
- Data collection and sharing among local entities
- Targeted quality and administrative improvement benchmarks
- Infrastructure that will ensure local collaboration over the long term

Reduce:

- Inappropriate emergency department and inpatient utilization

WPC by Numbers

5 year program

$1.5B total federal funds

$300M annual available

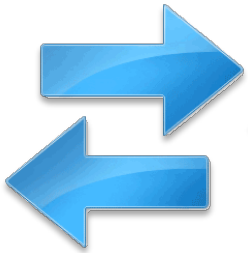
2 application rounds

18 applicants for Round 1

Funding

No single WPC pilot will be awarded more than 30% of total available funding unless additional funds are available after all initial awards are made

Funding is based on semi-annual reporting of activities/interventions



Non-federal share provided via intergovernmental transfer (IGT), matched with federal Medicaid funding

Lead Entities

Lead Entities

- County
- A city and county
- A health or hospital authority
- A designated public hospital
- A district/municipal public hospital
- A federally recognized tribe
- A tribal health program under a Public Law 93-638 contract with the federal Indian Health Services
- A consortium of any of the above entities

Lead Entity Responsibilities

- Submits Letter of Intent and application
- Serves as the contact point for DHCS
- Coordinates WPC pilot
- Collaborates with participating entities

Participating Entities

Participating Entities	Participating Entity Responsibilities
• (1) Medi-Cal managed care health plan • (1) Health services agency/department • (1) Specialty mental health agency/department • (1) Public agency/department • (2) Community partners	• Collaborates with the lead entity to design and implement the WPC pilot • Provides letters of participation • Contributes to data sharing/reporting

Relationships Between Entities

WPC Goals for Participating Entities

- Increase integration among county agencies, health plans, providers, and other entities within the county that serve high-risk, high-utilizing beneficiaries
- Develop infrastructure to ensure collaboration among the participating entities over the long term

Requirements

- Lead entities indicate in the application who the participating entities will be.
- DHCS encourages a collaborative approach.
- Only one Medi-Cal managed care plan is required to participate, but DHCS encourages including multiple plans.
- Medi-Cal managed care plan participation must include the plan's entire network (i.e., where delegation of risk has occurred to an entity in the plan's network).
  - Specific exclusions and exceptions may be considered on a case-by-case basis.
- Lead Entities cannot also be one of the two required community partners.

Target Populations

Identifying target population(s)

- WPC pilots identify high-risk, high-utilizing Medi-Cal beneficiaries in their geographic area.
- Pilots work with participating entities to determine the best target population(s) and areas of need.

Target population(s) may include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g., hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.)

May also include the following populations with certain caveats:

- Individuals not enrolled in Medi-Cal, but federal funding is not available for them
- Dual-eligible beneficiaries, but must coordinate with the Coordinated Care Initiative where applicable

Program Structure

Administrative Infrastructure

Description

- Builds the programmatic supports necessary to plan, build and run the pilot

Examples

- Core program development and support
- Staffing
- IT infrastructure
- Program governance
- Training
- Ongoing data collection
- Marketing materials

Delivery Infrastructure

Description

- Supports the non-administrative infrastructure needed to implement the pilot

Examples

- Advanced medical home
- Mobile street team infrastructure
- Community paramedicine team
- Community resource database
- IT workgroup
- Care management tracking and reporting portal

Payment Mechanisms

PMPM Bundle	FFS Items
• One or more services and/or activities that would be delivered as a set value to a defined population • Examples: Comprehensive complex care management, housing support services, mobile outreach and engagement bundle, long-term care diversion bundle	• Single per-encounter payments for a discrete service • Examples: Mobile clinic visit, housing transition services, medical respite, transportation, sobering center, care coordination

Performance Measures

Objective

- To assess the success of the Pilot in achieving the WPC goals and strategies

Reporting requirements

- All WPC Pilots must report initial baseline and subsequent year data on universal and variant metrics as outlined in Attachment MM of the Special Terms & Conditions (STCs)

Performance Measures

Health Outcomes Universal Metrics

- Ambulatory Care - Emergency Department Visits
- Inpatient Utilization - General Hospital/Acute Care
- Follow-up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Health Outcomes Variant Metrics, as applicable

- 30 day All Cause Readmissions
- Decrease Jail Recidivism
- Overall Beneficiary Health
- Controlling Blood Pressure
- HbA1c Poor Control <8%
- Depression Remission at Twelve Months
- Adult Major Depression Disorder (MDD): Suicide Risk Assessment

Housing Variant Metrics, as applicable

- Percent of homeless who are permanently housed for greater than 6 months
- Percent of homeless receiving housing services in PY that were referred for housing services
- Percent of homeless referred for supportive housing who receive supportive housing

Pilot-identified Pay for Outcome metrics, other than required universal and variant metrics

Summary of First Round Applications

First Round Applications

Counties with < 1,000 sq. mi. (7)	Counties between 1,001 – 3,000 sq. mi. (4)	Counties between 3,001 – 5,000 sq. mi. (4)	Counties with > 5,000 sq. mi. (3)
Alameda	Santa Clara	Los Angeles	Kern
Contra Costa	San Joaquin	Monterey	Riverside
Napa	Placer	San Diego	
Orange	Ventura	Shasta	
San Francisco			
San Mateo			
Solano			

Pilot Size

Larger: Over 100,000	Large: Between 10,000 and 100,000	Medium: Between 1,000 and 5,000	Small: Between 250 and 800
Los Angeles	Alameda	Kern	Monterey
	Contra Costa	Orange	Napa
	Riverside	San Diego	Placer
	Santa Clara	San Joaquin	Shasta
	San Francisco	San Mateo	Solano
		Ventura	

Target Population Selection

Target Population Criteria	# of Pilots that Selected this Target Population
1. High utilizers with repeated incidents of avoidable ED use, hospital admissions or nursing facility placement	15 Pilots
2. High utilizers with two or more chronic conditions	3 Pilots
3. Individuals with mental health and/or substance use disorder conditions	8 Pilots
4. Individuals who are homeless/at-risk for homelessness	14 Pilots
5. Individuals recently released from institutions (i.e., hospital, county jail, IMD, skilled nursing facility, etc.)	7 Pilots

Care Coordination Strategies

Navigation infrastructure (13 Pilots)	Standard Assessment Tool (9 Pilots)	Data sharing systems (9 Pilots)
Social determinants strategies (7 Pilots)	Data-driven algorithms (4 Pilots)	Prioritization of highest needs if on a waiting list (3 Pilots)

Data and Information Sharing

Expansion of existing data sharing framework (18 Pilots)	Bi-directional data sharing with MCPs (18 Pilots)	Health Information Exchange (12 Pilots)
Patient population software (11 Pilots)	Data warehouse (9 Pilots)	Query-based real-time data (7 Pilots)
Case management software (7 Pilots)	Real-time data sharing (6 Pilots)	New data sharing systems (3 Pilots)

Services and Interventions

Care Management (15 Pilots)	Wellness and Education (9 Pilots)	Housing Services (11 Pilots)
Flexible Housing Pool (17 Pilots)	Post-Incarceration Services (4 Pilots)	Mental Health (6 Pilots)
Mobile Services (4 Pilots)	Respite Services (4 Pilots)	Sobering Centers (4 Pilots)

Resources

Visit the Whole Person Care webpage:

- http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilo

Submit questions/sign up for the listserv:

- 1115WholePersonCare@dhcs.ca.gov

Attachment Seven

Fact Sheet: Whole Person Care Applications Statistics – Approved Pilots – First Round (November 2016)

Whole Person Care Pilot

Lead Entity	Estimated 5-year Beneficiary Count	Total 5-Year Budget
Alameda County Health Care Services Agency	20,000	$283,453,400
Contra Costa Health Services	52,500	$203,958,160
Kern Medical Center	2,000	$157,346,500
Los Angeles County Department of Health Services	137,700	$900,000,000
Monterey County Health Department	500	$26,834,630
Napa County	800	$22,686,030
County of Orange Health Care Agency	8,098	$23,500,000
Placer County Health and Human Services Department	450	$20,126,290
Riverside University Health System - Behavioral Health	38,000	$35,386,995
San Bernardino County - Arrowhead Regional Medical Center	2,000	$24,537,000
County of San Diego, Health and Human Services Agency	1,049	$43,619,950
San Francisco Department of Public Health	10,720	$118,000,000
San Joaquin County Health Care Services Agency	2,130	$17,500,000
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	10,000	$225,715,295
Shasta County Health and Human Services Agency	600	$19,403,550
Solano County Health & Social Services	250	$4,667,010
Ventura County Health Care Agency	2,000	$97,837,690

Health and Human Services Policy Committee

Thursday, May 18 ▪ 10:30 a.m. – 12:00 p.m.
Regency E ▪ Hyatt Regency
1209 L Street ▪ Sacramento, CA

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Candy Carlson, Tehama County, Vice Chair

Note: This policy committee meeting is an in-person meeting only and is being held as part of the CSAC 2017 Legislative Conference.

10:30 a.m.	**I.**	**Welcome and Introductions** *Supervisor Ken Yeager, Committee Chair, Santa Clara County* *Supervisor Candy Carlson, Committee Vice Chair, Tehama County*
10:35 – 11:10 a.m. **ACTION ITEM**	**II.**	**Governor's Proposal to End CCI and New County Maintenance of Effort** • Update on May Revision of Governor's Budget • Update on CCI/IHSS MOE Issue *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst* *Graham Knaus, Deputy Executive Director of Operations and Member Services*
11:15 – 11:25 a.m.	**III.**	**Federal Update** *Joe Krahn, Waterman & Associates*
11:25 a.m. – 11:55 a.m. **ACTION ITEM**	**IV.**	**Platform Update: Child Near Fatality Incidents** *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst*
11:55 a.m. – 12:00 p.m.	**V.**	**Other Items**
12:00 p.m.	**VI.**	**Adjournment**
Information Only	**VII.**	**Whole Person Care Pilots Update: Initial Implementation**

Supplement 1

Memo: Governor's Proposal Regarding In-Home Supportive Services and County Maintenance of Effort – ACTION ITEM

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

May 16, 2017 **SUPPLEMENTAL MEMO #1: NEW ACTION ITEM**

To: Members of the Health and Human Services Policy Committee

From: Graham Knaus, Deputy Executive Director for Operations and Member Services
Farrah McDaid Ting, CSAC Legislative Representative
Elizabeth Marsolais, CSAC Legislative Analyst

RE: Governor's Proposal Regarding In Home Supportive Services and County Maintenance of Effort – ACTION ITEM

The May Revision Budget proposal related to In Home Supportive Services (IHSS) and the county share of IHSS costs is before the Health and Human Services Policy Committee for a recommendation to the Board of Directors immediately following such review.

Staff Recommendation: Approve a SUPPORT position for the IHSS proposal within the May Revision, as it initially protects county general funding to the greatest extent possible, but caution that counties hold significant concerns with the out-year fiscal impact of the overall framework. Further, direct staff to continue to work with the Administration and stakeholders to draft Trailer Bill Language implementing the May Revision proposal to best protect counties.

Background. The May Revision Budget included a series of new proposals related to the end of the Coordinated Care Initiative (CCI) and a new framework for the county share of IHSS costs. Counties note that the proposal within the May Revision Budget reflects a significant improvement over the January Budget in which the Department of Finance notified Californians of the end of the CCI and the statutorily required shift of $623 million in new In Home Supportive Services (IHSS) costs to counties.

The May Revision updates the estimates of new IHSS costs to $592.2 million in 2017-18. It also proposes directing State General Fund dollars – $400 million in the first year and $1.1 billion over four years – toward IHSS program costs. The May Revision also proposes the following:

- Creating a new county IHSS maintenance of effort (MOE).
- In year one (2017-18), the MOE inflation rate would be zero percent. It would rise to five percent in year two (2018-19), and then seven percent in year three (2019-20) and beyond.
- The MOE inflator includes a mechanism to reduce the inflator in years in which 1991 Realignment revenues do not perform. For years with no revenue growth, the inflator would be zero; for years in which growth is between .01 and 2 percent, the inflator would be cut in half.
- Redirect all 1991 Realignment sales tax and Vehicle License Fee (VLF) growth funding over the next three years, and then half of these revenues in years four and five, to further offset IHSS costs. This redirection would preserve existing base funding for Health and Mental Health services but impact growth, and future base amounts, over the next five years. The proposal also includes redirecting the VLF growth supporting the County Medical Services Program (CMSP), which would be used to mitigate impacts in the 35 CMSP counties, including many of the smallest counties in the state.

- Institute an annually adjusted cap on funding for local IHSS Administration (IHSS social workers) and activities related to determining eligibility for the program.

- Return wage and benefit bargaining for IHSS providers to all counties, with adjustments to local bargaining that include increases to the current state participation cap on wages and benefits of $12.10 and language to allow an appeal to the Public Employees Relations Board in any county without a completed bargaining agreement within nine months. The state wage participation cap would "float" $1.10 over the state minimum wage and the state would also participate in 65 percent of the costs of locally-negotiated wages up to a 10 percent increase over three years.

While there are numerous provisions and complexities within this proposal, the result of this plan would be a significantly reduced overall county contribution for IHSS costs in 2017-18 and 2018-19 compared to the January budget. It also protects county general funds to the greatest extent possible during the first two years.

Mitigations
The May Revision proposal also contains several mitigations and policies designed to relieve fiscal pressure on counties as a result of redirecting 1991 Realignment growth funding. They include:

- Changing how counties are reimbursed for IHSS administrative costs from a lengthy accrual process to a month-by-month payment schedule, which would ensure that counties are reimbursed for IHSS activities in a timely manner.

- Holding counties harmless from any impacts related to the Board of Equalization (BOE) error in allocating Proposition 172, 1991 Realignment, and 2011 Realignment revenues to counties through fiscal year 2015-16. The estimated value of this forgiveness ranges from $100 to $300 million.

- Suspending county responsibility for a statutory 3.5 percent annual increase in Institutions for Mental Disease (IMD) rates in any year in which the Mental Health Subaccount does not receive its full growth allocation.

- For counties that may experience a financial hardship under this proposal, the Department og Finance would entertain an individual low-interest loan on a case-by-case basis. All elements of these loans – their structure, timeline, and required documentation – have yet to be developed.

- The May Revision language referenced the Administration's willingness to continue the dialogue with counties and stakeholders about the costs of the IHSS program and how best to fund this important state program. The Administration has verbally committed to a "look back" provision after two years, meaning that the framework could be reopened at that time.

These mitigations, coupled with the Governor's ongoing contribution of State General Fund toward IHSS costs, will assist counties in navigating the cost pressures imposed by the IHSS program over the next two years.

Out-Year Sustainability Concerns
Despite the Governor's ongoing commitment of state General Fund dollars and the mitigations above, counties retain significant concerns with the proposed high annual increase in the county MOE starting in 2019-20.

While a new MOE offers predictability to counties, the seven percent inflator starting in year three is not sustainable for counties. A seven percent annual increase in costs would not only exhaust all available 1991 Realignment revenues, but would force counties to cut vital health, mental health, and social services programming, as well as programs funded by county general funding, such as critical public safety programs.

The Administration's commitment to a "reopener" provision after two years is critical to counties' evaluation of the proposal.

Economic and Policy Uncertainties
Counties, like Governor Brown, are also keenly aware of the significant uncertainties that exist in the world today. California and its counties are facing a raft of fiscal unknowns in the coming years, including a precarious economy and instability at the federal level. These uncertainties increase the fiscal risks to counties within the limited 1991 Realignment revenue structure. Further, the IHSS program is growing rapidly due to demographic and policy changes. Within this context, counties strongly support the Governor's desire to find an equitable solution for IHSS costs, but remain concerned about the out-year ramifications of the May Revision proposal.

Again, the "reopener" provision after two years remains a critical component of the proposal.

Relevant CSAC Platform Language
The CSAC Platform was amended in 2012 when the CCI MOE was first authorized in statute. Below is the excerpt of the current IHSS section, which begins with an overview and concludes with specific policy direction related to the IHSS MOE:

2017-18 CSAC Platform
Human Services: 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.*
>
> *County social workers evaluate prospective and ongoing IHSS recipients, who may receive assistance with such tasks as housecleaning, meal preparation, laundry, grocery shopping, personal care services such as bathing, paramedical services, and accompaniment to medical appointments. Once a recipient is authorized for service hours, the recipient is responsible for hiring his or her provider.*
>
> *Although the recipient is considered the employer for purpose of hiring, supervising, and firing their provider, state law requires counties to establish an "employer of record" for purposes of collective bargaining to set provider wages and benefits.*

However, costs and caseloads for the program continue to grow. According to the Department of Social Services, caseloads are projected to increase between five and seven percent annually going forward.

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

2) Counties support the MOE as negotiated in the 2012-13 state budget and will oppose any proposals to change the MOE as outlined in statue.

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

The current CSAC Platform language above specifically addresses the county position regarding any IHSS cost shift to counties, changes to the IHSS MOE, and the transfer of collective bargaining to the state.

Regarding the first point (#1), the May Revision proposal does continue state and federal funding for the IHSS program. The January Budget had indicated a $623 million cost shift to counties, which has been reduced to $592 million in year one. Further, the state is committing $1.1 billion in state general fund contributions to mitigate the cost shift to counties over the next four years, including an ongoing state general fund contribution into future years. The $1.1 billion is allocated as follows:

- Year One -- $400 million
- Year Two -- $330 million
- Year Three -- $200 million
- Year Four & Every Year Thereafter -- $150 million.

Regarding the second point (#2), CSAC, along with county stakeholders, strongly opposed the elimination of the CCI, lobbying on behalf of the CCI for the last four years. When, in January, the Department of Finance notified Californians that the CCI "trigger" was pulled and the program, along with the county MOE, would no longer be operable, CSAC undertook efforts to identify all legal, legislative, and administrative relief.

CSAC President Keith Carson, of Alameda County, received a personal commitment from the Governor to elevate the IHSS MOE and county funding concerns as a top budgetary issue in March. Since that time, CSAC has worked with Department of Finance staff to outline the county concerns and data, and arrive at a workable multi-year framework that recreates the county MOE, providing counties with predictability and stability. The initial phases of the MOE framework achieve the current platform policy directive, but, as has been extensively noted, the out years continue to be problematic.

Regarding the third point (#3), CSAC joined with the Service Employees International Union (SEIU), United Domestic Workers (UDW), and the American Federation of State, County, and Municipal Employees (AFSCME) in support of returning collective bargaining for all 58 counties to the state. The current Governor has rejected this proposal, but CSAC will continue to collaborate with labor stakeholders on future efforts for statewide bargaining.

Given the complexities of this issue and the political climate, CSAC staff recommends that policy committee members consider the following:

- The May Revision proposal contains a significant state General Fund contribution to IHSS costs, especially in the first two years, and ongoing contributions in the future.
- The proposal includes a raft of mitigations to assist counties with the temporary reduction of 1991 Realignment growth funding.
- The proposal includes a "look back" or "reopener" at year two to respond to future fiscal realities and potential economic or federal changes.
- The proposal creates a county MOE and provides for predictability as counties navigate growing IHSS costs.
- Counties will work with the state and other stakeholders to examine the IHSS program as a whole and potentially recommend changes that will ensure a sustainable safety net program for years to come.

Staff Recommendation: Approve a SUPPORT position for the IHSS proposal within the May Revision, as it includes a MOE and initially protects county general funding to the greatest extent possible, but caution that counties hold significant concerns with the out-year fiscal impact of the overall framework. Further, direct staff to continue to work with the Administration and stakeholders to draft Trailer Bill Language implementing the May Revision proposal.

Materials:

CSAC Human Services Platform:
http://www.counties.org/sites/main/files/file-attachments/human_services_2-28-17.pdf
(IHSS language begins at the bottom of page 7)

CSAC Staff Contacts:
Graham Knaus, Deputy Executive Director, Operations and Member Services: gknaus@counties.org, (916) 327-7500 Ext. 545
Farrah McDaid Ting, CSAC Legislative Representative: fmcting@counties.org, (916) 327-7500 Ext. 559
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Chapter Twelve

Human Services

Section 1: General Principles

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

Inadequate funding for program costs strains the ability of counties to meet accountability standards and 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 and additional federal funding to help maintain service levels and access for the state's neediest residents. Counties are straining to provide services to the burgeoning numbers of families in distress. With each downturn in the economy, counties report 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.

Counties support health care reform efforts to expand access to affordable, quality healthcare for all California residents, including the full implementation of the federal Patient Protection and Affordable Care Act of 2010 (ACA) and the expansion of coverage to the fullest extent allowed under federal law. Health care eligibility and enrollment functions must build on existing local infrastructure and processes and remain as accessible as possible. Counties are required by law to administer eligibility and enrollment functions for Medi-Cal, and recognize that many of the new enrollees under the ACA may also participate in other human services programs. For this reason, counties support the continued role of counties in Medi-Cal eligibility, enrollment, and retention functions. The state should fully fund county costs for the administration of the Medi-Cal program, and consult with counties on all policy, operational, and technological changes in the administration of the program. Further, enhanced data matching and case management of these enrollees must include adequate funding and be administered at the local level.

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.

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.

2) Counties also support providing services for indigents at the local level. However, the state should assume the principal fiscal responsibility for administering programs such as General Assistance. The structure of federal and state programs must not shift costs or clients to county-level programs without full reimbursement.

Section 2: Human Services Funding Deficit

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

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

Section 3: Child Welfare Services/Foster Care

A child deserves to grow up in an environment that is healthy, safe, and nurturing. To meet this goal, families and caregivers should have access to public and private services that are comprehensive and collaborative. Further, recent 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 mid--1980's. Since that time, dramatic changes in child welfare policy have occurred, as well as significant demographic and societal changes, impacting the workload demands of the current system. 2011 Realignment provides a mechanism that will help meet the some of the current needs of the child welfare services system, but existing workload demands and regulations 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 under AB 403, the Continuum of Care Reform. Providing stable family homes for all of our foster and probation youth is anticipated to lead to better outcomes for those youth and our communities. However, funding for this massive post-2011 Realignment system change is of paramount

importance. Any reform efforts must also consider issues related to collaboration, capacity, and funding. County efforts to recruit, support, and retain foster family homes and provide pathways to mental health support are but some of the challenges under AB 403. Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.

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.

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

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

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

4) 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.

5) Counties also support adequate state funding for adoption services.

6) 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.

7) 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.

8) 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.

9) As our focus remains on the preservation and empowerment of families, we believe the potential for the public to fear some increased risk to children is outweighed by the positive effects of a research-supported family preservation emphasis. Within the family preservation and support services approach, the best interest of the child should always be the first consideration. Counties support transparency related to child fatality and near-fatality incidents so long as it preserves the privacy of the child and additional individuals who may reside in a setting but were not involved or liable for any incidents. The Temporary Assistance for Needy Families (TANF) and California Work Opportunity and Responsibility to Kids (CalWORKs) programs allow counties to take care of children regardless of the status of parents.

Section 4: 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), 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.

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

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

6) Welfare-to-work efforts should focus on prevention of the factors that lead to poverty and welfare dependency including unemployment, underemployment, a lack of educational opportunities, food security issues, and housing problems. Prevention efforts should also acknowledge the responsibility of absent parents by improving efforts for absent parent location, paternity establishment, child support award establishment, and the timely collection of child support.

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

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

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

Section 5: 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. Counties support maximizing federal funding for child support operations at the county level.

1) The way in which child support enforcement funding is structured prevents many counties from 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.

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 10: The First Five Commissions

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

1) Local children and families commissions (First 5 Commissions), established as a result of the passage of Proposition 10, must maintain the full discretion to determine the use of their share of funds generated by Proposition 10.

2) Local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate 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.

3) Counties oppose any effort to lower or eliminate state support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues.

Section 7: Realignment

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

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

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

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

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

Section 8: 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

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 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.

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.

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. Counties must retain local flexibility in meeting the needs of our aging population, and timely response by local APS is critical, as studies show that elder abuse victims are 3.1 times more likely to die prematurely than the average senior.

1) Counties support 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.

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

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

However, costs and caseloads for the program continue to grow. According to the Department of Social Services, caseloads are projected to increase between five and seven percent annually going forward.

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

2) Counties support the MOE as negotiated in the 2012-13 state budget and will oppose any proposals to change the MOE as outlined in statue.

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

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.

Supplement 2

Memo: Child Near-Fatality Incidents Platform Language Review – ACTION ITEM

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327.7500
Facsimile
916.441.5507

May 16, 2017 **UPDATED MEMO**

To: CSAC Health and Human Services Policy Committee

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

RE: Child Near-Fatality Incidents Platform Language Review – ACTION ITEM

Staff Recommendation. Staff recommends adopting the language as previously approved by the HHS Policy Committee. This language would allow CSAC to engage on legislation related to child fatality and near-fatality incidents to ensure transparency, and ultimately, the health and safety of all children within the Child Welfare Services system.

Background. At the end of each two-year legislative session, CSAC undertakes a policy platform review process. Following CSAC staff's solicitation of comments from counties and members of the HHS Policy Committee in October 2016, staff presented an initial draft of the policy platform chapters on health, human services, and realignment to the committee at its November 29, 2016, meeting. However, the Committee undertook a closer examination of the federal portions of the proposed platform in the wake of the federal election, particularly the section on the Affordable Care Act. Additionally, at that initial meeting in late November, Yolo County Supervisor Matt Rexroad requested that language be added to the Human Services chapter of the Policy Platform related to the always tragic situations of child fatality and near-fatality within county Child Welfare Services systems.

Based on the HHS Policy Committee's feedback in November and a subsequent truncated conference call in January, CSAC staff undertook additional rounds of edits to better reflect Supervisor Rexroad's suggestions on the child fatality and near-fatality incidents. After consulting with the County Counsels Association of California, CSAC staff presented a modified child near-fatality paragraph to the policy committee on February 8. The staff version was approved by the committee and forwarded to the CSAC Board of Directors.

During its February Board Meeting, the CSAC Board voted to approve the Health and Realignment Chapters as approved by the HHS Policy Committee on February 8. However, after a lengthy discussion regarding the child fatality and near fatality incident language, the Board ultimately voted to approve the Human Services Chapter without the suggested language on child fatality and near fatality incidents. The Board additionally voted to re-refer the language on child near fatality incidents to the HHS Policy Committee for continued discussion and approval.

Proposed Language. The language before the HHS Policy Committee at this meeting is identical to the language approved by the HHS Policy Committee in February, as directed by the Board. The underlined portion represents the proposed addition to existing CSAC Platform language:

> *When a child who has been left with a family that has been subject to a report of abuse and neglect dies or nearly dies, the best course is to try and learn what, if anything, could be improved in county operations and policies so that children in the future do not suffer similar fates. <u>As an important part of this effort, counties support transparency related to child deaths and near deaths that occurred because of abuse and neglect, so long as all identifying information is redacted from the documents that are released.</u>*

The language above, would allow CSAC to support the release of appropriately redacted portions of a juvenile case file that are germane to understanding how a foster child's fatality or near fatality occurred. The focus on documents that are germane to a foster child's death or near-death helps counties and the public understand how the tragic event occurred, but would also protect counties against potential liability for violations of privacy that may arise from including documents or individuals, both adult and minor, that are not related to the event at the focus of the investigation.

Supervisor Rexroad has communicated a keen interest in both transparency and accountability within the county Child Welfare Services system. To that end, he has offered the following language that builds on the previous example for review and discussion by the HHS Policy Committee. His specific suggestion is underlined :

> *When a child who has been left with a family that has been subject to a report of abuse and neglect dies or nearly dies, the best course is to try and learn what, if anything, could be improved in county operations and policies so that children in the future do not suffer similar fates. As an important part of this effort, counties support transparency related to child deaths and near deaths that occurred because of abuse and neglect and, specifically, at minimum support the release of original documents in case files so the public and stakeholders can be engaged in the important task of protecting children, and to ensure maximum accountability for counties in such life and death matters, so long as all identifying information is redacted from the documents that are released.*

Process. In response to the CSAC Board of Directors' action in February, staff has brought the proposed platform language back to the HHS Policy Committee for consideration. Once language on this issue is approved by the HHS policy committee, these changes will be submitted to the CSAC Board of Directors for approval during their next scheduled meeting. We wish to thank each of the supervisors, county affiliate organizations, and county staff who reviewed the proposed changes and suggested additional clarifications throughout this process.

Staff Recommendation. Staff recommends adopting the language as previously approved by the HHS Policy Committee. This language would allow CSAC to engage on legislation related to child fatality and near-fatality incidents to ensure transparency, and ultimately, the health and safety of all children within the Child Welfare Services system.

CSAC Staff Contacts:
Farrah McDaid Ting, CSAC Legislative Representative: fmcting@counties.org, (916) 327-7500 Ext. 559
Jennifer Henning, CSAC Counsel and Litigation Coordination: jhenning@counties.org, (916) 327-7535
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524